

State of Hawaii  
Department of Health  
Adult Mental Health Division

# **Addendum Number 1**

**September 15, 2006**

**To**

**Request for Proposals**

**RFP No. HTH 420-1-07**  
**Community-Based Case Management**  
August 23, 2006

September 15, 2006

**ADDENDUM NO. 1**

To

**REQUEST FOR PROPOSALS  
Community-Based Case Management  
RFP No. HTH 420-1-07**

The Department of Health, Adult Mental Health Division, is issuing this addendum to RFP Number HTH 420-1-07, Community-Based Case Management for the purposes of:

- Responding to questions that arose at the orientation meeting of August 31, 2006, and written questions subsequently submitted in accordance with Section 1-V, of the RFP.
- Amending the RFP.
- Final Revised Proposals

The proposal submittal deadline:

- is amended to September 29, 2006.
- is not amended.
- for Final Revised Proposals is <date>.

Attached is (are):

- A summary of the questions raised and responses for purposes of clarification of the RFP requirements.
- Amendments to the RFP.
- Details of the request for final revised proposals.

If you have any questions, contact:

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Responses to Question Raised by Applicants  
For RFP No. HTH 420-1-07 Community-Based Case Management

**1. Question:**

Who defines what qualifies for CEU's and who determines if CEU's qualifies provider?

**Answer:**

The case management agency will be required to document the frequency and type of continuing education units completed by each case manager annually. The content of the continuing education requirements shall enhance the case managers' and team leaders' skills and knowledge in the provision of services. Due to the variety of topics available, and the Division's inability to predict what may be offered by the Division or other organizations in the future, a specific listing of required courses is not available. Rather, it is each provider's responsibility to ensure that the type of training received by staff is pertinent to their clinical and professional growth and applicable to the provision of case management services to the severely and persistently mentally ill (SPMI) population. Examples of topics which would be appropriate include, but are not limited to, psychiatric illnesses and treatments, engagement strategies and motivational techniques, co-occurring disorders, and medical co-morbidities. Examples of topics which would not be appropriate for CEU credits include, but are not limited to, trainings exclusively on billing codes or other billing issues. These lists are intended as a general guide as to appropriate CEU topics and are not exhaustive in nature due to the vast number of training topics which may be pertinent and available to case managers. Case Management agencies are encouraged to use their best judgment in monitoring the quality of the trainings completed by case managers which would be appropriate to meet this requirement in order to tailor the trainings to the specific needs of the individual or organization.

**2. Question:**

What is the incentive to get continuing education units if the contract is awarded annually with no guarantee of renewal?

**Answer:**

The continuing education requirement was established to ensure that case managers and Team Leaders are provided adequate training and educational support to remain current on national Best Practices, therapeutic approaches and additional issues or information which may assist them with the provision of services. It is essential that case managers and Team Leaders keep abreast of

these pertinent topics and have access to necessary trainings to continue to provide quality services and to enhance their professional development. In this regard, there are clear incentives for agencies to support case managers in their pursuit of continuing education units to ensure ongoing quality of services and positive outcomes for consumers. From a strictly administrative stand point, although the initial term of the contract is one year, fulfilling the continuing education units throughout the course of the year will ensure contract adherence in the event that additional extensions are available.

**3. Question:**

Since there is a requirement for an implementation plan, do the case-by-case exceptions or based on special circumstances exceptions have to be defined? At the point of proposal or when the contract is awarded?

**Answer:**

The provider should inform the Division as soon as it becomes apparent that any exceptions must be made in consideration of the services they intend to provide. In some instances, providers may realize that they will require an exception while drafting their proposal, and will be required to provide adequate justification as to the need for the exception. In other instances, providers may not be cognizant of their need for an exception until efforts have been unsuccessful for some time after contract award (with recruitment, for example). In either case, it is in the provider's best interest to seek an exception as early in the planning process as possible to ensure that all other aspects of their service will adhere to the requirements of the RFP and contract. The provider's familiarity with the issues surrounding the general geographic area will likely give them better insight at the time of proposal submission as to whether an exception may be necessary.

**4. Question:**

Does AMHD have a schedule of CEU offerings since AMHD is listed as a potential source?

**Answer:**

The Division does not have a comprehensive schedule of CEU offerings available at this time. A number of trainings have already been scheduled over the next few months, however. Additional trainings will be developed in the future and case management providers will be notified of these CEU opportunities as they arise.

**5. Question:**

40 hours continuing education prior to working as CM?

**Answer:**

Any person employed by an agency as a Case Management Specialist who fulfills the education requirement with a High School diploma or GED will be required to have already completed 40 hours of continuing education prior to working in that capacity.

**6. Question:**

2-19 numbering error “e” should be “d”.

**Answer:**

There is a drafting error in the lettering on page 2-19. The section identified as “e” should in fact be identified as “d.” No information is missing from the RFP.

**7. Question:**

16 hours continuing ed/annual can this training be done by the agency if approved by the DIVISION?

**Answer:**

Case Management agencies are permitted to provide internal trainings for their staff which may be counted towards the 16 hours of CEUs required annually for case managers and team leaders. However, in order for trainings to be used towards the CEU requirement, the content and topic area must be directly relevant to the direct provision of case management services. Please refer to the response provided to Question #1 above for further clarification as to appropriate content areas. Agencies are also encouraged to confer with the AMHD Case Management and Support Services Director if there are any questions or concerns about the relevance of proposed training topic areas.

**8. Question:**

Although a CM is assigned to each consumer, the consumer may be seen by other members of the team as needed, as long as only one member of the team is billing at a time? (ex: RN may need to see consumer CM may be on vac/sick. Another member of the team may be a “specialist” (housing/CSAC, etc) and the consumer can benefit from seeing that specialist face to face.

**Answer:**

A consumer shall be assigned to a primary case manager who will maintain the overall responsibility of coordinating the development of and monitoring the implementation of the Recovery Plan. However, the consumer may be seen by other members of the team as needed, either in the absence of the primary case manager or as additional support/expertise for a specific condition or issue. Only one team member may bill for services at a given time, and it is the provider's responsibility to ensure that adequate coverage is available to the consumer and that the identity of the primary case manager is clear to the consumer.

**9. Question:**

Is the only way for CM's to obtain continuing educational requirements/training is to attend AMHD sponsored workshops/conferences? What would be other opportunities that one could pursue?

**Answer:**

Case Managers and Team Leaders may obtain continuing education requirements/trainings on human/social service subjects. These may consist of seminars, conferences, adult education courses, certification coursework, employer trainings, Division sponsored workshops/conferences, or similar educational activities. The entire continuing education requirement does not need to be filled exclusively through Division sponsored workshops/conferences.

**10. Question:**

Is CM services an MRO service?

**Answer:**

Yes.

**11. Question:**

Peer Support Specialist rate – how established?

**Answer:**

The Division conducted research on peer specialist programs in other states to establish the rate.

**12. Question:**

CM specialist – Mental Health Specialist?

**Answer:**

There is a drafting error in the “References” section on page 2 of attachment M which clarifies the qualifications of the Case Management Specialist. It should read “...duties and responsibilities of a *Case Management Specialist*...”

**13. Questions:**

Is there an AG published opinion on the subject of the applicability of Admin Procedures ACT to the requirements of this RFP?

**Answer:**

The Division has not received any published opinion from the Department of the Attorney General on the subject of the applicability of Administrative Procedures Act to the requirements of this RFP.

**14. Question:**

Training at page 2-34 and Attachment M compared.

**Answer:**

Section 1.1. on Page 2-34 describes the continuing education requirement for case managers and Team Leaders, indicating that continuing education and training may be obtained through Division sponsored trainings, or those sponsored by other professional organizations. This list is not intended to be an exhaustive list of possible training to fulfill the continuing education requirements. Rather, it merely reinforces the option and benefit of attending Division-sponsored trainings to fulfill this requirement. Page 1 of Attachment M provides a more comprehensive list of possible training opportunities.

**15. Question:**

Team or Individual approach – what is this?

**Answer:**

Community Based Case Management services shall be provided for consumers by a multi-professional team. Each team serving 300 consumers shall be comprised of one (1) Psychiatrist or APRN-Rx, up to ten (10) case managers (depending on the credentialing of the team leader), two (2) Registered nurses, and two (2) Peer Specialists. Consumers will be assigned to an individual case manager who is responsible for coordinating the development of and monitoring the implementation of the Individual Recovery Plan. The MD/APRN-Rx shall have clinical leadership of the case management team, and the RN and Peer Specialist

shall provide additional support and assistance in the areas of their expertise. Please refer to page 2-31 and 2-32 for more detailed information on the functions of the various team members.

**16. Question:**

Was RFI considered in constructing this RFP?

**Answer:**

The DIVISION published an RFI in February 2006.

**17. Question:**

MRO? Who collects from Medicaid? Division or contractor?

**Answer:**

The Division will collect from Medicaid.

**18. Question:**

Can you please provide a description and examples of what is meant by code H201543, Collateral Contact Without Consumer Contact, and code H0023, Behavioral Health Outreach Without Consumer Contact? What is allowable under these codes?

**Answer:**

As defined in AMHD Administrative Directive 2004-07, Collateral Contacts Without Consumer Contact (H2015 U3) are those contacts, whether telephonically or in person, with the consumer's family members, support system, or providers to monitor consumer progress and intervene proactively and in crisis.

Behavioral Health Outreach Without Consumer Contact (H0023) would be used when a case manager or other case management team member attempts to locate a consumer in the community but is unsuccessful.

**19. Question:**

The Case Manager and Psychiatrist are required to attend the Recovery Planning meetings (billing 99362 Joint Planning Meetings for the psychiatrist, and H2015U2 for the Case Manager, we assume?) We assume that they will both bill for their time. Is this a correct assumption? What are the limits on billing for attendance at Recovery Planning meetings? Who can and cannot bill for

attendance and participation? Also, is there a way to confirm that you received these questions in the prescribed allowable format?

**Answer:**

Only one person per agency can bill for a service provided at the same time. Please refer to AMHD Administrative Directives for further guidance on billing for attendance at Recovery Planning meetings.

**20. Question:**

What was the process undertaken by AMHD in collecting and considering the responses to the RFI issued relevant to Community Based Case Management?

**Answer:**

The Division published an RFI in February 2006, seeking input regarding community-based case management services. A total of six organizations responded to the RFI. Of these, four were currently providing services under contracts with the Division. Responses were reviewed by Division staff to determine if this input should be included in an RFP.

**21. Question:**

Who were the individuals or team of individuals who reviewed the answers or responses to the RFI?

**Answer:**

The responses to the RFI were reviewed by appropriate Division staff.

**22. Question:**

What process was taken in considering the responses to the RFI and what impact or influence did the responses have in the design of the RFP?

**Answer:**

See question 20, above. The RFI responses were carefully reviewed by Division staff, in consideration of service requirements of the Community Plan, SAMHSA EBP, Toolkits, Hawaii Administrative Rules, and MRO requirements to determine the final design. Additional feedback provided by providers was also incorporated into the changes reflected in this RFP.

**23. Question:**

Are there any meeting notes or minutes taken reflecting on the consideration given to the RFI in designing the RFP?

**Answer:**

No.

**24. Question:**

How did the Department of Health ensure community involvement in determining the service delivery arrangements appropriate to the Wai`anae community as required by Chapter 334, HRS? Were there meetings in the community? Are there notes or minutes of meetings with Wai`anae community residents or representatives in which the subject of Community Based Case Management were considered? If so, where are these notes or minutes located? How can we obtain a copy of such notes or minutes? Please consider this a request for copies of such notes or minutes under the State's Freedom of Information Act or equivalent State mandate for public disclosure of public information.

**Answer:**

Community involvement is assured through the Service Area Boards' input into the Division's CISAP and the Statewide Comprehensive Integrated Service Plan.

**25. Question:**

Has the Department of Health established a service area center to be the focal point in the development of community based case management for the Wai`anae community as required by Chapter 334, HRS?

**Answer:**

The Department of Health is not required to establish a service area center per amendments to section 334-11, HRS.

**26. Question:**

Please identify the service area board member(s) representing the Wai`anae community for the relevant period in which this RFP was written.

**Answer:**

The service area board has been unable to solicit representation from the Wai`anae community despite numerous requests.

**27. Question:**

Please provide any minutes of the service area board relevant to the provision of community based case management services over the past year.

**Answer:**

A review of the Service Area Board Minutes for the period September, 2005 to August 2006 indicates that there was no discussion of the community-based case management model except for mention of the availability of an RFP.

**28. Question:**

The RFP at page 2-2 identify planning activities conducted in preparation for this RFP. No mention is made of the involvement of the service area board's involvement. Was there involvement by the service area board in the development of this RFP?

**Answer:**

Please see Question 24.

**29. Question:**

The RFP at page 2-2 identifying planning activities conducted in preparation for this RFP. Of the series of planning events, including needs assessment conducted in 2000, please identify the public input considered in the drafting of this RFP. Please provide meeting notes, minutes, and other documentation of such public input, which were considered in the construction of the current RFP.

**Answer:**

Please see question 22, above.

**30. Question:**

Hawaii Administrative Rules Sec. 11-175-16(a) Community-based planning calls for "Each service area center in conjunction with its service area board shall seek information, opinions, and recommendations from service area residents through such measures as community forums, public meetings, formal and informal surveys." Please inform me of the information, opinions and recommendations made from service area residents, citing documentations reflecting notes, minutes or other records of community forums, public meetings, or formal and informal surveys relative to community based case management services contained in the RFP under discussion.

**Answer:**

A service area center is not required. Information was gathered through Service Area Board Meetings, the Statewide Mental Health Council, and the RFI process.

**31. Question:**

At page 2-19 of the RFP, 5. b., the applicant is required to provide a service of “initial face-to-face intake contact” with each consumer. In the event a referral is made when the consumer is in a hospital or if the consumer is immediately hospitalized after the referral and the consumer is not released from the hospital within 3 days from the referral, is the intake person expected to make a face-to-face intake contact in the hospital with the consumer? What is the fee to be charged for this service as it is not noted in the fee schedule on page 2-41 and 2-42 of the RFP? Who is the person able to perform this intake contact? Is this contact called for with the expectation that the consumer will present him/her self to the out-patient clinic conducting this CBCM service?

**Answer:**

There is no separate billing code specific to initial, face-to-face contact. Providers should use the appropriate code and bill according to the Fee Schedule provided with the RFP.

**32. Question:**

At page 2-19 of the RFP, 5. b, paragraph 3, an intake assessment is called for which includes “significant others involved in each consumer’s treatment and recovery.” Is this requirement not predicated on the consumer’s consent to release and disclose information to those “significant others?” In view of the fact that this is merely an intake assessment which may not provide the circumstance to complete a master recovery plan, taking into consideration all significant others who may be involved in the consumer’s plan, is this requirement at this point of service to involve such others not “jumping the gun?”

**Answer:**

As suggested in this question, the decision to include any other individuals in the interview, recovery planning process, or treatment shall always remain at the discretion of the consumer who is a competent adult and retains decision-making capacity. Consent by the consumer is required for the release or exchange of any information. As further indicated, in some instances, the nature of the initial intake assessment may not lend itself to a comprehensive assessment, but may rather serve to begin the development of the therapeutic relationship and rapport building. In such instances, it would be premature to expect that significant others would be present or be identified at this early juncture of the developing

relationship. If the situation does not lend itself to include the involvement of significant others at the initial intake, the inclusion of these significant others in the consumer's treatment and recovery should be incorporated as a future goal if desired by the consumer and supported by the treatment team.

**33. Question:**

At page 2-19, 5. e. the provider is expected to provide each consumer with a single, individualized, coordinated master recovery plan through a treatment team.

- a. How will this service be paid for?
- b. How will the psychotherapist on the team be reimbursed for the time spent working with the team at a meeting when the psychiatrist and the case manager are also present at the meeting and one of those team members will bill for his time while attending the team meeting? Can multiple members of the team bill under this contract for attending the same IRP planning meeting?
- c. Who specifically will be charged with writing the IRP?
- d. Will the Division prepare billing codes for this service?
- e. An RN is required to be a member of the team when the consumer has significant medical issues. How is the RN to be reimbursed for services to the team? What is the billing code?

**Answer:**

- a. Please refer to the treatment planning billing codes included in this RFP.
- b. When the team is conducting recovery planning meetings, only one member of the case management team can bill for this process.
- c. The team is charged with writing the IRP.
- d. Please refer to the RFP for billing codes.
- e. The RN may bill for therapeutic injections. An RN who also meets the minimum qualifications as a case manager may also bill under case management codes if functioning as a case manager.

**34. Question:**

Under the same subject but at page 2-20, the case manager is charged with coordinating the development of and monitoring the implementation of the IRP

and shall act as the communications liaison for the CM team both internally and externally. Please identify the billing code under which the case manager will be paid for this service.

**Answer:**

There is no separate billing code.

**35. Question:**

At page 2-20, 6. Outreach, “Partnering of CM team members shall be utilized as an option to engage consumers.” How will the partnering members be paid for their individual service, i.e., a psychiatrist, a nurse, and a case manager are required to go to a cave to provide psychiatric examination by the psychiatrist, and medication injection by the nurse. The case manager, in this case, is the only individual who has developed sufficient relation and trust with the consumer to be able to engage the consumer. The case manager’s presence is absolutely necessary to introduce the psychiatrist and nurse to the consumer and to give the consumer a needed sense of comfort, trust and safety. Will all of these team members be able to bill for the same time and in which they each were present to provide service?

**Answer:**

Only one team member may bill.

**36. Question:**

At page 2-21 7.c. the program is required to “Ensure that crisis services shall be provided twenty-four (24) hours per day, seven (7) days per week.” Does this mean that the current crisis services such as crisis mobile outreach will not be available to the consumers who are serviced by the community based case management services? What is the parting line between CMO and CBCM?

**Answer:**

Current crisis services will continue to be available. Case Management agencies are required to be available to respond to consumers in crisis twenty-four (24) hours per day, seven (7) days per week. CMO is a distinct and separate service from case management. It is expected that the CMO team will be dispatched to a scene in addition to, not instead of, the case manager when CMO services are needed

**37. Question:**

At page 2-21, medication administration is called for in addition to education to the consumer. For these services, what are the appropriate charge codes, amounts of reimbursement and who are the appropriate service providers? How does medication administration differ from medication management and medication monitoring?

**Answer:**

Medication administration refers to the physical administration of a therapeutic agent through an injection or other means. This can be only completed by the appropriately licensed clinical staff and billed as a therapeutic injection. Medication management involves the clinical oversight, intervention, and prescriptive authority of a psychiatrist or APRN-Rx, while medication monitoring may involve non-clinical inquiry and follow-up with the consumer.

**38. Question:**

At page 2-21, psychoeducation is called for. For this service, what are the appropriate charge code amounts of reimbursement and who is the appropriate service provider?

**Answer:**

Psychoeducation can be provided by a RN, case manager, Team Leader, or MD/APRN-Rx. This should be billed under case management services.

**39. Question:**

At page 2-22, Dual Diagnosis Substance Abuse Services is addressed. How does “DDC-MH” service differ from MI/SA service? Is a CSAC required to be on the case management team?

**Answer:**

MI/SA service is consultative and not intended for the provision of services. A CSAC is not required to be on the case management team

**40. Question:**

In providing the basic substance abuse identification and treatment service called for at paragraph b., page 2-22, what will be the billable code under which the practitioner will be reimbursed?

**Answer:**

Basic substance abuse identification falls within the scope of general case management assessment and services may be billed according to the Fee Schedule listed in the RFP.

**41. Question:**

At page 2-22, b. 1), reference is made to the Division's approved tools for screening, assessment, and reporting co-occurring data, At page 2-32, paragraph f., reference is made to the Division's approved tools for measuring staff competencies. What are such tools, and where may they be found? If not yet approved, how would such tools be reviewed and approved by the Division?

**Answer:**

The Division's tools for screening, assessment, and reporting co-occurring data are the CAGE-AID and MIDAS and can be found on the Division's website, located under MI/SA Tools. Additional MI/SA Psychopharmacology guidelines can be found in Attachment I of the RFP. The Division has created tools for measuring staff competencies which can be obtained by contacting the Division's MI/SA Service Director. Applicants also have the flexibility to create their own tools and standards tailored to their agency. These tools shall be submitted to the MI/SA Service Director for approval prior to contract implementation.

**42. Question:**

The RFP calls for extensive involvement of an RN. At page 2-26, through 2-32, the RN provide medical assessments, basic health care, education, coordination of medical needs, and psychotropic and medical medication administration. Working directly with consumers, the R.N. is called upon to help them on their support system, on management of symptom distress, and development of wellness responses to co-morbid conditions. The RN's ratio to consumers is 1 to 150. Yet, the RFP provide no avenue for the RN to be paid a fee for their services. Why has AMHD determined not to reimburse for these very important service? Is it because AMHD has failed to negotiate an MRO code with Medicaid? If so, should not AMHD carry the burden of this cost and not foist such a burden on the provider of service by requiring such service but not fairly reimburse for it in this cost-reimbursement finance arrangement?

**Answer:**

With the exception of Therapeutic Injection, there are no billing codes specific to RNs listed in the RFP. A registered nurse may bill for any services identified under case management services if the RN meets the minimum qualifications of a case manager.

**43. Question:**

The RFP calls for extensive involvement of a certified Peer Support Specialist. It has set the reimbursement rate for the Peer Support Specialist at \$13.75 per unit, as compared with a case manager at \$20.25 per unit. How did the Division determine the fee for a peer specialist? Was there a process by which an opportunity for public input was given? Was there a study of the value or the market rate for peer specialists? Was an expert contracted to advise the Division on rate setting for the peer specialist position? Please provide any notes, communications, or documentation within the possession of the Division or any of its employees upon which or reflecting upon the decision to set the peer specialist reimbursement rate.

**Answer:**

Please see Question 11.

**44. Question:**

The Division has proposed the qualifications of case managers as a minimum education requirement of high school. Such a case manager – high school level shall be counted as two FTE Bachelor’s level or higher case managers for purpose of determining the number of case managers each team leader may supervise. The effect of this rule discriminates unfavorably against case managers – high school level as against others. Other discriminatory practices against case managers – high school are called for with regards to amount of supervision and ratio to the overall team. Please explain how the decision was made to discriminate between case manager – high school as opposed to case managers – bachelors’ or higher degrees. Were there any evidence-based experiences to support this decision? If so, what were the experiences? Was there any opportunity to allow for public input into this decision by AMHD to treat such case management categories differently? If so, please describe the public opportunity and the public input. Please provide copies of all documents, notes, and records within the possession of AMHD upon which consideration was given in reaching the decision to treat case managers- high school different from case managers with college degrees.

**Answer:**

In the absence of a standard case management degree or certification, case managers vary widely in their level and focus of formal education and work experience. Unfortunately, there are no national standards or best practices with regards to the minimum qualifications of case managers as the populations served and the scopes of their practices vary significantly across organizations and states. This is most evident when taking a cross-sectional look at state funded case

management programs for the SPMI population nation-wide, which reflects these variances and underscores the importance of tailoring the requirements to the needs of the state and the severity of the consumers served. As such, recommendations from consultants supported the inclusion of case managers with a high school diploma with the requirement of additional supervision requirements. While it is erroneous to suggest that case managers who have obtained college degrees are more qualified than their colleagues with a high school diploma/GED strictly on the basis of their education, it is also important to recognize the advantage additional formal training and education may have on the enhancement of their clinical skills and knowledge base. Therefore, the changes made to the minimum qualifications and accompanying supervision requirements were an attempt to allow for increased flexibility for applicants to retain their skilled case managers who might otherwise not meet the minimum qualifications, while accounting for the education disparity across the systems' case managers. The increased supervision requirement was intended to offer additional support and was not intended as a punitive or "discriminatory" measure, as indeed case managers who have extensive work and life experience are valued in our system, as are case managers who have endured the challenges of formal undergraduate and graduate education and training.

**45. Question:**

This RFP calls for case managers with Bachelor's degree to have at least one and a half years of experience. This requirement is a new requirement from all previous AMHD contracts calling for requirements of case managers with Bachelor's degrees. How was the determination made to add this requirement to the Bachelor's degree case manager requirement? Was the public given an opportunity to address this change in AMHD's policy or procedure? Is there any evidence-based experience to support this decision? If so, what is it? Please describe and provide any reports, writing, or study results which support the decision to increase the case management Bachelor's degree requirement to 1 ½ years experience. Please also produce all minutes, records, notes and any other documentation or recording upon which this decision was made or consideration was given when making this decision.

**Answer:**

The minimum qualification for a case manager reflected in the definition of a Mental Health Worker is currently a Bachelor's Degree and one and one-half years specialized experience. The previous case management RFP HTH-420-5-06 utilized the qualifications of the Mental Health Worker as the minimum qualifications for a case manager, and this current RFP adopted those qualifications as previously published.

**46. Question:**

Attachment M appears to be a new document or at least a changed requirement from prior practice, policy, or procedure of the Division. Representatives of the Division have represented that the State's Administrative Procedures Act does not apply to such changes. If the Attorney General's office was consulted on this matter, please provide a copy of the opinion issued from that office regarding the applicability of the APA to the adoption of this Attachment M. Please also provide any notes of discussions taken by AMHD with representatives of the AG's office relative to the adoption of the contents of Attachment M. If no reference was made to the AG's office, please provide the name of the individual, the position of such individual, and the advice said individual provided upon which the Division determined that the APA did not apply to AMHD's adoption of Attachment M.

**Answer:**

It is the opinion of the Division that RFP design issues such as staffing requirements are not subject to the Administrative Procedures Act.

**47. Question:**

Case Management supervision and limitation on the number of high school level case managers on a team appear to be convoluted. An MHP team leader is to provide supervision at least three times per month over RN, peer specialist and case managers with a Bachelor's degree or higher. An MHP team lead will face a reduction in the number of members on the team, by one member for each high school level case manager on that team. The MHP team lead will also face a decrease in the amount of caseload he or she may carry if a high school level case manager is on the team. This reduction in case load an MHP team lead may carry, as well as the reduction of the number on a team is presumptively due to the increased supervision the MHP team lead must provide the high-school level case manager. However, this MHP team lead will actually have a lightened supervisory role whenever a high school case manager becomes part of the team. Every high school case manager is to be supervised by a QMHP, and side-by-side observation sessions may be accomplished by an RN. Therefore, the MHP Team Lead has a reduced load of supervision in the event a high school level case manager becomes part of the team, as opposed to the supervision required of a Bachelor's level case manager. (See generally page 2-30, d. Staff Supervision) This being the case, there should be no reduction in team members for each high school level case manager on a team, and in fact, due to the lessened load of supervision for a MHP Team Leader, the number on a team should actually be increased by the number of high school level case managers. Please explain the rationale behind the Division's requirement for a reduced team membership and a reduced case-load which an MHP Team Leader may carry in the event of a high-school level case manager becomes a member of the team.

**Answer:**

Numerous factors contributed to the decision to limit the number of case managers supervised by the team leader and also in the reduction of the consumer caseload of the team leader who supervises high school level case managers. In an ideal team composition, the Team Leader would be a QMHP, who may then be responsible not only for clinical supervision but also, perhaps an individual caseload. In this instance, it would be helpful to reduce both the consumer caseload and number of case managers they would be supervising in light of the increased supervision requirements of high school graduate case managers. A second concern contributing to the decision to limit the number of high school case managers on a team reflected the preference that case managers possess a Bachelor's degree, but allowed for the flexibility of a provider to hire high school graduate case managers on a case-by-case basis. The reduction is therefore intended to encourage providers to continue to employ Bachelor's level case managers as much as possible, but also allows for the flexibility of hiring non-bachelor's level case managers as appropriate.

However, recognizing that a Team Leader might not be a QMHP, a generic restriction limiting the number of high school case managers supervised by the Team Leader due to the increased supervision requirement would not be appropriate for a MHP team leader who would not be responsible for meeting the increased supervision requirements of the high school case manager.

For this reason, the Division has amended the RFP through this Addendum to reduce the number of high school graduate/GED case managers that may be supervised by a QMHP. This amendment deals only with QMHP supervisors and does not effect MHP supervisors. Please note the amended sections listed below immediately following the Questions and Answers.

**48. Question:**

Consumers who have had stability as measured by “no recent hospitalization or emergency room visit” are to be seen once per month. What constitutes a “recent” hospital visit? Once within the last week, month, quarter, year?

**Answer:**

Recent hospitalization is only one of the possible variables that should be factored into determination of a consumer's stability. As a general guide, a hospitalization within 90 days or less may be considered a recent hospitalization.

**49. Question:**

Under this RFP, crisis and emergency services are to be provided. If more than one member of a team is required to respond to a crisis, will all of the team members who responded be reimbursed for their service?

**Answer:**

The RFP does not require more than one member of a team to respond to a crisis. Only one team member can bill for the response to a crisis.

**50. Question:**

At page 2-29, CM team members are required to meet at least two times per week for case reviews and all consumers' status are to be reviewed. If a consumer is required to be seen only once in a month, why must that consumer's status be reviewed by that team every two weeks? What is the extent upon which "all consumers' status shall be reported?" Who is the report to be given to? How will these CM team members be paid for this service? Will all of them be authorized to bill? What code will the Case Manager bill under? What code will the Psychiatrist bill? What codes will be used by the psychologist and the nurse?

**Answer:**

Due to the nature of the blended model of case management introduced through this RFP, there will naturally be a variance in the intensity of services needed among consumers. The minimum requirement for services is a monthly visit, however, there will be consumers who require services several times a week. Reviewing a consumer's case every two weeks will provide the opportunity for ongoing discussion of all consumers regardless of their acuity and help to ensure that they are all receiving the appropriate level of services, even if not being physically seen as often. As such, the extent of the reports for each consumer should be based on the intensity of services they are in need of. Consumers who are in need of less intense service will likely have less to be reported on. The CM team may bill for time spent conducting treatment planning with a specific consumer. Only one team member may bill for this service, using the code for treatment planning on page 2-41 of the RFP. Case review team meetings conducted for the purpose of internal quality management are not billable under this RFP.

**51. Question:**

This CBCM service is promoted as a team service. For example, it requires, at p. 2-34, "Each consumer's entire treatment team shares responsibility for coordination and continuity of the consumer's care ...." At page 2-17 III. A. it is stated,

*Specific CM activities shall be assigned to individual CM team members through recovery planning that includes designation of responsibility for service implementation. Specific CM activities shall be assigned to individual CM team members based on each individual's professional preparation, appropriate licensing, and educational preparation. (emphasis added)*

See also page 2-21 Service Provision, paragraph 8.

However, it also appears that the focus is placed on individual case managers to manage the IRP and provide the case management services for the assigned consumers without additional case managers participating in the service on an individual consumer. Assume a consumer's MRP identifies several goals to be achieved, including coordination with primary medical care, overcoming homelessness, engagement and maintenance with alcohol and drugs treatment services, addressing issues over gender identity, and conformity with public assistance programs, and further assume that the CBCM service team consists of individual case managers, one having extensive experience in housing and services for the homeless within the geographic area, another having previously run a drug/alcohol addiction program, a third having worked with a public assistance program and understands the in's and out's of available programs, and yet another who have developed a specialty in the area of gender identity and management of crisis over such issues. Will this team of case managers all be permitted to provide case management services in their area of specialty to this consumer, or must case management only be provided by one individual who may have no particular talent in any one of these areas? If a team of case managers is permitted to service this consumer, should there be one primary case manager who undertakes overall administrative and coordination responsibility to see that the MRP is carried out, with secondary case managers identified to address specific goals for said consumer?

**Answer:**

Please refer to the response provided to Question #8 of this RFP.

**52. Question:**

At page 2-14, MRO services are listed from a) to j). That listing does not contain Community Based Case Management services. Is this CBCM service an MRO service or is it not?

**Answer:**

Yes, community-based case management will be an MRO service. It will take the place of ICM.

**53. Question:**

If a provider is currently providing MRO services from among the list of MRO services described at page 2-14, must that provider make another application for certification by the Division under m. at page 2-13?

**Answer:**

Yes, another application is required to ensure that new requirements under the RFP are monitored.

**54. Question:**

At page 2-12, i. The terms “medical necessity and appropriateness” and “not medically necessary” are used. At page 2-13, 2<sup>nd</sup> paragraph, it is said that the Division has final determination in what is considered a necessary, reimbursable service. What is the Division’s reference standard upon which such determinations will be made?

**Answer:**

The reference standards used are the service criteria which have been established by the Division and based on best practices.

**55. Question:**

At page 2-11, g. the applicant is charged with maximizing third party reimbursements and other sources of funding before using funds awarded by the Division. It says, “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 Division is the payor of last resort and the applicant shall consider payment from third party sources as payment in full.” On the other hand, the Division, through Dr. Thomas Hester, and others, have represented that a) CBCM would be considered an MRO service, and b) AMHD would collect directly from Medicaid for MRO services performed by an MRO qualifying provider, and reimburse directly the provider. Those are two very important and independent issues.

- a. If CBCM services is not yet contracted with the State’s Medicaid Division as an MRO service, will AMHD continue to treat it as one as it regards the contract under the CBCM services with service providers.
- b. Irrespective of CBCM qualifying or not qualifying as an MRO, will the Division amend the RFP to delete the requirement that the service provider must maximize TPL reimbursements from Medicaid for Case

Management services provided under this CBCM contract as is presently required at page 2-11, g.?

**Answer:**

a) Yes.

b) If there are other payors available to pay for this service, the provider must bill them first.

**56. Question:**

At page 2-10, paragraph d., there are numerous references to case managers which make little sense. For example, in the first full paragraph, a case manager is called upon to report changes to their case manager. In the third full paragraph, the applicant “shall notify each case manager of consumer changes. Please clarify what those paragraphs are trying to say with respect to “case managers?”

**Answer:**

At page 2-10, paragraph d, the first full paragraph is somewhat unclear as currently stated. The intent of the second sentence of this paragraph is to indicate that any information affecting a consumer’s status should be known by the consumer, case manager and case management agency. The individual who first learns of the information shall determine the manner in which it is shared; the consumer shall inform their case manager or the case management agency, or the case manager shall inform the consumer and case management agency. The third paragraph of the same section intends to explain that if the applicant is aware of this change in status before the case manager, the applicant shall ensure that the case manager is informed, as well as the Division

**57. Question:**

With reference to page 2-10, paragraph e. 2) is homelessness an address or must a consumer’s status reflect the address of the homeless consumer whenever the consumer moves from place to place?

**Answer:**

The reference to homelessness in this section pertains to the loss of housing and is not considered an address. The consumer’s status should reflect this change in housing status as opposed to movement between addresses for a homeless consumer, as it may necessitate further collaboration with a homeless provider if the consumer is newly homeless or is known to frequent services from a particular homeless provider.

**58. Question:**

With reference to page 2-9, paragraph 11.c.2) what does the Division mean by “Live in Hawaii?” Is this a definition of a person’s residence or is it one’s domicile?

**Answer:**

“Living in Hawaii” in this section pertains to the consumer’s residence anywhere within the State of Hawaii. One criterion for eligibility is that consumers are residents of the State of Hawaii.

**59. Question:**

At page 2-11, f. consumers are to be disenrolled if “no longer living in Hawaii.” At page 2-18 4. a., consumers are to be discharged if they move outside the geographic area of the CM organization’s responsibility. How long must one’s absence be in order to constitute “no longer living in Hawaii” or “move outside the geographic area?” If the consumer has left Hawaii or the geographic area, but with the intent of returning, at what point shall the consumer be disenrolled or discharged?

**Answer:**

There are no strict guidelines as to the time parameters surrounding eligibility for a consumer who has temporarily left the state or geographic area with the intent of returning. As case management providers, thorough their therapeutic relationship and ongoing recovery planning with the consumer are in the most cognizant of the consumer’s goals and plans, it remains within the case management team’s discretion to determine at which point discharge of the consumer from their program due to the above reasons would be appropriate. It would be in the consumer’s best interest to resume services with their original provider if they will be out of State temporarily, however, it remains within the applicant’s reasonable, best judgment to determine at which point the consumer can appropriately be discharged or disenrolled

**60. Question:**

Consumers are to be disenrolled for refusing all services that are not court ordered. Suppose a consumer treats the services as a “cafeteria plan” electing to accept only certain medication, and disclosure to government agencies to qualify for eligibility under a program, but consumer refuses to accept psychiatric reevaluations, refuses to participate in case management services called for in MRP, and refuses to otherwise engage with case manager? Are consumers to be disenrolled for reasons less than those called for in paragraph f., page 2-11?

**Answer:**

Effectively engaging with SPMI consumers can be challenging, particularly when negotiating compliance with psychiatric services, medication, and basic case management services with a consumer who is not interested in any of these services. At this time, many of the services available to consumers through the

Division require that they are linked and working with a case manager. Therefore, it is the primary challenge of case managers to remain actively engaged with a consumer to work towards identifying their goals and accepting additional treatment or services over time. This relationship is a work in progress as the time it may take for a consumer to accept treatment and progress through recovery is never known. Consumers for whom documented outreach efforts have been unsuccessful over time and for whom there has been no activity should be reported to the Division for further consideration.

**61. Question:**

Consumers are to be discharged under conditions set forth at page 2-18, 4. a. Must CBCM service providers continue to maintain consumers who fall within the description in paragraph 41 above or refuses to agree to recovery as a goal?

**Answer:**

Please refer to the response provided to Question 60. Case Managers should continue engagement efforts with consumers and implement additional motivational strategies to develop the therapeutic relationship and begin to explore the consumer's goals over time.

**62. Question:**

Page 2-12, h. at the third full paragraph calls for providers to report suspected physical, emotional or financial abuse or neglect of a consumer to Adult Protective Services. Elsewhere, providers are also required to abide by 42 CFR part 2 which does not have an exception for reports on adult abuse as it does for child abuse. Does the Division counsel service providers to violate the Federal Law in this instance?

**Answer:**

Service providers should continue to abide by State and Federal laws as they pertain to the reporting requirements for suspected abuse and neglect of dependent adults and children

**63. Question:**

Can Case Managers – high school level, who have been hired and have performed as case managers under ACT, ICM or TCM programs, prior to the start of the CBCM contract or prior to the announcement of awards to applicants, be grandfathered into positions as qualified case managers, although not meeting all of the prerequisites of a case manager specialist, as defined in Attachment M? In the event case managers are permitted to be grand-fathered into CBCM case management positions, can the 75% Bachelor's degree & higher on a CBCM

team be waived to allow for the high school level case managers to act as case managers?

**Answer:**

The revision of the minimum qualifications for case managers was intended to assist service providers with retaining their current staff who might otherwise not meet the minimum qualifications of a case manager for the CBCM program. As such, case managers who are currently providing services must meet the minimum qualifications as stated in the RFP and will also be held by the additional parameters set forth in the RFP.

**64. Question:**

We have qualified case managers who had previously qualified and held positions as Case Managers IV and V, had worked for years as case managers, had received extensive State sponsored training, have served as heads of quality assurance teams, team leaders, trained and supervised other case managers, both high school and college degreed, and provided invaluable case management services over the years. Yet, they are not graduates of any college. What in the world had AMHD been thinking about when they demoted such individuals to a status less than a person straight out of college, with a year and a half of “specialized experience?” Were any practicing case managers with high school degrees consulted in the development of Attachment M? If so, what was the consultation? Are there any documents to evidence that such consultation did occur? If so, please provide said documentation. Were community service providers given the opportunity to comment on the Division’s Attachment M? If so, who were they, and what are the available documentations to evidence said consultation? Please provide copies of said documentations to such consultation.

**Answer:**

Please refer to the response provided to Question 44. The development of Attachment M was created to allow for flexibility for providers to retain existing case managers who might otherwise not have met the minimum qualifications set forth in the previous CBCM RFP. There were numerous verbal requests to include high school level case managers as service providers, but there is no written documentation of these requests.

**65. Question:**

At page 4-2, Evaluation Criteria, B. 1. Experience and Capability, “Up to 10 points may be deducted from agencies who in the past demonstrated unsatisfactory performance.” Several concerns are raised here for which it is requested that the Division clarify or answer:

- a. This creates an uneven playing field between organizations, which have worked with AMHD previously and those, which have not, exposing those that have to a penalty of up to 10 points without such similar exposure to other competing organizations. Such a rule appears against public policy, provides much room for discretion, and raises the fear of retaliatory practice by the Division. No definition of or standard for determining “unsatisfactory performance” in the RFP. The RFP and many other State AMHD contracts are written in such uneven language, become adhesion contracts, and require, at times, that the contracting parties violate State and Federal laws.
- b. There has been no formal determination of “unsatisfactory performance” procedures contained in prior State contracts. Thus, there are and have been no methods by which an applicant could challenge such determination of “unsatisfactory performance” at the time such performance was done, or soon after. Therefore, a determination by the Division, if made, would not permit the applicant due process in contesting such determination.
- c. This provision does not identify the office or individual who will be making the determination of whether or not an agency has “demonstrated unsatisfactory performance.” Some AMHD offices have personnel who will recognize that an organization has done exceedingly well in their contract performance, while other personnel in another office may reach a totally different conclusion. How is the Division going to make a determination of demonstrated unsatisfactory performance, and what appeal process will be provided to the agency which falls victim to such a determination?
- d. The AMHD has followed a practice, in some instances, of pushing the provider agencies to do what is not allowed by law, such as releasing confidential information to the division without proper authority. Whenever a contracting provider opposes the Division’s request, such an opposition can be determined to be “unsatisfactory performance.” Yet, more often than not, the provider is correct in the interpretation of the law and the prohibition against release of confidential information. This evaluation provision will have a chilling effect upon the exercise by the provider agencies of their contractual, statutory and constitutional rights and obligations. It allows for a pernicious abuse of power by the Division without a proper oversight by any independent body.

**Answer:**

The section on page 4-2, Evaluation Criteria, B.1. Experience and Capability is standard language included in all Division Requests For Proposals.

A finding that an applicant had demonstrated unsatisfactory performance would be based on documented, objective criteria such as performance monitoring. Any applicant penalized through this provision would have the right to protest the decision as provided in this RFP and Hawaii Administrative Rules.

**66. Question:**

What is the definition of "Specialty Teams" as stated in the RFP, Section 2, page 2-16, second paragraph? We would appreciate if AMHD can provide additional examples beyond what are mentioned in the RFP i.e. homeless, HIV+?

**Answer:**

Specialty Teams are those teams who intend to serve a specific population of Division consumers who require additional expertise or skills. These additional skills or expertise are requisite to assisting consumers with effectively accessing and utilizing case management and mental health services which they would otherwise be unable to without such specialized support. Examples provided in the RFP include the homeless population who may require further engagement or motivational techniques as well as a deeper understanding of homelessness and surrounding issues. Similarly, SPMI consumers who are HIV+ may also require a specialty team that has additional expertise in HIV+ issues and associated implications to mental illness. Other examples of specialty teams may include, but are not limited to, bilingual, geriatric (65 years and older), or diagnosis-specific populations. These examples are not intended to represent an exhaustive list of possibilities and applicants are encouraged to provide additional documentation and support for the importance and relevance of the Specialty Team for which they are proposing.

**67. Question:**

If we respond to the RFP as a Specialty Team service provider and it is deemed by AMHD proposal evaluation team that the targeted AMHD population identified in our proposal doesn't constitute our proposal as a Specialty Team based proposal, will our proposal be eliminated from the overall evaluation or will we be included in the general pool and be considered as one of the contenders for the five contract awards per county as indicated in the RFP?

**Answer:**

If your application does not meet the criteria of a specialty team, it will be considered and included in the general pool and be considered as one of the contenders for contract awards.

**68. Question:**

On page 2-30, d. Paragraph 2, The CM team leader shall provide and document clinical supervision at least three (3) times per month RN, peer specialist and case manager, who meet the minimum requirements with a Bachelors degree or higher. Please clarify the amount and type of supervision. Are there two levels, such as bachelor level and above and less than bachelors?

**Answer:**

There are two separate clinical supervision requirements depending on the minimum qualifications of the case manager. For case managers who meet the minimum qualification with a Bachelor's degree or higher, they are required to receive clinical supervision from the CM Team Leader three times a month, along with the RN and Peer Specialist. There is no required format for this level of clinical supervision, although a variety of methods are identified on page 2-30.

Case managers who meet the minimum qualification with a high school diploma or GED are required to receive weekly, individual clinical supervision from the QMHP. As the Team Leader is not required to be a QMHP, the case manager who fulfills the requirements with a high school diploma may or may not be receiving clinical supervision from the Team Leader. In addition to weekly supervision, case managers who meet the minimum requirement with a high school diploma are also required to receive monthly side-by-side observations sessions with the Team Leader or RN. Please refer to Page 2-30 in the RFP for more information.

**69. Question:**

Section 5, Attachment M, page 3, #7:

Number 7 is written to say the "caseload of the Team Leader shall be reduced by 25% for each Case Manager they supervise who meets the minimum education requirement with a High School diploma." Does this mean the entire Team Leader's caseload, for example if 300 cases, is to be reduced by 75 cases (for a total caseload of 225) if at least one member of the team has the minimum educational requirement. Or, does this mean the Team Leader's caseload shall be reduced by 25% of the particular Case Manager's caseload. For example, if the Case Manager in question carries a caseload of 20, then the Team Leader's caseload will be reduced by 5 cases for a total caseload of 295.

**Answer:**

The reduction in the caseload of the Team Leader refers only in the event that a team leader is a QMHP and has a consumer caseload of their own. For example, if the QMHP Team Leader is providing clinical supervision to the case managers,

and is also working directly with consumers and has their own caseload of 30 consumers, if they are supervising one case manager with a high school diploma, the maximum number of consumer that can be on the Team Leader's individual caseload is 22. The restriction of the consumer caseload is strictly on the Team Leader's caseload and the not individual caseload of the case manager.

If the Team Leader is a MHP, and case managers with high school diplomas are employed and supervised by the QMHP, the Team Leader's individual caseload shall be unaffected.

**70. Question:**

I had a quick question that I'm hoping you will be able to give me the answer to regarding the RFP. There is a page with website references that refers to the campaign spending commission. I have looked on the proposal application checklist and it does not reference the campaign spending commission, but just wanted to be sure that we do not need any forms regarding that. Here at IHS, we do not contribute to anyone's campaign, but just want to be absolutely sure of the attachments we need.

**Answer:**

There are no required forms.

**71. Question:**

Is case management?

**Answer:**

This incomplete question was submitted, unsigned, at the August 31, 2006 RFP Orientation Meeting.

RFP No. HTH 420-1-07 Community-Based Case Management  
is amended as follows:

*Subsection Page*

**Section 1, Administrative Overview**

I. 1-1 The Procurement Timetable on page 1-1 is modified  
as follows:

**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	8/23/06
Distribution of RFP	8/23/06
RFP orientation session	8/31/06
Closing date for submission of written Questions for written responses	9/8/06
State Purchasing Agencies response to Applicant’s written questions	9/15/06
Discussions with applicant prior to submittal deadline (optional)	N/A
Proposal submittal deadline	9/29/06
Discussions with applicant after submittal deadline (optional)	N/A
Final revised proposals (optional)	N/A
Proposal evaluation period	Mid to Late October 2006

Provider selection	November 2006
Notice of Statement of findings and decision	November 2006
Contract start date	3/1/07

**All references in the RFP to the proposal  
submittal deadline or other sates are modified to  
conform with the amended Procurement  
Timetable.**

## **Section 2, Service Specifications**

III.A.11.2) 2-27 Subsection III.A.11.2) on page 2-27 is modified to read as follows:

- 2) A team leader may supervise up to ten (10) case managers with the following exception. When the team leader is a QMHP, each case manager who meets the minimum education requirement with a high school diploma/GED will count as two (2) FTE case managers for the purpose of determining the number of case managers each team leader may supervise. In other words, the number of case managers that a QMHP team leader may supervise must be reduced by one (1) case manager for every case manager with a high school diploma/GED on the CM team. This requirement is intended to ensure that team leaders have sufficient time to conduct the additional clinical supervision/observation and record review necessary. Example: If a typical team size is ten (10) case managers per team lead, the organization must reduce the team size to nine (9) case mangers if one of the case managers meets the minimum qualification with a high school diploma/GED (8 Bachelor's level or higher case managers plus one (1) high school/GED level case manager), to eight (8) case managers if two (2) of the case managers have a high school diploma/GED (6 Bachelor's level or higher plus two (2) high school diploma/GED case manager).

III.A.11.5) 2-28 Subsection III.A.11.5) on page 2-28 is modified to read as follows:

- 5) If the team leader is a QMHP, the individual caseload of the team leader shall be reduced by twenty-five percent (25%) for every case manager they supervise who meets the minimum education qualification with a high school diploma/GED.

**Section 3, Proposal Application Instructions**

No changes

**Section 4, Proposal Evaluation**

No Changes

**Section 5, Attachments**

No changes