

**State of Hawaii
Department of Health
Alcohol and Drug Abuse Division**

**RFP 440-08-1
Substance Abuse Treatment Services**

**RFP QUESTION AND ANSWER
October 27, 2008**

The following is the response to the written questions submitted prior to midnight on Monday, October 20, 2008, and after the Orientation Session for RFP 440-08-1 Substance Abuse Treatment Services, as specified in Section I of the RFP.

1. “If client’s families are unwilling to utilize insurance or feel that they cannot afford the co-pay, or if the adolescent client wants to access services confidentially without parents/insurance involvement, can they access ADAD funds even if they do have insurance?”

The Alcohol and Drug Abuse Division (ADAD) will not cover the treatment costs for community-based outpatient treatment services if the family has insurance that covers it. Insurance must be used, if available, and parents therefore must be notified.

2. “If the agency chooses to do an expenditure based contract can the co-pay for insurance based clients be covered by ADAD funds?”

ADAD funds cannot be used to cover insurance co-pay.

3. “Can an agency bid for just one school in a complex if another agency is bidding for the other school in a complex? Can the complex services be split if schools want different agencies?”

The entire complex must be covered under the proposal. This does not preclude a sub-contract arrangement between agencies but prior approval for sub-contracting must be requested at the time of application.

4. “Can expenses such as court case management, attendance at school administrative meetings, and meeting with school staff be part of expenditure cost in a combined expenditure performance based contract?”

No. However, these services can be billed under case management. An addendum will be forthcoming that allows providers of adolescent services to bill for case management services face-to-face with a client, face-to-face with a community resource or through direct telephone contact with a client or community resource.

5. “Can costs such as training and clinical supervision be part of expenditure costs in a combined expenditure and performance based contract?”

No, as training and supervision costs were factored into the performance rates ADAD set for this RFP.

6. Eligibility - “Does a client qualify for ADAD funding if he/she is eligible for AMHD but doesn’t qualify?”

Clients who qualify for Adult Mental Health Division (AMHD) services are not the population that ADAD serves. Therefore, AMHD qualified clients would not qualify for services funded by ADAD.

7. “Can you apply for parts of a continuum of care i.e., adult services –outpatient only?”

Yes, you may apply for any part of a continuum, singly or together with other modalities, with the exception of Clean and Sober Living. If applying to provide Clean and Sober Living you must also provide an additional ADAD treatment modality.

8. “When looking at the adult continuum of care the total amount of dollars seems to leave little for residential care. Is there a shift in emphasis away from residential care?”

There has been no significant decrease in the amount of funds available for adult residential services. Additionally, the amounts specified in the adult continuum, on pages 2-1-3 to 2-1-5, do not specify separate amounts for each level of the continuum. ADAD is shifting emphasis, however, from an acute care model to a recovery oriented system of care. As such, the limits on residential treatment have shifted from clients having a total number of days per year to having one episode of care per client with a minimum of 12 calendar months in between each episode. This holds true whether the episode consists of 3 days or the entire number of days allowed per year. Providers are encouraged to use other levels of care (e.g. Motivational Enhancement, Outpatient or Intensive Outpatient Treatment, Continuing Care) to help prepare clients for admission into or transition out of residential treatment so that the most can be gained from the residential experience. Once this is received, all other modalities of care should be used to reinforce the lessons learned in residential treatment.

9. “Does case management service apply to clients in residential treatments?”

Case management services are expected to be provided in residential care but the costs are considered to be included in the daily rate. A separate unit rate for case management may not be billed.

10. “Please clarify the billing for screening and assessments, for residential services this occurs prior to admission and is therefore not covered in the per diem rate. This requires significant professional time. Is this billable?”

Both activities are billable if the client is admitted to services. For residential services, screening and assessment are considered part of the residential rate. The date of admission would then be the date the client was screened. Screening should take a minimal amount of time. After the date of admission the client would be assessed, and this would be included in the daily residential rate. If the client is screened considerably before they are able to be admitted, however, it may not make clinical sense to have the admission date be the date the client is screened. In this case, the date the client was assessed would be used as the date of admission.

11. “For adolescent community based IOP and OP, would a proposal for a gender responsive program for adolescent girls be considered responsive to the proposal.”

Yes, a gender specific proposal would be considered to be responsive.

12. “For Pregnant and Parenting Women and Children, can we accept NI women into the Oahu program without writing a proposal for each island?”

(Note: It is assumed that NI stands for Neighbor Island.) If the services are provided on Oahu then a separate proposal would not be required. Residential treatment services do not need to be applied for by the Island the client is from.

13. “Do I understand correctly that clean and sober housing is not just Oxford Houses, but is an addition to the continuum available to ADAD providers?”

You are correct. Clean and Sober Housing is a new modality of service for ADAD and is different from both Oxford House and Therapeutic Living Homes. Oxford Houses are democratically run and operated by the residents with support from an overseeing structure that includes a revolving loan fund that covers rental deposits. Therapeutic Living Programs provide housing, 24/7/365 staffing, program support and must be licensed as Special Treatment Facilities. Clean and Sober Homes may be in a variety of living arrangements in the community and do not require 24 hour a day/7 day a week supervision. They must be associated with another modality of ADAD treatment. Clean and Sober Housing providers may partner (such as through a Memorandum of Understanding) with

ADAD treatment agencies or ADAD treatment agencies may establish their own housing.

14. “If QUEST is paying for Outpatient, can we bill ADAD for the case management which is not funded by QUEST?”

Yes.

15. “We are responding to both PPW and Children and Dual Diagnosis. If a Dual Diagnosis woman is admitted with her child to residential treatment, will her child be billable under the PPW contract? Should this be described in both proposals?”

Under Dual Diagnosis Substance Treatment Services, a child will be billable solely under the PPWC contract at the child’s rate. A short description should be placed in each proposal.

16. “Can we bill ADAD for continuum care when a dual diagnosis has exhausted here (their?) Quest Behavioral benefits for psychotherapy and medication management related to here (their?) MH disorder?”

The services ADAD reimburses for are related to substance abuse treatment. Psychotherapy and medication management are not billable services.

17. “If a woman is in Therapeutic Living or Clean and Sober Housing with her child and is attending IOP/OP provided by a different organization can the TL or CSL program bill for childcare while she is in treatment activities?”

(Note: It is assumed that CSL means Clean and Sober Living [Housing]) This may be possible under the actual expenditure portion of the contract but the details will need to be evaluated when the proposal is reviewed.

18. “Can you explain the Quest – QexA relationship with ADAD funding for IDU and adult Sub. Abuse Tx?”

For both Adult Substance Abuse Treatment Services and the Injection Drug Use Continuum, ADAD’s relationship with QUEST funding is the same. ADAD funds may be used to supplement QUEST-Net, and other applicable medical programs’ substance abuse services, after the benefits have been exhausted and up to the limit of QUEST or QexA substance abuse benefits. For those clients that have a diagnosis of Methamphetamine Dependence, ADAD will supplement QUEST, QUEST-Net, QexA and other applicable medical program benefits for substance abuse treatment, who have appealed and exhausted their insurance coverage, up to the limits of ADAD coverage.

19. “What if someone has a Quest plan but the plan will not contract with program due to capitation with another program or plan’s decision not to contract with more providers?”

The client needs to seek treatment that is supported by the insurance plan they are enrolled in.

20. “Can you bill cultural activities on top of IOP rate?”

Yes.

21. “School base modality is required to do more services than any other modality that are non-reimbursable (faculty meeting, school events, classroom presentations, IEPs, coordination and communication with teachers and school administration) in order to be effective in the school setting. The rate has traditionally been higher to reflect those unfunded needs. Now the group rate has been decreased by almost 10%. A 3.5% increase in the individual rate does not help bridge the gap as substance abuse treatment tends to be comprised mostly (2/3 to 3/4) of group sessions. What is the justification for the school based rate decrease?”

Please note that additional services are also provided by adult and community based adolescent treatment programs, e.g. appointments with Parole/Probation officers, court appearances, discussions with therapists, psychiatrists, social workers, family therapy and education and coordination with domestic violence, child welfare services, courts, etc.

ADAD made decisions about treatment rates based on information provided by ADAD contractors, rates from other states providing similar services, and from technical assistance paid for by the Center for Substance Abuse Treatment and the current fiscal climate. ADAD decisions on rates took into consideration the entire continuum of service needs for all populations served. Adjustments were made to enable the provision of the most efficient services to the greatest number of clients.

The services described in the question above will also be allowed to be billed under ADAD as case management services. An addendum will be forthcoming that allows providers of adolescent services to bill for case management services face-to-face with a client, face-to-face with a community resource or through direct telephone contact with a client or community resource.

22. “Some of the complex includes two different schools that have had services from two different agencies, some for many, many years. What if two different DOE schools within the same complex prefer different service providers?”

The procurement process is based upon the requirements of state statutes, specifically, Chapter 103F, and the results of the proposal evaluations.

23. “What criteria will ADAD use to decide who to award the complex to if both agencies apply and different school want different agencies?”

The criteria for selection is contained in Section 4 of the RFP, Proposal Evaluation.

24. “Also, if ADAD awards service providers not supported by DOE, how will ADAD help to resolve the probable conflicts created by ADAD’s bid process? As ADAD knows, provider agencies need DOE support to be successful in schools.”

Please note that it is the state’s procurement statutes, Chapter 103F, that guide the competitive Request for Proposal process, not “ADAD’s bid process” as stated in your question. ADAD has been working closely with the DOE on school based services over the past several years and will continue to do so. Provider preference or school personnel preference cannot take precedence over the procurement process.

25. “Can adolescent programs bill for face to face case management with a client or face to face with a community resource or for case management through live telephone contact?”

Yes. An addendum will be forthcoming that allows providers of adolescent services to bill for case management services face-to-face with a client, face-to-face with a community resource or through live telephone contact with a client or community resource.

26. “Can adolescent programs bill phone contact with families? When we call parents to discuss client’s attendance and participation it is not uncommon for the call to last 20 minutes or longer.”

An addendum will be forthcoming that allows providers of adolescent services to bill for case management services face-to-face with a client, face-to-face with a community resource or through live telephone contact with a client or community resource. This includes a client’s family.

27. “Can adolescent programs bill for face to face contact with families without the client present? We sometimes have meetings with families to discuss expectations or program participation without the client present, especially when it involves the school as they often want to meet without the student present.”

Yes. Per Attachment E-1, Substance Abuse Treatment Guidelines, the family may involve parents, children, partners or other significant others within the client's home environment who will have a major role to play in the client's recovery, e.g. aunts, foster parents, boarding home operators. The client need not be present at all family counseling sessions.

28. "Will agencies be able to subcontract some schools out to other providers if they feel another agency has already build a relationship at that particular school?"

This is possible if the request is submitted with the proposal and is approved by ADAD. It is also possible after the contract is awarded with prior permission from ADAD.

29. "Can agencies submit a bid entirely for reimbursable by actual expenditure for school based OP (not in combination with performance based)?"

Only agencies that are applying for schools that have been designated as "Rural Remote" in the RFP are able to submit proposals consisting entirely of cost reimbursements (actual expenditures).

30. "Can all types of groups (including skill building, education, and recreational groups) be reimbursed through a performance unit cost (billing)?"

Some changes to the structure of school based services were needed to be made due to ADAD's intention of seeking Medicaid reimbursement for these services in the future. One of those changes is that recreational activities need to be funded through cost reimbursement and separate from the unit rate.

31. "If a provider receives awards for multiple complexes/schools, will all those schools be under one contract per agency to ensure easier management or movement of funds?"

If the complexes are all on one island this may be considered. If complexes are on different islands it may require different contracts.

32. "If all schools awarded to a given provider are under 1 contract to allow for easier management or movement of funds, would it also include those schools at different islands?"

No. Funding for different Islands needs to be evaluated with other services on that island.

33. "Is ADAD going to [ask?] all provider[s] to utilize the revised ADAD assessment form?"

Providers will need to use the Adolescent Drug Abuse Diagnosis assessment form that is incorporated in our Web Based Infrastructure for Treatment Systems (WITS).

34. “Can Adolescent Community Based IOP/OP take place on a school campus as long as it is not during school hours?”

This may be permissible as long as the school based services and community based services are clearly separated.

35. “Can Adolescent Community Based IOP/OP [take] be provided at the same facility where adult services are provided?”

Only if the two populations can be kept entirely separate, such as in different wings.

36. “Can there be any integration of adult and adolescent treatment programs where there might be some groups that mix older adolescents with younger adults: For example 17,18 years old with young adults in their early 20s?”

No, these two groups need to be treated separately from each other.

37. “Using taxis to transport adolescents to the program site from schools might be an effective method to ensure attendance. With reimbursement by actual expenditure, will transportation such as van rental, bus costs, and taxi ride be reimbursed?”

Transportation costs will be reimbursable by actual expenditure. The specific method and its effectiveness in achieving the goal will be evaluated.

38. “If an agency bid for a contract as reimbursable by actual expenditure due to the challenges of establishing a new program, will the possibility of being able to switch to performance based in a year or two after the program gets established? What if it begins as performance based and wants to switch to actual expenditure at some point?”

Both of these options are possible at the discretion of ADAD, with the preference being toward having all agencies be reimbursed by performance units as much as possible for the basic substance abuse treatment services.

39. “Page 2-1-12 and 2-1-13 related to Unit of Performance Services a. Motivational Enhancement Services “up to two (2) hours in any combination of processes group or education group counseling may be scheduled with each client weekly.

Question: Currently we do up to 4 (2-2 hour group) per week per client, would this mean we would have to reduce client contact to 1 group a week

or reduce group time to 1 hour twice a week or have 2 -2 hours groups per week with different clients in each group?

(This also appears in 2-3-13 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-14 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

Your interpretation is correct for all sub-categories.

40. “Page 2-1-16 and 2-1-17 related to Cost Reimbursement Services 3) Cultural Activity Expenditures.

Question: Can we bill for treatment and cost reimbursement for the same client group (for different activities, of course)?

(This also appears in 2-3-16 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-20 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

Yes, if it conforms to the RFP requirements.

41. “Page 2-1-18 #7 Adult treatment program shall administer the Addiction Severity Index (ASI) as part of the initial assessment and upon discharge to all clients admitted for treatment. Results of the ASI must be included in the WITS.

Question: 1) Does this mean at discharge from the continuum or discharge from every level of care? What is ADAD’s definition of payment source?”

Discharge refers to discharge from the continuum. Definition of payment source refers to either ADAD funding or non-ADAD funding (e.g. private insurance, Med QUEST).

“2) How does ADAD distinguish between treatment transitions vs. treatment discharge?”

Treatment transition refers to a client’s moving from one modality of treatment to another modality. Treatment discharge refers to discharge from all treatment, excluding recovery support services.

“3) Will the discharge ASI in WITS be modified to be more efficient to minimize the time it takes to complete this document?”

ADAD will use the current version of the ASI.

“4) Does this requirement include those individuals discharged incomplete?”

Yes. The ASI must be administered at admission and at discharge, treatment completed or not completed.

“(This also appears in 2-3-18 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-19 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

42. “Page 2-1-18 #11 Programs shall comply with the following sections of P.L. 102-321 (440-08-1 says 106-310, not 312) regarding treatment services for pregnant women and women with dependent children.
- a. Prenatal care and childcare while women are receiving services. Please clarify.
(This also appears in 2-3-19 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-20 Sub Category Integrated Case Management (ICM) for Offenders Statewide.)”

Programs providing services for pregnant or parenting women with children must provide or arrange for prenatal care or childcare while women are receiving substance abuse treatment services.

43. “Page 2-1-19 b.2. Advertise that pregnant women shall receive preference for treatment on any brochures or materials published by agency.

Question: Can we use marketing materials we have now or do we incur additional cost to get this language included or would website and periodic newsletter be sufficient?
(This also appears in 2-3-13 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-20 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

The preference for treatment for pregnant women needs to be stated on any brochures and printed materials. This is accomplished easily by using a stamp or stick-on labels.

44. “Page 2-1-21 d. ADAD will allow the Applicant to supplement QUEST, QUEST-Net, QUEST Expanded Access (QExA) and other applicable medical programs benefits for substance abuse treatment for client with a primary diagnosis of methamphetamine dependency, who have appealed and exhausted their insurance coverage, up to the limits of ADAD coverage.

Question: ONLY methamphetamine?
(This also appears in 2-3-21 + 22 Sub Category 3, Dual Diagnosis

Substance Treatment and 2-1-6(b)-22 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

Correct. This is allowable only if the client has a primary diagnosis of methamphetamine dependency.

45. “Page 2-1-22 #4 Outpatient and performance/outcome measurements a. “The applicant shall set a threshold percentage of achievement for each of the following WITS data items

Question: 1) If each applicant sets their own threshold what is considered standard expectation for providers?””

ADAD has not set a standard expectation for providers. The agencies’ proposal will be evaluated by the methods they use to set those for themselves.

“2) Also item #12 who collects this data after 6 months?
(This also appears in 2-3-23 + 24 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-24 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

The same agency who admitted the client.

46. “Page 2-1-23 #5 Experience “Applicant shall have one year experience in the provision of dual diagnosis substance treatment services and/or in the provision of Therapeutic Living Program (Supportive Living) services for substance abuse clients.

Question: Is this an either or OR?””

“The APPLICANT shall have a minimum of one year experience in the provision of substance abuse treatment services or in the provision of Therapeutic Living Program (Supportive Living) services for substance abuse clients.”

The requirement applies depending upon whether the applicant is providing only treatment services, only Therapeutic Living Program Services or both. If both types of services are provided then both requirements must be met.

“8a. Is there waiver process for provider with substantial experience in providing treatment services?
(This also appears in 2-3-23 + 24 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-25 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

The question is not clear. However, if the treatment experience mentioned above is mental health treatment, for instance, then it does not meet the required substance abuse treatment experience. If it is not dual experience, then it does not meet the criteria. If the applicant cannot meet the personnel requirements at the time of application then they must state plans for meeting them at the soonest possible point after the beginning of the contract.

Page 2-1-23, under #5. Experience, replace the paragraph with the following:

The APPLICANT shall have a minimum of one year experience in the provision of substance abuse treatment services or in the provision of Therapeutic Living Program (Supportive Living) services for substance abuse clients.

47. “Page 2-1-24; 2. The applicant will be required to submit the Admission, Discharge and Follow-up data for all substance abuse clients regardless of payment source directly into the WITS system.

Question: Who has access to this information? Is it in compliance with HIPAA? Do the insurers approve?
(This also appears in 2-3-25 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-27 Sub Category Integrated Case Management (ICM) for Offenders Statewide.)”

WITS is a HIPAA-compliant system. Each agency will be able to determine who has access to information placed into WITS. Each agency should consult with its HIPAA Privacy Officer and HIPAA Security Officer to determine levels of information access for agency staff as well as information to be released to private or other public insurers.

48. “Page 2-1-25 A. Cost Reimbursement 1. Cultural Activities “ADAD will access [sic] these requests based on various factors, including but not limited to, the number of ADAD supported clients that would participate in the activity or practice on an on-going and consistent basis; if the cultural activity or practice is considered an integral component of the overall design of the program or services; and if the proposed cultural activity or practice is unable to be sustained a unit reimbursement basis.

Question: How are these factors applied and who determines this?
(This also appears in 2-3-27 Sub Category 3, Dual Diagnosis Substance Treatment Services)”

The Technical Review team evaluates proposals and makes recommendations that are reviewed by the Division and Department.

49. “Page 2-1-25 and 2-1-26 Compensation and method of payment

Question: Can you submit for both Cost Reimbursement and Units of services and Unit rate?”

Yes.

50. “Page 2-1-26 (3) Residential Substance Abuse Treatment (c) and (4) Non-Medical Residential Social Detoxification (c). “Residential Program can bill for the day of admission but not for the day of discharge, with the exception of Residential Social Detoxification which may bill for both day of admission and day of discharge.

Question: We understand that the original reason for billing on admission and discharge was that on the average, a client enters treatment for a half day and discharges after a half day of service so that billing for one day covers both. Given that original reason and that there are separated costs associated with each level of care, can a provider bill for IOP on the same day as discharge from residential if attending in the evening? If not, then the providers would not transition clients into outpatient on the same day as discharge from residential, which would place the client at greater risk for loss of continuity of care. While this would happen if outpatient services are not available at the same day, we would want to minimize risk whenever possible.

(This also appears in 2-3-28 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b0-30 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

No, a provider cannot bill for IOP on the same day of discharge from residential if attending IOP in the evening. They can receive their treatment from the residential program that day and start IOP services the following day.

51. “Page 2-1-27 (5) Intensive Outpatient Substance Abuse Treatment item d. “the maximum length of stay shall be forty days per client per year.

Question: Does that mean if a client is admitted in January, uses up 15 days and then leaves treatment and resurfaces for treatment in August, then would that client only have 25 days remaining for treatment in the current year?

(This also appear in 2-3-28 Sub Category 3, Dual Diagnosis Substance Treatment Services and 2-1-6(b)-30 Sub Category 6 Integrated Case Management (ICM) for Offenders Statewide.)”

Yes.

52. “Page 2-3-5 Sub Category 3, Dual Diagnosis Substance Treatment Services

Question: Why is Kauai excluded?”

With limited available funds, ADAD is only able to support services on three islands. The islands identified have demonstrated the ability to utilize funds based on population and need.

53. “Sub Category 7 Adult Substance Abuse Recovery Homes Program

Question: What’s the difference between this service and Clean and Sober Home?”

Clean and Sober Housing is a new modality of service for ADAD and is different from both Oxford House and Therapeutic Living Homes. Oxford Houses are democratically run and operated by the residents with support from an overseeing structure that includes a revolving loan fund that covers rental deposits. Therapeutic Living Programs provide housing, 24 hours a day, 7 days per week, 365 days per year staffing, program support and must be licensed as Special Treatment Facilities. Clean and Sober Homes may be in a variety of living arrangements in the community and do not require 24 hour a day/7 day a week supervision. They must be associated with another modality of ADAD treatment. Clean and Sober Housing providers may partner (such as through a Memorandum of Understanding) with ADAD treatment agencies or ADAD treatment agencies may establish their own housing.

54. “We like the idea of one RFP for multiple services but have few questions regarding this method.

Question: 1) How do you want us to submit proposal with separate narrative and budgets per service, per island and/or per site? (Such as separate narrative services and budget for Waipahu, Kaneohe, Kauai and I.H.S.)”

Budgets should reflect the services in one sub-category (i.e. 440-08-1, adult services) on one Island (Island of Kauai, for instance.)

“2) If one budget is preferred for all services we are submitting in the response does this mean that we will have flexibility to move fund[s] around within the contract dollar amount among the various services we would be contracted to provide?”

Possibly, but it would depend on the service. There may be issues involved in moving funds away from one school to another school, especially in another complex.

55. “The ADAD Windward contract that CARE already has, is that a separate RFP from the new Adolescent Community Based Treatment RFP that just came out? Is there going to be another RFP for that contract?”

The current adolescent community based outpatient service providers must re-apply for this RFP.

56. “I have a quick question for you regarding tobacco and the RFP. I was reviewing the criteria and wondered if we are able to admit clients based solely on their tobacco use. As you may know, many of our clients that are pregnant are in our program now because of tobacco issues. Is it necessary for them to also have a Substance Abuse issue in order to qualify for the new grant funds?”

A client may be admitted solely for a DSM diagnosis of a Nicotine-Related Disorder, which is considered a substance-related disorder.

57. “On page 2-1-21 under Administrative 2d. Will ADAD consider expanding the use of funds to supplement QUEST for clients who have a dependency other than methamphetamine dependency?”

Not at this time.

58. “On page 2-1-27 and 2-1-28: The limit on IOP services is 40 days per year. For Outpatient, it is 96 hours per year. Is this a calendar [calendar] year, a fiscal year or with-in any 12 month period? If it is a calendar year or a fiscal year, if the client’s stay overlaps the year-end date, does the client get a bank of 40 more days of treatment as of the first day of the next fiscal/calendar year?”

It is by contract year, July 1 – June 30th. Clients are able to access services the following year but it should not be tacked on at the end of one year to the next year to double services.

59. “There are different rates listed for Education and Skill Building classes. Skill building often includes an educational component. Is this going to be a problem for ADAD to differentiate during monitoring visits? Why are there two different reimbursement rates?”

ADAD expects that skill building groups will have a maximum of fifteen clients so that clients may benefit from interactive instruction. Education groups may be larger because the instructor may provide hands-on experience.

60. “I have a question regarding the school based adolescent contract. We are planning to submit a proposal for all of the complexes on the Big Island – totaling 10

complexes. Do you want one RFP and one budget, or do you want the budget broken out by complex? Please advise.”

The budget can represent the total amount applied for but the proposal needs to clearly indicate what services and staffing patterns will exist at each school and the amount anticipated to be allocated to each school.

61. “Providers often perform services in a school based environment that are not compensated by ADAD but are essential to maintaining a positive relationship with the school administration. Often such services include teacher consultations, student assemblies, and attendance at frequent administration meetings. Can services that are needed in a school setting in order to support students and school community, that cannot be paid for through performance based billing, be reimburse through expenditure? In order to be effective in the extremely challenging school setting counselor must work to build a relationship[s] with the school and also partner with the school in order to serve the best interest of the client. Examples of this include:

- Classroom presentations – school based provider can go to classrooms and present information about the program as well as drug education information. Depending on the school Teen CARE does between 25 to 70 presentations a year that last from 15 to 20 minutes at each school Sometimes we do 30-45 minutes presentations, but generally we have to keep it to 15 minutes due the pressures of classroom time in the DOE.
- School based providers sometimes attend student Individualized Education Plan (IEP) for students, some of who are clients and some for who the school wants help with outside referral. We estimate counselors attending on average about 2 – 3 a year per school.
- School based providers attend other meetings with school administration to discuss client concerns, especially for kids that have been caught using on campus – some of which are clients and some who are not. These meetings sometimes have parents involved and sometimes don’t. We estimate attending anywhere from 0 to 20 of these a year per school depending on the school.
- School based providers do a lot of mandatory reporting of child abuse and bringing case of suicidal intent to the school, as well as working with CPS or the Crisis Line folks. These types of reporting issues take hours per case due to the need to work the school and outside agencies, as well as being available for support for the student. For mandated reporting of child abuse it is not common to spend 4 – 5 hours talking to the school, making the report, being with the client when they talk to the police, filling our CPS reports, talking to the police and CPS reporting line, talking to agency supervisors and writing up the notes – which very little if any if actually billable. We estimate reporting 2 – 8 cases of child abuse, suicidal intent, or risk of hard to others per school per year.

- School based providers can attend faculty meetings in order to keep abreast of issues within the school and DOE as well as to build relationships with teachers and school administration. This is part of the effort to be considered part of the school in order to partner together with the school to provide the best service to students. Also, if teachers perceive us as part of the school they are more likely to send students and cooperate with the program. Occasionally we present information about the program or drug education information at the faculty meetings. Faculty meetings are once a month.
- School based providers can attend the departmental counselor meetings in order to function as a team with the counseling department, receive referrals, work together on school related issues that the counselors can provide support for. These are normally once a month though some schools do them once a week.
- School based providers can attend School Services Team (SST) meetings (sometimes called other things in other schools). These meetings are where kids who have been identified as potentially needing additional services are discussed for referral and support purposes. These are normally once a month though some schools do them once a week.”

An addendum will be forthcoming that allows providers of adolescent services to bill for case management services face-to-face with a client, face-to-face with a community resource or through direct telephone contact with a client or community resource.

62. “We ask for consideration that school based adolescent screenings that do not result in admissions be considered for cost reimbursement. We screen between 2 – 3 times as many clients as are brought in. We get many referrals from peers, teachers, and administrators and upon screening the student may not be eligible or appropriate for treatment or may not be willing to enter treatment. We screen between 2 – 3 times as many clients as are actually brought into treatment. Sometimes students request to be screened by us and when we interview them we discover it is because they are concerned about a friend or a family member but may have not drug use themselves. We take the time to talk with adolescent to provide support and sometimes referral but we cannot bill for the time. Sometimes kids are referred who are not appropriate in any way for treatment because they don’t use. We recommend cost reimbursement because our understanding is that WITS could not be used since the screened clients would not be admitted.”

Make the request via your proposal and it will be considered under cost reimbursement.

63. “Will we have the option to bill through performance based units for recreational and educational groups instead of doing an expenditure based reimbursement for those groups if performance based is our preference?”

No.

64. “Page 2-1-28, Item C “...The APPLICANT can bill only for screenings that results in a client’s admittance into the Outpatient Program.”

Just wanting confirmation that the rate for this is \$88.00 for sixty (60) minutes, and the APPLICANT may bill by quarter hour (15 minutes) increments in excess of 30 minutes?”

Yes.

“What are the screening time limits, if any, as the time frame between a screening and admission may span several days, weeks, or months given the consumer’s individual circumstances? That is, staff may screen a potential admission who is in the jail but doesn’t get admitted until perhaps 6 months later. There may also be multiple visits to the jail between pending the release of the consumer from the jail into treatment. The same may hold true for school based adolescents who may take more than thirty (30) days to complete the enrollment into treatment.”

For clinical utility, the screening should be done as close to the admission date as possible. If significant time passes before admission can occur, ADAD strongly recommends administration of a new screening.

“May the APPLICANT bill for screening hours which result into a placement into other levels of care other than outpatient? For example, screening a consumer which results in an admission into the TLP only? Perhaps screening a consumer for admission into a facility run Clean and Sober home who happened to complete treatment elsewhere in the past 6 months? On page 2-1-28, item c, states “The APPLICANT can bill only for screening that result in a client’s admittance into the Outpatient Program.” Shouldn’t this be listed under other levels of care as well, if one is able to bill for screenings which result in an admission into a TLP as long as the service is only counted one time for the current course of care? What Category for billing does one use for screening? Case Management for face-to-face? Case Management for telephone contact? Individual counseling rate?”

Screening would be billed under the individual counseling rate for outpatient services provided the screening leads to admission for either outpatient or intensive outpatient.

“Is there a cap on the number for billable screening hours for a given consumer, or it just included as part of the total number of maximum hours

of services, per year?”

It is included as part of the total number of maximum billable hours of services per year for a consumer.

65. “Our fiscal department had the following questions:

2-1-15 b – If the client remains on TLP for 6 months after discharge is that billable?”

A TLP admission needs to occur within six months of discharge from a substance abuse treatment service. Provider may bill for up to six months of TLP after admission.

“2-1-16 3 – Can staff working outside their normal work schedule, who then facilitate cultural activities as an independent contractor on the weekends bill their time separately? We have key staff who provide direct cultural services and training to others outside their normal scheduled time.”

If the hours they put in are separate.

“2-1-21 c – Please define supplement. May we bill ADAD for the same encounter group as we bill quest[QUEST] if it includes motivational enhancement as part of the group?”

You cannot bill ADAD for the same group you are getting reimbursed for through another payment source.

“2-1-26 1 – If using motivational enhancement in individual session, is this billed as an individual session or is this billed as an motivational enhancements limited to only group activities?”

A provider may bill for a single individual receiving Motivational Enhancement (ME) or for several individuals receiving ME in a group.

“2-1-27 5 – Under the supplement scenario, if ADAD pays for IOP up to 5 days (\$600 limit @120 per day) a week and Quest covers 3 days a week, it is possible someone may clinically need 6 days of IOP treatment. In this scenario, would ADAD be billed for 3 days and Quest for the other 3 days (obviously one could not bill both for the same service on the same day)?”

If QUEST has determined that a client needs only 3 days a week of IOP, ADAD would not pay for additional days of IOP treatment simultaneously for that level of care that was not deemed necessary by the insurance company. ADAD will allow providers to supplement insurance coverage for substance

abuse treatment for clients with a primary diagnosis of methamphetamine abuse by extending the length of stay if documented that this is clinically necessary according to ASAM criteria.

“2-1-27 6b1 – When doing clinical case reviews with staff, which covers treatment planning and updates, when the client is present is this billable under a treatment planning or modification session at the incremental rate (15 minutes) of \$88? When the client is not present, is this billable as a case management face-to-face with a community resource if a member of the ADAD-ICM team or other referral source member is present? May case management be billed without the client present as long as other staff members are part of the treatment planning/update?”

Treatment planning and updates are billable at the rate of \$88 per hour, as long as a minimum of thirty minutes are initially provided. Additional billing by quarter hour increments are permitted. When the client is not present, the provider may bill for face-to-face case management services with a family member, face-to-face or case management with a community resource. Case management may be billed without the client present as long as the activities are on behalf of the client and documented sufficiently.

“2-1-28 6 & 7 – Are case management activities (face-to-face, phone) done by the Peer Specialist (Staff) working in the TLPs billable? Are individual sessions in the TLPs by Peer Specialist a billable service? Does Case Management activities include “transportation time” for each sub-category Program?”

The rate for TLP is all inclusive. Individual services may not be added on to the unit rate. Transportation time is not a covered expense under any case management services. The van rental, gas, and staff salaries may be eligible for coverage under actual expenditures for recreational or cultural activities.

“2-1-27-28, item 1-7 – What are the limits per week or are services capped by the year (96 hours per client year)?”

Services are capped by the year.

“2-1-28 8 – May we mix TLP beds and Clean and sober beds under one roof as long as the clean and sober clients have their own room?”

As long as this meets any accreditation requirements it would be acceptable.

“2-2(a) 13 – Is “d” missing? Page 2-2(a)- 14 starts with the letter ‘e’.”

Please review the Addendum issued on October 3, 2008.

“2-5-36 #6 – Does a pregnant woman qualify under sub-category 5 for entry into a TLP without any other children? That is, it is possible to admit 2 pregnant women with only 3 women each having a child for a total of 8 residents (5 women and 3 children).”

Yes, this is acceptable.

“2-5-36 #6-7 – Is case mgmt (face-to-face, telephone) for child a billable service?”

Yes.

“Is treatment planning/update for the child a billable service with the parent present?”

Yes.

“Is there an age limit on children in the home? That, from birth through 12? Birth through 18? What about male children in the TLP? Up to what age?”

From birth through age three.

66. “There is a reference in the RFP to administering the ASI (Addiction Severity Index) as part of the initial assessment and upon discharge to all clients admitted for treatment. This has existed in other RFPs, however, administration of an ASI upon discharge has been enforced by ADAD for many years. Will an ASI be required upon discharged? If required, is it sufficient to report only the ASI index scores into WITS? Can ASI index scores be substituted with ASI Composite Scores for reporting purposes?”

ADAD requires administration of the ASI upon discharge. ADAD requires at present the reporting of the ASI index scores only into WITS.

67. “In the RFP in [it] states that “Clients cannot be excluded solely on the basis of use of medically prescribed medication.” Does this mean that clients currently receiving methadone (or any other pharmacotherapy intervention for opioid addiction) are eligible for entry into all services under this RFP?”

Yes.

68. “Do you want one RFP and one budget, or you want the budget broken out by complex under sub-category 2? Please say one budget and one RFP as this would mean 10 complexes for the Big Island. That translates into 10 originals plus 40 copies in addition to the current 40 other manuals we’re putting together at present in order to address the RFP as specified. You would received 100 manuals from BISAC alone if you request one submitted RFP for each complex (original plus 4 copies). Please advise.”

One RFP and one budget are sufficient. The narrative can describe how the Applicant will serve each complex and provide a budget breakdown.

69. “In regards to the WITS system, will there be a time frame for the awarded [ICM] case management provider to be in compliance with utilizing the aforementioned system?”

The ADAD WITS system is ready to be utilized by all providers effective July 1, 2009. Training and orientation to the WITS system will be provided after the award is made.

70. “In utilizing the WITS system and the sharing of information with awarded drug/alcohol treatment providers, will the Screening/Clinical Assessment done by a case manager be sufficient for an individual to be admitted into the drug/alcohol treatment program? Note: Duplication of Screening/Assessment for clients.”

ADAD requires that an ICM case manager (CSAC or masters level counselor or professional supervised by either) complete the screening/clinical assessment prior to referring a client to a drug/alcohol program. The ICM treatment services program may elect to accept the ICM case manager’s screening/clinical or perform their own.

71. “Can Olomana Youth Center funding be separated from Kailua HS since it is an Alternative Learning Center (A.L.C) for the windward district. Olomana accepts students with behavioral and academic challenges from windward school – King IS, Castle HS, Kalaheo HS, Kailua HS, Kailua IS, Waimanalo IS) and is not a feeder into Kailua High school. When students make up necessary credits they then go back to their home school which is any of the above schools. OYC serves both intermediate and high school students from all windward intermediate and high from the Castle, Kalaheo, and Kailua complexes.”

Yes, Olomana may be applied for separately.

72. “The RFP describes a ratio of one counselor to sixty clients. Is that sixty clients per year? Can you elaborate? What if we do not use this specific ratio in our bid, will we have points deducted?”

The client to staff ratio stated was intended for a year. Client to staff ratio is a factor in evaluating a proposal, points will not be deducted if a smaller ratio is used .

73. “The RFP describes having one counselor at larger schools and less than one counselor at smaller schools. To form an effective relationship with a school, there is normally a need for at least one full time counselor per school. Can you elaborate on this aspect of the RFP? If we have full time counselors at each of the school in our bid, will we have points deducted?”

Fiscally ADAD will not be able to justify 1 FTE for smaller schools.

74. “For community based adolescent services will an agency be required to take students from anywhere on the island or can they focus on a geographic area?”

You may focus on a geographic area.

75. “For adolescent community based IOP/OP services, can an agency create a plan to serve adolescents in a community based setting in the evening at an office on the school campus if they already have that space to work in?”

Yes, services may be provided at a school as long as the students being served are not school-based students.

76. “For the adolescent Intensive Outpatient Program services in Sub-Category 2-A:

Is there any flexibility with the minimum service hours needing to be 3 hours per day and 9 hours per week? What if a youth is serviced for less than 3 hours on one or more days? In doing the Intensive In-Home & Community Based services with CAMHD youth, higher amount of hours are authorized in the first couple months (20 hours and 10 hours per week, respectively) and then lowered to 5 hours per week for the duration of the admission, unless the youth experiences a crisis. Given our experience with youth receiving this level of care, we anticipate that it will likely be difficult to get a youth to commit to a participating in 9 hours of services every week, especially as the youth targeted in this RFP are non-adjudicated youth?”

This is not the CAMHD population. If the client requires less than 9 hours of treatment per week, then this client should be transferred to the Outpatient level.

77. “Could phone calls also be incorporated as part of direct services? These would include phone calls between the counselor and the youth and/or youth’s parents (when appropriate and particularly when family counseling is being provided)? In the CAMHD Intensive Home & Community Based services, phone calls often play an integral part of the intervention. As an example, phone calls between

youth/parents and their mental health counselors are key in teaching youth & their families coping, problem solving, and communication skills and support the work that is done in the direct face-to-face individual and family counseling time. There is a general rule of thumb that is followed and monitored through supervision, in which phone calls are typically no more than 20% of the direct service time.

In addition, phone calls with collateral workers, such as school counselors or other community service providers is also important in treatment planning and the coordinating services and for this reason, is a billable through the CAMHD Intensive In-Home & Community Based services.”

These are not CAMHD clients, however, an addendum will be forthcoming that allows providers of adolescent services to bill for case management services face-to-face with a client, face-to-face with a community resource or through direct telephone contact with a client or community resource. Community resources can include parents, family members, relatives, mental health counselors, school personnel or other professionals/persons considered important in the coordination of services for the client.

78. “For the Adolescent School-Based Outpatient Treatment services in Sub-Category 2-B:

Page 2-2B-4 states, “ADAD estimates one counselor position will be needed for approximately 60 students requiring treatment services”. Does this mean 60 students per program year? In previous discussions with Dr. Jared Yurow, we have been advised that a typical active caseload at any given time should be approximately 15 students. If program enrollment at a particular school should exceed 15-20 students for a prolonged period, would the providing agency be able to add another counselor, providing there is consultation with ADAD? In most situations, we would try to utilize available resources, such as practicum students.”

The client to staff ratio stated was intended for a year. Client to staff ratio is a factor in evaluating a proposal, points will not be deducted if a smaller, preferred ratio is used.

79. “If an agency is awarded a contract to provide school-based outpatient treatment services in a particular complex, could that agency decide to sub-contract with another agency to service one the schools in that complex? If so, would this sub-contract option need to be included in the proposal, even though it may not be certain at the time the proposal is submitted that sub-contracting would be pursued?”

Yes, it is possible, describe it in your proposal. Sub-contracts could be added later with prior approval from ADAD.

80. “(p. 2-2B-4, *Geographic coverage of service*, Section E. The RFP states that “APPLICANT shall apply by school complex area.”

Question: Does this mean that if the APPLICANT is seeking an award to provide services to more than one school complex area, that they must submit a separate and complete application for each of the school complex areas they wish to serve, or can the APPLICANT submit one application to serve multiple school complexes and provide relevant information for each school complex when required (e.g., needs assessment, ability of APPLICANT to provide required services to the specific school complex), while providing a single set of required documentation that applies to all school complexes (e.g., description of the APPLICANT organization, facilities, project organization, etc.)?”

One application is acceptable as long as all of the complexes being applied for are on the same island. Separate proposals are required for separate islands.

81. “(p. 2-2B-4, *Geographic coverage of service*, Section E). The RFP states:

Since some schools have small enrollments, the amount awarded for treatment at each school complex area will take into account the number of students enrolled and the needs of the district based on the 2003 Department of Health’s Student Alcohol, Tobacco and Other Drug Use Survey. ADAD estimates one counselor position will be needed for approximately 60 students requiring treatment services. Since funds are limited, APPLICANTS should anticipate that no school be staffed for more than one counselor and smaller schools will be funded for less than one counselor.

Question: It is unclear how the different criteria for funding each school complex (size of each school complex, identified needs of each complex, and a counselor to eligible youth of 1 to 60) are used to determine the Probable Funding Amounts as described in the Tables on 2-2B-5 to 2-2B-8. Are the Probable Funding Amounts set as stipulated in the Tables with the staffing pattern predetermined by ADAD, or are the amounts negotiable, with the APPLICANT able to receive a different amount to hire staff based on justifications and identified needs relevant to the individual school complex that is documented in the application?”

Should less funds be applied for by applicants, then the remaining funds would be redistributed.

82. “Similarly, is the counselor to eligible youth ratio of 1 to 60 predetermined, or is this ratio also negotiable, based again on justifications and identified needs relevant to the individual school complex?”

Comment: Our experience has been that the identified individual treatment needs of schools in terms of the number of youths who can be recruited into the treatment

program typically number between 35 to 40 during the school year, and do not reach as high as the 1 to 60 ratio indicated in the RFP. Further, a more accurate predictor of need is the number of youths served in previous years at a particular school, as well as the number of risk factors in the community, including lack of access to treatment-related services and programs, especially in rural areas. While developing a formula to account for multiple factors is difficult, there should be flexibility in the amount of money actually granted for each school complex that is not based solely on total enrollment and a pre-set ratio of 1 to 60, but also on demonstrated need.”

The client to staff ratio stated was intended for a year. Client to staff ratio is a factor in evaluating a proposal, points will not be deducted if a smaller, preferred ratio is used.

83. “(p. 2-2B-4, *Geographic coverage of service, Section E*). If two agencies are applying for the same school complex area, but would prefer by mutual agreement to divide the complex between themselves with each providing services to half the schools (where the complex consists of two schools), or one agency providing services to two schools and the other providing services to one school (where the complex consists of three school), would ADAD approve of this arrangement, and if so, how should the two agencies submit their applications?”

Yes, it is possible and it should be clearly stated in both agencies’ proposal.

84. “For the Island of Oahu, if the location of the site is located where the greatest need for any substance abuse treatment, i.e., Windward District, will preference for admission be given to the Windward District or open for all geographical areas on Oahu.”

Preference will be given to providers who serve the areas with greatest needs.

85. “In regards to the Cultural Activity Expenditures, will this be a line item on the budget for use as cultural activities such as excursions and other activities that are integrated into the curriculum?”

Yes, cultural activities such as excursions and activities could be billed as an expenditure, however, it would not be a line item in the budget. It should be a separate program cost that should be submitted as part of the proposal.