

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

Addendum Two

September 30, 2011

To

Request for Proposals

**RFP HTH 460-12-01
Comprehensive Behavioral Health
Services for
Children, Youths, and Families**

September 1, 2011

September 30, 2011

ADDENDUM NO. TWO

To

**REQUEST FOR PROPOSALS
RFP HTH 460-12-01**

The Department of Health, Child and Adolescent Mental Health Division, contract Management Section is issuing this addendum to RFP HTH 460-12-01 Comprehensive Behavioral Health Services for Children, Youths, and Families for the purposes of:

- Responding to questions that arose at the orientation meeting of September 16, 2011 and written questions subsequently submitted in accordance with Section 1-V, of the RFP.
- Amending the RFP.

The proposal submittal deadline:

- is not amended.

Attached is (are):

- A summary of the questions raised and responses for purposes of clarification of the RFP requirements.
- Amendments to the RFP.

If you have any questions, contact:

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**Responses to Question Raised by Applicants For RFP HTH 460-12-01
Comprehensive Behavioral Health Services for Children, Youths, and Families.**

- 1. Since Ancillary services will be automatically incorporated into residential programs, do we need to propose these services as a separate program with a separate budget? Or will these services be automatically added when criteria is met?**

Ancillary One on One service level of Care will automatically be included with all residential service contracts. There is no budget as it is a unit rate. When the criteria is met and approved by the CAMHD Medical Director via the CAMHD Branch, the provider will receive notice of the units and dates of the approved Ancillary One on One service.

- 2. For the RFP response, is CAMHD wanting one response per agency - for all geographic areas/ all services, or one proposal per geographic area which may include multiple services?**

*The RFP response is by level of care. The applicant must submit a proposal for each level of care they intend to provide and include all geographic areas they intend to provide the service in that proposal. For example, should the applicant want to propose TFH services for the counties of Maui and Hawaii, the applicant will submit one proposal for TFH services with a clear identification of the geographic locations of their services. The CAMHD Evaluation teams will be evaluating proposals by individual Care Level and not geographic area. **See Question 20** to determine which Evaluation Team(s) will be evaluating the particular Care level(s) that you are interested in applying for. You will need to have a separate proposal for each different Evaluation Team that will be evaluating your Care Levels.*

- 3. On Page 4-3, can you clarify the last sentence under D. Coordination of Service? It seems to be missing a portion of the sentence.**

*The evaluation question **III. B. 1. D. Coordination of Services** is missing the word “community” and is corrected as shown below:*

- Demonstrates agency commitment and capability to coordinate services with schools, other child serving agencies, primary care provider and informal community programs and resources in the community.
[4 points]*

- 4. The RFP does not ask for CMO services for the Big Island? Please confirm that these services will still be contracted for, but that the contract period is on a different time period?**

The current CMO contract on the Big Island does not expire until Fiscal Year 15. It will be procured with other 103F contracts that expire at that time through a new RFP specific to those contracts.

5. Please confirm that the Therapeutic Group Home services are being eliminated

Therapeutic Group Homes will not be part of the CAMHD Array of Services offered beginning in Fiscal Year 13.

6. For changes in the CBR bed capacity (page 2-36), please clarify how much notice will be given to the provider.

Any planned changes to the bed capacity or the percentage of guaranteed payment would normally be given a ninety day notice but this does not supersede the State's General Conditions right to terminate in whole or in part as shown below:

4.2. *Termination in General. This Contract may be terminated in whole or in part because of a reduction of funds available to pay the PROVIDER, or when, in its sole discretion, the STATE determines (i) that there has been a change in the conditions upon which the need for the Required Services was based, or (ii) that the PROVIDER has failed to provide the Required Services adequately or satisfactorily, or (iii) that other good cause for the whole or partial termination of this Contract exists. Termination under this section shall be made by a written notice sent to the PROVIDER ten (10) working days prior to the termination date that includes a brief statement of the reason for the termination. If the Contract is terminated under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.*

4.3 *Termination for Necessity or Convenience If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days' written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.*

7. How many youth & families are anticipated needing Functional Family Therapy – by Island?

The CAMHD Annual Fact Book for FY2010 is available on the CAMHD website. The Fact Book presents data on the number of youth served, broken down by Family Guidance Center, for each levels of care separately. The data on use of FFT are found on page 8.9.3. The data shows that a total of 76 youth received some FFT services over the fiscal year including 5 from Central Oahu, 1 from Windward Oahu, 23 from Leeward Oahu, 10 from Honolulu, 23 from the island of Hawaii and 12 from Kauai. These numbers should be seen as the minimum estimates for FY13. We expect enrollments in CAMHD to go up at least slightly from FY210, and we are opening FFT to ES youth for the first time beginning with the new contracts. As FFT services has shown some successes, we are expecting demand to increase for this Evidence-Based service.

- 8. Please clarify what is meant by “the provider having a separate contract with the DOE for educational services” on page 2-11 under CBR-III. Is this a new requirement? In the past a provider could hire a special education teacher for this service. Is that still an option?**

CAMHD staff worked very hard up until the RFP was issued to get clarity from DOE about how they will be funding the educational portion of our residential services going forward. Rather than the current practice where CAMHD includes education in our payment to providers, and then bills DOE for a portion of each child’s residential daily rate, they would prefer to contract directly with providers for the educational costs. We are not sure how the DOE will support this approach.

- 9. How many youth are anticipated needing Intensive Home Therapy services and Intensive In-Home Paraprofessional Support services by contract area?**

The data for the 2010 fiscal year are available on-line in the CAMHD fact book. <http://hawaii.gov/health/mental-health/camhd/library/pdf/rptheval/ge/ge029.pdf> This is probably our best estimate of the numbers likely to utilize these services in FY2013. We expect enrollments in CAMHD to go up at least slightly from FY2010. The availability of more community-based support services such as Therapeutic Respite Homes may make it more feasible to serve youth in their own families. The data for FY2010 show a total of 814 youth receiving some IHH services, including 110 in Central Oahu, 91 in Windward Oahu, 159 in Leeward Oahu, 99 in Honolulu, 250 on Hawaii Island, 34 on Kauai and 74 on Maui.

- 10. How many youth are anticipated needing Intensive Independent Living Skills services and Independent living Skills Paraprofessional Support service by contract area?**

Because this is a new service, it is hard to anticipate demand using any data on past usage. In FY2010 there were a total of 450 youth older than age 18 registered in the CAMHD system. Only 181 of them received procured services. The registered youth included 24 in Central Oahu, 23 in Windward Oahu, 64 in Leeward Oahu, 43 in Honolulu, 110 on Hawaii Island, 36 (high end) on Kauai and 33 on Maui. An additional 69 youth over 18 were registered with FCLB. The ILS service can be used for youth as young as 16, and it is our only service particularly targeted at the young adult (18-21) population.

11. For Therapeutic Crisis Homes, will ancillary services be allowed for overnight watch – should the youth be suicidal and require close observation?

No. Youth requiring such close observation should qualify for acute hospitalization.

12. Could a Crisis Home client be in the same home with TFH and/or Therapeutic Respite Home client?

No. Since this is a cost reimbursement contract, the Crisis home should be reserved for Crisis clients.

13. If we want to apply for Therapeutic Respite Home would that be part of the Transitional Family Home proposal (see page 2-22 of the RFP).

Yes.

14. How many youth are anticipated needing the various support services for Emotional and Behavioral Development Performance Standards?

As stated above, the CAMHD Fact Book is available on-line at: <http://hawaii.gov/health/mental-health/camhd/library/pdf/rptheval/ge/ge029.pdf> . This provides the most recent reliable data about the use of all current levels of care. Since past behavior is our best predictor of future behavior – these data provide the best available estimates for future system use. Other variables may be a factor. We believe FY 2010 may have been a particularly poor year for CAMHD referrals because of the poor economic situation and the impact of issues such as school furloughs and DHS lay-offs. Since we are eliminating group homes, it is anticipated that we may see a slight increase in the use of both CBR-III and TFH.

15. In comparing the CAMHPS and the RFP there are differences:

- **The forms for the Sentinel Events and Weekly Census are different in both Procedure 80.308 in the RFP titles the procedure as Initial and Re-credentialing of Licensed Health Care Professionals and the CAMHPS**

procedure titles the same document Initial and RE-credentialing of Licensed Qualified Mental Health Professionals.

For both instances listed above which one do we use in submitting the proposal? Do we use the RFP version or the CAMHPS?

Proposal shall follow the amended CAMHPS which will be posted to the CAMHD website with all noted corrections to date and the inclusion of Initial and Re-credentialing of Mental Health Professionals and Paraprofessionals policy and procedures. Next updated post to be October 3, 2011.

- 16. On p. 3-7 under Staff Qualifications, applicants are asked to submit resumes for corporate officers and key personnel, as well as the Youth Specialist and Family Specialist, if available. Do we also need to include resumes for direct line staff?**

No – that is not necessary.

- 17. Would CAMHD be willing to accept one proposal per geographic area (which incorporates all services being offered for that area) rather than one proposal per level of care? This would eliminate the number of proposals an agency may have to write, which could be up to 9 for organizations applying for everything.**

No! The Evaluation teams will be Care Level Specific and Proposals will be assigned by CARE Levels to the various trained teams.

- 18. Will a separate Proposal be required for Therapeutic Crisis Homes or can it be included with another level of care such as Transitional Family Homes with Respite Homes and Ancillary One on One Service?**

Therapeutic Crisis Home is a Cost Reimbursement Care level and should be a separate Proposal.

- 19. Will budgets be required for all levels of service?**

Cost Reimbursement proposals will require the use of the Budget Forms. Cost Reimbursement levels of care are identified in Attachment M

- 20. What Care levels may be grouped together in a single proposal?**

The Care Levels that will be evaluated by a specific team may be grouped together if you are applying for more than one level of care within that team's group. You may use one proposal to apply for all the levels of care in that team's group or only a single level of care in that group.

EVALUATION TEAM 1

Emer. Crisis Mobile Outreach

Emer. Therapeutic Crisis Home

EVALUATION TEAM 2

Functional Family Therapy

*Intensive In-Home Therapy, including Intensive In-Home
Paraprofessional Services*

*Intensive Independent Living Skills, including Independent Living Skills
Paraprofessional Services*

*Evaluation Services and Out Patient Services to include:
Mental Health Evaluations, Summary Annual Evaluations
Psychological Testing, Psychiatric Evaluations
Medication Management, Individual Therapy
Group Therapy, Family Therapy*

EVALUATION TEAM 3

*ES Transitional Family Homes (formerly contracted as Therapeutic Foster
Homes)*

ES Therapeutic Respite Homes

*Ancillary One on One Service (automatically included with all outpatient
services)*

EVALUATION TEAM 4

Psychosexual Assessment

Community-based Residential – Level III

Community-based Residential – Level II

Community-based Residential – Level I

Hospital-based Residential

Partial Hospitalization (Include with HBR or as standalone)

Ancillary One on One Service (automatically included with all outpatient services)

21. What geographic areas are desired for statewide CBR III? Do you want to be on the Big Island to replace the Closed CBR III?

We would like a CBR III on the Big Island but since these programs are Statewide Facility Programs, it is more desirable to be able to select the best provider proposals rather than specific geographic locations.

22. CAMHPS Book: The seclusion and restraint policy for hospital-based providers specifies that a face-to-face assessment be conducted by a physician or psychologist within one hour. Why doesn't the CAMHD policy align with CMS (Center for Medicare and Medicaid Services) and the Joint Commission, which require the assessment be conducted by a 'Licensed Independent Practitioner'? There is content in the CMS and Joint Commission Standards that permit an RN to do the face to face assessment also. We request that LIP's and RN's be added to providers allowed to perform face-to-face assessments. It is not logistically possible for our hospital to comply with the requirement that a physician or psychologist provide the face-to-face assessment during night hours.

The CAMHPS Book has been amended to allow APRN and RN with specialized training and experience in the diagnosis and treatment of mental health disorder to conduct the one hour face-to-face assessment in addition to the physician and psychologist. p 30

23. In the liability insurance sections, the RFP specifies several clauses which cannot possibly be met by providers who are ‘self insured’ –for example, CAMHD must be named as an additional insured. All of our past and current contracts with CAMHD and other State departments have language which allows for valid ‘self insurance’ by our parent company. Why doesn’t the RFP contain language which is applicable to self-insured organizations?

Section 1. XXII. General and Special Conditions of Contract, Liability Insurance and Section 2. II. General Requirements in the Insurance section shall be modified to allow for Self Insurance Providers that are covered by Hawaii Captive law (H.R.S. 431: 19-102 to eliminate the requirement to include the statement on page 2-25 as shown below:

“Each insurance policy required by this Contract shall contain the following clauses:

- 1. The State of Hawaii and its officers and employees are additional insured with respect to operations performed for the State of Hawaii.*
- 2. It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy.*

The certificate of insurance shall indicate these provisions are included in the policy.”

24. CAMHPS Book. The seclusion and restraint requirements do not align with CMS and the Joint Commission. For example, the RFP allows for and defines ‘chemical restraint’ differently from CMS/Joint Commission. Would it be possible to:

- a. Remove the policy and procedure wording from the ‘CAMHPS Book’ (which cannot be changed for 6 years).**

b. Align the policy/procedure with the current CMS requirements and Joint Commission standards, and allow for modifications to keep in compliance with upcoming changes

The CAMHPS Book definition of “Chemical restraints” has been changed to “Drugs used as a restraint” and its definition taken directly from CMS. p 28

Additionally, the following has been added to the Restraint and Seclusion section of the CAMHPS Book. “The current Centers for Medicare and Medicaid Services accreditation standards sets the minimal requirements with regards to the use of restraints and seclusion, but CAMHD goes beyond these minimum requirements in keeping with its commitment to violence-free and coercion-free treatment environments that ensures the safe treatment of youth. CAMHD requirements are outlined in this section and defined in its policies and procedures. CAMHD reserves the right to revise its policies and procedures periodically or as new requirements are established by the Center for Medicare and Medicaid Services. All Contractors will be notified of any policy or procedural change.” p 28

25. CAMHPS Book, page 146 refers to a pre-admission meeting. Page 147 refers to admission criteria. We are currently working with CAMHD and other payers on an authorization procedure for residential youth. How is it possible to have a pre-admission meeting for youth who are approved for CAMHD services during the course of their residential stay or for those youth who only require brief crisis stabilization in acute care prior to their transfer to residential?

Pre-admission meeting need to occur before or on the day of admission to HBR. The meeting is intended to ensure that all involved parties are informed about treatment target, discharge criteria and expectations of involvement in the treatment process. This can be a stand-alone meeting or combined with discharge or treatment planning meetings in other levels of care.

26. CAMHPS Book, starting on page 146 mentions family involvement at time of admission and during the course of the stay. Will children in need of service and meeting admission and continued stay criteria be denied service authorization if the parent is unwilling or unable to participate at time of admission or during the stay?

No not necessarily, these decisions need to be made on a case-by-case basis. Generally, CAMHD does not support the treatment of children in isolation from their parents, therefore it is imperative that the provider make reasonable effort to engage the parent and document their efforts.

27. RFP page 2-32, states that the provider's submission of electronic billing will comply with HIPAA. It would be better to include a general statement in the RFP that CAMHD and providers billing will comply with HIPAA and any other applicable laws rather than specify that what is required under current law. Billing regulations change frequently: I believe HIPAA Administrative Simplification requirements for CAMHD and providers pre-dated the previous RFP; use of the 5010 version of the X12 standards and the NCPDP D.0 standard will be required by federal law by January 1, 2012; etc.

The statement will be revised as follows:

“All Providers will be required to adhere to the CAMHD billing reporting requirements. CAMHD and providers billing will comply with HIPAA and any other applicable laws and will be revised in accord with the current applicable law.”

28. Will CAMHD accept a valid electronic 837 transaction file (in lieu of the time-intensive manual input into the CAHMIS system), as required by HIPAA Administrative Simplification rules?

By Federal Law CAMHD will accept a valid electronic 837 transaction file if requested by the Provider. In addition to the electronic 837 transaction file, the Provider will be required to enter the encounter data through the VistA Electronic Health Record.

29. The RFP should specify that CAMHD department policies and procedures can be changed to comply with changing law, regulation, rules as required.

*GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
(AG Form 103F (10/08)) paragraph 1.3 states that:*

“The PROVIDER shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the PROVIDER’s performance of this Contract, including but not limited to the laws specifically enumerated in this paragraph.”

Which certainly implies CAMHD shall change department policies and procedures to be in compliance with any changes in the laws, ordinances, code, rules and regulation as required.

The following has been added on p 2 of the CAMHPS Book “CAMHD will periodically revise its policies and procedures to comply with department policies, changing laws, regulation and rules as required. All contractors will be notified of any policy and procedure change that may affect their operations.”

30. CAMHPS Book: Documentation requirement that a psychiatrist document progress notes 3x per week with at least 2 face-to-face notes. In accordance with other payer requirements, we request that the psychiatrist document a progress note for residential patients once a week to include all activities and face-to-face meetings with the patient.

CAMHD requires all progress notes to be in the chart within 24-hour of service delivery.

- 31. Residential staff ratios: These ratios seem to be a vestige of the consent decree. We recommend changing the requirement to read ‘clinical staff ratios must be adequate and in accordance with community standards’**

CAMHD will not be changing staffing ratios, it will remain as written.

- 32. Page 191 CAMHPS Book- Partial Hospitalization Services Offered- #3 daily educational programming and #5 onsite educational program that addresses the educational goals and objectives-Please clarify what type of educational programming or educational program is expected. Our hospital-based program meets TRICARE certification requirements. As such, education hours are not counted toward the number of hours of programming for partial hospitalization. We assist the parents to request home-hospital tutoring through the DOE upon admission. Education is usually 5 hrs a week tutoring in hours outside of partial hospitalization or the number of special education hours identified in the IEP.**

The program needs to work with the DOE to ensure the educational needs of the youth are met including any IEP requirements. Since CAMHD will not longer be contracting for this service the special education teacher requirement will be removed from the staffing requirements. Additionally, the following statement will be added under the clinical operations: “CAMHD expects the Contractor to ensure the educational component of the program, including its teaching staff, meet all CAMHD CHAMPS requirements, even if it is under a separate contract with the DOE.”

- 33. CAMHPS Book: P.192 Admission criteria #2- Pre-admission meeting prior to admission: Currently, the initial treatment team meeting is held at partial hospitalization within 7 days of admission. For those patients referred from**

hospital-based residential: If the meeting is required prior to admission, can the last treatment team meeting on residential be used as the pre-admission meeting for partial hospitalization?

Yes, the two meetings can occur simultaneously.

34. CAMHPS Book: P.195 Partial hospitalization Exclusions #2 partial-‘Not offered at the same time as any intensive outpatient service (IIH, IILS, MST, FFT) except when clearly documented in PHPs treatment/discharge plan and within 2 wks of discharge from PHP’: we often have CAMHD kids who also receive in-home services while they’re at PHP, sometimes coming over from RTS with the services already in place, not just within 2 weeks of discharge. Services are used as support for patient/parents in evenings/weekends during hours PHP not available and is all done through the care coordinator. Will this be allowed to continue?

Each case will be determined on a case-by-case basis but yes it can happen when medically necessary.

35. CAMHPS Book: P. 196 partial hospitalization#5- Psychological testing will be provided: in our current program, psych testing is only provided if ordered by the physician. Psych testing is timely and time-consuming. Will it be required of every patient? What tests are included in ‘psych testing’? Will there be a separate payment for the testing?

Psychological testing will not be paid separately as it will be expected as part of the partial hospital service. Any standardized measurements, instruments or procedures will be accepted provided it is appropriate to the specific diagnostic question it is intended to answer. Not every youth will require psychological testing, it will only be needed in those rare circumstances when there is a need to clarify the diagnosis or provide treatment direction.

- 36. CAMHPS Book: Partial hospitalization: Individual/ family/group therapy progress notes; every nurse contact, *including medication administration*; daily progress note: Our program and scope of license do not allow us to administer medications in our partial hospitalization program.**

If the program cannot administer medication, it must describe in detail how it will meet the needs of youth who have medication administration needs during program operation hours.

- 37. CAMHPS Book: Restraint rule, page 29 hospital-based residential: Can a face hood especially designed to prevent spitting and protect respirations be approved and then utilized as a safe alternative to staff using a towel or other item to block exposure when patients are spitting? This is necessary to protect staff from body fluid exposures.**

CAMHD does not support the use on any device that covers the mouth. It is explicitly prohibited in the section on restraints and seclusion in the CAMHPS Book.

- 38. CAMHPS Book: Page 29: seclusion and restraint orders-Other forms of restraint and seclusion may be ordered only by: a) a board-certified psychiatrist, b) a licensed psychologist, or c) a physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases. Please consider adding “Licensed Individual Practitioner (LIP) to this. An APRN (Advanced Practice Nurses) with special training in S/R should be permitted to write orders. Why would a psychologist be any better qualified here?**

Orders for other forms of restraints and seclusions can now also be ordered by APRN with specialized training and experience in the diagnosis and treatment of mental health disorder as well as the application of seclusion and restraints p 29

39. CAMHPS Book: Page 31: seclusion and restraint debriefing --The youth and all staff (except when the presence of a particular staff person may jeopardize the well-being of the youth) involved in the emergency safety intervention must have a face-to-face discussion. Please consider removing the word “all” staff. It is not feasible to involve all staff since following the emergency some must return to attending to patients on other units. We try to include as many as possible especially those present at the initiation.

When possible all staff involved in the seclusion or restraint should be included in the debrief, but when staff patterns prevent this, the initial staff involved in the event will be included.

40. Seclusion and restraint policy: The facility must require or adhere to: Staff certification in the use of cardiopulmonary resuscitation, including annual recertification; The American Hospital Association now allows for two-year certifications (rather than annual) for Basic Cardiac Life Support. Will CAMHD accept two-year certifications?

Every two years is acceptable.

41. Seclusion and restraint policy: requires initial training must be a minimum of eight (8) hours in duration. Staff must receive at least eight (8) hours of training in crisis intervention annually. At least two (2) times a year, a staff person must safely demonstrate the safe use of restraint or seclusion techniques...our current CPI renewals are 4 hours per year. Please further define what qualifies as a ‘competency assessment’, what evidence there is that an additional 4 hours of training leads to

higher levels of competency, and if CAMHD will provide additional funding for staff training

Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a youth in a restraint or seclusion before performing any of these actions, as part of orientation, and subsequently on a periodic basis consistent with hospital policy. The training is not intended to just be CPI renewals but include training that teaches de-escalation interventions from a verbal standpoint as well. All training staff receives for restraint and seclusion also apply to the required thirty (30) hours of training annually.

42. Will the provider agency be required to encumber FFT consultant costs, such as the annual training on-site for FFT teams?

Yes, any training the provider needs to be compliant with the level of care will be part of their budget. Applicants interested in becoming a FFT Provider should contact Douglas E. Kopp, CEO, of FFT LLC. 1251 NW Elford Drive, Seattle, Washington 98177 Phone 206-409-7198 Email: dkfft@msn.com to determine the training and licensing cost of becoming a FFT Provider agency..

43. Are interisland travel costs allowable, for example:

- **Supervisor costs for on-site consultation/training between supervisors and/or with each other's teams;**
- **Supervision of a therapist on another island when that island is needs back-up supervisor coverage; and**
- **Supervisors' joint efforts to do outreach and conduct marketing sessions between islands with stakeholders?**

These travel expenses should be included in the submitted budget with justifications. Anytime that supervision can be done via teleconference rather than face to face, that is the expectation.

44. Does CAMHD have any preferences for service coverage of Hawaii County, with regards to containing mileage expenses and staffing?

There is only going to be one FFT contract for all of Hawaii county so the cost reimbursement budget needs to include the expenses based on coverage of the entire island.

45. Please confirm that applicants seeking to provide the FFT service for more than one county must submit only one proposal. If applying for all counties—Kauai, Honolulu, and Hawaii--does one proposal mean:

- **One application narrative and 3 separate budgets OR**
- **One application narrative and 1 budget to cover all three counties?**

There should be one application and a labeled separate section for each area being applied for that would contain any unique information along with their separate budget. The contracts will be issued for each level of care by each county listed in the RFP. Proposals will be evaluated and the applicants rated on each separate section requested by county. For example, if the application was for two separate geographic areas (two separate contracts) there would be two separate proposal sections, one of each area, and therefore two separate scores, one for each area being requested. The application narrative for that level of care score would be the same for each proposal but the score for the specific geographic section and budget could be different. The intent is to eliminate all

the duplicate information that would be required if each geographic area required a separate proposal.

46. If one proposal for multiple counties is required, will an applicant be scored on the basis of "all or nothing"? In other words, since a single proposal will be reviewed, will CAMHD score the proposal in such a way that the applicant will either be awarded for all of the counties proposed for or none at all?

Since there is a separate section required for each geographic area that is being applied for, there will be a separate score for each area. But Applicant will be evaluated on their qualifications and abilities as described in their proposal to provide that particular level of care and that portion of the rating would be consistent for the total proposal. There will be a separate rating for each geographical area but the variations should be limited to any operating changes that may apply to that area and the area budget.

47. Would CAMHD allow for an applicant to submit three separate proposals by county and one proposal that encompasses multiple counties?

Each County being contracted for will have a separate contract and would require a separate budget for that contract. If you are implying that you would be able to provide the services at a reduced price if you were awarded more than one county contract then that information could be addressed by stating the proposed budget could be reduced by a particular percentage based on economies of size for each additional geographic contract awarded for that level of cost reimbursement care. These are proposals that are weighted on experience and capabilities and other areas more than financial issues. Willingness to adjust budget on economy of scale should be a positive influence on the scoring of

degree of competitiveness in your budget assuming the initial separate budget was competitive.

48. Would the HBR and PHP programs be allowed to share space and staff?

In accordance with CAMHPS standards, HBR population staffing ratios cannot be counted at the time as staffing for other population. Therefore, both partial and HBR must have their own staffing. While the two populations may share the same space the staffing patterns must be distinct.

49. Could the HBR and PHP clients attend the same groups?

No, CAMHD does not want to see a mixing of youth in HBR with youth in partial on therapeutic matters. CAMHD believes keeping the two populations separate will allow the acuity needs of each grouping to be appropriately addressed. Additionally, when running groups the group therapy standard would need to be considered as well. The footnote for group, family and individual therapy is missing from p 146 and will be added in the amended book.

50. Could the HBR and PHP clients attend the same education classes?

For educational purposes, CAMHD will allow the mixing of populations provided that the staffing ratio for each population is met.

51. Do we need to submit resumes higher than level of Director? e.g. CFO, COO.

The resumes should be for the executive staff that would directly oversee or influence the particular program

52. If we are to bill electronically and be HIPAA compliant, we can't use the HCPCS H0017 for HBR since they are inpatient accounts. HCPCS and CPT codes cannot usually be billed on the inpatient claims. We bill on the UB-04 with Revenue Code 1001 which is Behavioral Health Accommodations-Residential Treatment-Psychiatric and the appropriate ICD-9 diagnosis codes. We could use H0035 for the PHP outpatient claims, however.

We are re-evaluating all CPT/HCPCS codes and these will be corrected prior to implementation of the contract. However, the changing of codes will not change pricing structure at this juncture.

53. Since this contract will still be in place when ICD-10 becomes effective in 2013, does CAMHD have plans for accepting claims with the ICD-10 diagnosis codes?

CAMHD will be compliant with all regulations as they change

54. A 30 day post service target for billing is not reasonable since we must work the denials, pursue documentation for progress notes, obtain the correct authorization, etc in the period after the date of service. We currently have a 90 day billing target and this is more practical.

Billing is to be submitted within 30 days post service, yet CAMHD will allow up to 60 days to get the billing in. If there is a delay, a billing appeal can be filed with the CAMHD PHAO to extend beyond the 60 days.

55. When will the CAMHPS Book be finalized for the RFP proposals?

A revised CAMHPS book will be posted on Monday, 10/3/2011 that covers the changes discussed in this Addendum 2.

During the year prior to the actual start date of the Child and Adolescent Mental Health Performance Standards book, to be effective 7/1/2012, the book may be revised to correct errors or changing rules and laws. All providers and awardees will be notified of the changes as they occur.

RFP HTH 460-12-01 Comprehensive Behavioral Health Services for Children, Youths, and Families is amended as follows:

Subsection Page

Section 1, Administrative Overview

No Change

Section 2, Service Specifications

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|-------------|------|---|
| I. (A.2) | 2-13 | <u>Ancillary Services</u> title is modified to <u>Ancillary One on One Service</u> to clarify the intent of the ancillary service care. |
| II. (A.) | 2-25 | The following paragraph is added to Insurance section

Self Insurance Providers that are covered by Hawaii Captive law (H.R.S. 431: 19-102 may eliminate the requirement to include the two (2) clauses on additional coverage for the State. |
| III. (B.7.) | 2-32 | The sentence for submittal of billing claims later than sixty (60) days is corrected to read “the Provider should contact the CAMHD PHAO before the end of the Sixty (60) day period or no appeal will be granted.” |
| IV. (A) | 2-36 | The following paragraph is added to Pricing Methodology: Unit Cost

“Initial Authorization unit limits will be followed in accordance with standards in the CAMHPS manual to be effective July 1, 2012.” |
| IV. (C.) | 2-36 | The following paragraph is added to Pricing Methodology: Cost Plus

“Based upon the Provider’s quarterly reconciliation (within sixty (60) days of the end of each quarter), the State would pay the difference if the quarterly |

utilization was less than the minimum guaranteed utilization each quarter.”

Section 3, Proposal Application Instructions

V. (A.1.) 3-11 There is no requirement to select a unit rate for those services requiring a unit cost rate. Therefore ,the following sentence is delete:

“The Applicant shall submit a unit rate for each proposed service identified in Section 2, III, Scope of Work.”

Section 4, Proposal Evaluation

III. (B.1.D.) 4-3 The evaluation question III.B.1.D. **Coordination of Services** is missing the word “community” and is corrected as shown below:

- Demonstrates agency commitment and capability to coordinate services with schools, other child serving agencies, primary care provider and informal community programs and resources in the community.

[4 points]

Section 5, Attachments

Attachment M Attachment M, CAMHD Maximum Allowable Rate Schedule, is amended as follows:

“Therapeutic Respite Homes’ rate has been revised from Negotiated to a Unit Cost rate with Unit of Measure: 1-Day and Maximum Rate: \$190.55.”