

State of Hawaii  
Department of Health  
Adult Mental Health Division

## **Addendum Number 3**

**April 18, 2006**

**To**

**Request for Proposals**

**RFP No. HTH 420-5-06**  
**Community-Based Case Management**  
**March 14, 2006**

The Department of Health, Adult Mental Health Division (AMHD) is issuing this addendum to RFP Number 420-5-06, Community-Based Case Management Services:

- Responding to questions that arose at the orientation meeting of March 24, 2006 and written questions subsequently submitted in accordance with Section 1-V, of the RFP.
- Amending the RFP.

The proposal submittal deadline:

- is amended to
- is not amended. (NOTE: The proposal deadline was extended to May 5, 2006 per Addendum 1.)

Enclosed is (are):

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

Should you have any questions, contact:

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RFP No. HTH 420-5-06 Community-Based Case Management is amended as follows:

<i>Subsection</i>		<i>Page</i>	
<b>Section 1, Administrative Overview</b>			
I.	1-1		The Procurement Timetable has been changed as follows:  The Notice of Findings and Decision date has been changed to May 22, 2006.
<b>Section 2, Service Specifications</b>			
II.A.	2-15		A new paragraph has been added to Section II.A. <b>Specific qualifications or requirements including, but not limited to, licensure or accreditation,</b> to read as follows:  14. If a subcontractor is used, the applicant shall insure the DIVISION that they, as the applicant, have ultimate responsibility that the subcontractors will provide behavioral health services that meet the criteria of this RFP. Subcontractors must be responsive and responsible to meet the expectations of the applicant and the DIVISION.
III.A.5	2-18		Subparagraph a. has been deleted and replaced with a new subparagraph to read as follows:  a. Have intake policies and procedures outlining criteria for eligibility for services.
III.B	2-31		Subparagraph i. has been deleted and replaced with a new subparagraph to read as follows:

- i. The applicant shall ensure and document that all staff receive appropriate and regular clinical and administrative supervision at least three (3) times each month. Clinical supervision may utilize a combination of the following methods:

III.B. 2-40 A new paragraph has been added to Section III.B. **Management Requirements**, to read as follows:

12. Providers shall be compensated for community-based case management services, in accordance with the Fees described above, upon submission of claims identifying the services performed for DIVISION consumers.

Section 2.I.F. describes provisions for an initial payment of up to \$2,000.00 for the purpose of setting up electronic billing systems.

### **Section 3, Proposal Application Instructions**

No Changes

### **Section 4, Proposal Evaluation**

No Changes

### **Section 5, Attachments**

Attachment F

Attachment F, QMHP and Supervision, has been changed as follows.

In the minimum requirements for Mental Health Professionals (MHP), the requirements for a registered nurse

qualifying as a Mental Health  
Professional has been changed as  
follows:

- Licensed Registered Nurse with two (2) years experience in behavioral health.

Responses to Question Raised by Applicants For RFP No. HTH 420-5-06  
Community-Based Case Management

**1. Question:**

Expected number of clients to be served per geographical area?

**Answer:**

Due to numerous factors, it is difficult to provide an exact number of consumers to be served. As a result, the figures provided are rough estimates. Currently on Oahu, ICM and TCM case management services are being provided for approximately 2,900 consumers with an average of 32 new consumers each month authorized for case management services. Similarly, Hawaii County is providing case management service to approximately 1,000 consumers, Maui County is providing services to approximately 600 consumers, and Kauai County is serving approximately 300 consumers. The total number of new neighbor island consumers eligible for case management services each month is about 15.

**2. Question:**

Contract term 11/1/06 – 6/30/07?

**Answer:**

The initial contract term is projected to run from 11/1/06 - 10/30/07 with the possibility of three (3) one-year extensions. The maximum length of the contract is four (4) years.

**3. Question:**

Can we propose for less than 300 clients? Or partial team?

**Answer:**

Yes. Partial teams may also be proposed.

**4. Question:**

What rate/code do the RN & peer specialist bill under (as required on pg 2-26, #4 – yet not listed on rate sheet)?

**Answer:**

There are no billable codes for the peer specialist. The DIVISION intends to amend this RFP at a later date to establish billing codes for peer specialists. The RN may bill for therapeutic injections. RNs who meet the minimum requirements for a case manager may also bill under case management codes if functioning as a case manager.

**5. Question:**

Is Community-Based CM qualified under MRO same as ICM (since ICM is a very different service)?

**Answer:**

This service replaces TCM and ICM and is an MRO service.

**6. Question:**

Why are psychologists excluded from team?

**Answer:**

Psychologists are not required to be members of the case management team. However, a psychologist may be a part of the case management team in a position for which they meet the personnel requirements identified in this RFP.

**7. Question:**

Are Hilo & Kona seen as separate areas or are they both just Hawaii?

**Answer:**

If you are submitting a proposal for services on the Big Island, the specific geographic areas that you propose to serve on the island should be identified.

**8. Question:**

Could Peer Specialists have MRO status as paraprofessionals for billing purposes? Doesn't AMHD have a Mental Health Worker category already that has MRO approval?

**Answer:**

The State Plan Amendment does not include Peer Specialists as an MRO reimbursable service. The DIVISION intends to amend this RFP at a later date to establish billing

codes for peer specialists. (See Question 4, above.). The Mental Health Worker is defined by the DIVISION.

**9. Question:**

On page 2-28 it states that Clinical Supervision must occur 3 times a month. However, on page 2-31, it states that Clinical Supervision must occur 1 time a month. Please clarify.

**Answer:**

Clinical Supervision is required three (3) times each month. See the amendment to this RFP on page 3, above.

**10. Question:**

If we had 1 team of 300 consumers could we use 1 CARE psychiatrist for 250 consumers and have 50 consumers see a community psychiatrist or would we need 1 FTE psychiatrist to see 250 consumers and a .2 FTE CARE psychiatrist to see the other 50 consumers?

**Answer:**

One psychiatrist or APRN-Rx is required for 250 consumers. Additional consumers served in excess of 250 must be receiving mental health services from a private psychiatrist or through additional staffing by the Case Management agency.

**11. Question:**

What is the anticipated # of consumers for this service on each island?

**Answer:**

See Question 1, above.

**12. Question:**

Please be specific: i.e.: "Division's approved tools for screening, assessment and reporting co-occurring data: in Section III A.i.b. Dual Diagnosis Substance Abuse Services.

**Answer:**

The DIVISION approved tools are CAGE-AID and MIDAS.

**13. Question:**

Personnel requirements include a psychiatrist. Will there still be an option for these community-based case management clients to see community MHC MD's? More importantly, will there be capacity for these clients at the CMHC's and what will be the wait times for screening?

**Answer:**

Community-based case management consumers may receive services from a private psychiatrist or CMHC psychiatrist as available. The standard wait time for initial screening at the CMHC is less than seven (7) days.

**14. Question:**

Please clarify MD: Consumer ratios?

**Answer:**

The psychiatrist or APRN-Rx to Consumer ratio is 1 to 25 0.

**15. Question:**

How does DIVISION plan to address the barriers to DBT treatment for our CM clients?

**Answer:**

DBT is beyond the scope of this RFP.

**16. Question:**

Why are the credentialing requirements for Case Manager defined in such a rigid manner? This might impair services by rural providers, especially on the neighbor islands. How will Division assist rural providers?

**Answer:**

Credentialing requirements are the same as are currently in place for TCM case managers. Provisions have been made for rural providers by allowing the use of an APRN-Rx in place of a psychiatrist.

**17. Question:**

Why is there no peer review conducted prior to the clinical denial? This is not community standard.

**Answer:**

The AMHD Medical Director or physician designee makes all clinical denials.

**18. Question:**

HMSA does not require prior authorization for psychological testing. Why is Division requiring this for testing?

**Answer:**

Psychological testing is not reimbursable by this RFP.

**19. Question:**

Why is group therapy not included in the schedule for reimbursement?

**Answer:**

Group therapy is beyond the scope of services for this RFP.

**20. Question:**

Many providers think that this RFP is problematic. Should this RFP be revised and reissued due to policy problems?

**Answer:**

The RFP will be amended as appropriate.

**21. Question:**

We were told by Dr. Hester that the \$200.00 sanction/penalty would not be enforced. Why was it included in this RFP for CM services?

**Answer:**

The DIVISION retains the option to impose sanctions as appropriate.

**22. Question:**

The ICM rate was previously lowered from \$22 to \$20 per unit. Why is this rate being used, when more requirements have been added to this RFP?

**Answer:**

The ICM service rate is \$20.25 per fifteen (15) minutes. This service will include consumers with less acute needs than just ICM. This will balance out the requirements.

**23. Question:**

With the ACT model being required now, we expect that more activity will exist in the CM clients. Why are the CM rates not equivalent to the current ACT rates (e.g. \$27.00 per unit)

**Answer:**

The ACT model is not being required for this RFP. This is an RFP for community-based case management.

**24. Question:**

By adding a psychiatrist & peer specialist to the CM team, Division seems to requiring a kind of ACT model for these services. Why are ACT staffing models being used for this level of care?

**Answer:**

The ACT staffing model is not being used for the case management services identified in this RFP.

**25. Question:**

Why are Quest rates being used for the MD and APRN? This population has much more risk/liability than the general population, so these rates appear to be low for the proposed CM services.

**Answer:**

The rates in the RFP are the same rates that the CMHCs are paid for SMI consumers.

**26. Question:**

Why are the criteria so vague regarding the low intensity clients who need only monthly visits?

**Answer:**

The criteria listed in this RFP are intended to serve as a general guideline and example since it would be difficult to account for all possible scenarios encountered by case managers.

**27. Question:**

Why does the provider not have the right to decline a referral? This is not community standard, and seems very hostile to providers, especially given that the CMHC's will also provide CM services.

**Answer:**

Providers may decline a referral if they are unable to meet a consumer's clinical needs. Providers must work with the DIVISION to identify alternative services.

**28. Question:**

Why are mileage billing codes not included for Oahu CM services?

**Answer:**

There is no mileage reimbursement for case management services on Oahu or neighbor islands.

**29. Question:**

Why is there now such a trend by Division to be prescribing and directing treatment for providers?

**Answer:**

It is the responsibility of the DIVISION to ensure that quality standards are defined and available to providers. The RFP process is a vehicle to do so.

**30. Question:**

Why is the RFP requiring so many UM requirements, when Division rarely generates any administrative or clinical denials? For this LOC, would it not be appropriate to eliminate all prior authorizations?

**Answer:**

UM requirements must be followed for all levels of care in order to ensure appropriate utilization, support claims payment, and support availability monitoring.

**31. Question:**

By requiring that the MD be the ultimate leader, AMHD seems to be advocating the medical model. Why has AMHD violated the community-based model by emphasizing the MD?

**Answer:**

The DIVISION's Community Plan requires a psychiatrist to have ultimate clinical responsibility for the recovery planning team. However, the case manager is responsible for the overall coordination of services.

**32. Question:**

AMHD seems to be kind of derivative, using a CCS model for these CM services. Why not use a capitation or even a case rate for reimbursement rather than a FFS methodology? How about cost-reimbursement unit?

**Answer:**

The DIVISION is not a health plan and is limited to fee-for-service rates approved by the Med-QUEST Division in order to obtain MRO reimbursement.

**33. Question:**

Some agencies pay their workers on an hourly basis rather than by salary. How does AMHD assure that difficult or complex clients do not fall in the gaps or experience underutilization of CM services?

**Answer:**

The DIVISION will employ the following measures to ensure appropriate CM utilization: site visits, annual monitoring, review of treatment records, review and processing of claims and billings, interviews with consumers, and exploration of utilization history.

**34. Question:**

The providers have expressed concerns about the definition of a QMHP. Why has Division adopted higher credentials than other states for this QMHP definition?

**Answer:**

The definition of a QMHP has been directly incorporated from the State Plan Amendment and Hawaii Administrative Rules.

**35. Question:**

What does division plan to do regarding improving provider relations?

**Answer:**

This question does not apply to this RFP.

**36. Question:**

Why are rural issues/considerations not included in this RFP?

**Answer:**

The DIVISION took into consideration the limited number of psychiatrists on neighbor islands by permitting the use of APRN-Rx.

**37. Question:**

Why are ACT terms not included in all neighbor islands? Some CM providers have felt that they actually do ACT services for CM clients on the neighbor islands. How does AMHD propose to address this common problem?

**Answer:**

This RFP only applies to CM. As such, this question does not apply.

**38. Question:**

Why are potential contracts from this RFP slanted so negatively against the provider?

**Answer:**

The DIVISION believes that this RFP has attempted to take into consideration the limitations and needs of providers and tempered them with the goal of improved continuity and efficiency of care for the consumer.

**39. Question:**

We have been asked to attend an inordinate amount of meetings and trainings, taking time away from direct service. Why not pay providers for their time in such meetings?

**Answer:**

Administrative costs, including attendance at meetings, are included in the stated rates.

**40. Question:**

There is a statement that consumer consent is not required for oversight activities of the Division and its agency. Do oversight activities include utilization management?

**Answer:**

Yes.

**41. Question:**

I am assuming that case managers would come under the category of mental health worker. The minimum for a mental health worker is a B.A. with 12 semester credit hours in certain courses and 1.5 years of specialized experience. In our work with bilingual staffing to work with limited non-English speaking clients we have found it very difficult to obtain bilingual staff with their minimum qualifications. Would exemptions or waivers be acceptable to assist in obtaining or retaining bilingual CM staff?

**Answer:**

All staff must meet the minimum qualifications stated in the RFP.

**42. Question:**

Based on the RFP model which seems to reflect an outpatient clinic with bilingual CM. Is there a role for a targeted case management bilingual CM that works within or alongside this type of model? Would future RFP's for bilingual case management and /or interpretation/translation service be made available?

**Answer:**

Providers interested in providing bilingual case management services should do so through this RFP. Bilingual CM staff must meet the stated qualifications in this RFP. Interpretation/translation services not provided as part of case management services are outside the scope of this RFP.

**43. Question:**

Therapy is necessary for case managers need to be able to contract with master's level or PhD level therapists to assist consumers in the recovery process. If therapy is a MRO reimbursement that is an additional benefit to the state.

**Answer:**

The current scope of this RFP does not include psychotherapy, except as provided by the psychiatrist or APRN.

**44. Question:**

Please explain rationale for paragraph 1 maximum of three hundred (300) consumers total for a CM team versus the psychiatrist or APRN-Rx ratio of 1:200-250. What happens to persons 251-300 and does this RFP assume persons 251-300 receive services through a private psychiatrist? Or, will the applicant be expected to hire another psychiatrist or APRN-Rx should the 251<sup>st</sup> consumer be enrolled?

**Answer:**

Please refer to the explanation provided in Question 10 for further clarification.

**45. Question:**

Is there any demarcation for proposals that are for services for less than the three hundred (300) maximum consumers? For example, if my proposal states I want to serve a maximum of two hundred (200) consumers in Oahu County.

**Answer:**

Please refer to the response provided in Question 3 for further clarification.

**46. Question:**

What is AMHD's position on the number of CM teams being awarded a contract in a specific area as this is not stated in the RFP?

**Answer:**

The DIVISION may award multiple contracts to meet the needs of the specified target population.

Applicants may propose to serve as many geographical areas as they wish. They should describe the number of teams required to serve the proposed areas in their discussion of staffing and organization. See Question 47, below.

**47. Question:**

Clarification on single and multiple contract awards, 2-15, sub-section D. Are applicants able to submit multiple proposals for services to be provided in specific geographical areas in different counties? For example, submitting a proposal for services with maximum of three hundred (300) consumers in the Waianae/Leeward coast area in Oahu County and a second proposal for services with a maximum of two hundred (200) consumers in the Hilo area in Big Island County.

**Answer:**

The RFP does not allow multiple or alternate proposals. Applicants proposing to serve more than one area should do so in a single proposal.

**48. Question:**

Are the RN and peer specialist required for the CM team? If not, what are their required roles and responsibilities?

**Answer:**

The RN and peer specialist are required for the CM team.

**49. Question:**

What has been the discussion about the involvement of the psychologist in the CM team? With the thought that applicants be self-contained/self-sufficient with staffing and with

the providing of services, what is the reimbursement process for psychologists as a FTE or PTE within the applicant's agency? Currently there is no reimbursement for psychologists for CM team participation.

**Answer:**

Please refer to the response provided to Question 6 for further clarification. Psychologists on the team could be reimbursed at the rate indicated for the appropriate CM team member identified in the RFP for which they are qualified.

**50. Question:**

The role of the psychologist is applicable to the QMHP supervisory role, but no inclusion in the RFP for the psychologist in the CM team. Please explain the expectation for psychologist involvement in the current RFP compared to the current TCM and ICM treatment teams?

**Answer:**

Please refer to the response provided in Question 6 for further clarification.

**51. Question:**

Please restate the purpose of this RFP, including reasons for levels of current services (TCM/ICM) being redefined.

**Answer:**

The primary purpose of this RFP and the revision of CM services is to provide improved continuity of care and efficient services for both providers and consumers.

**52. Question:**

Why was there no opportunity presented by AMHD to the public regarding consultation concerning rule changes for case management levels? For example, ICM and TCM under this RFP being combined as CBCM? This is a historical change in services from clear case management services to a combination of case management and outpatient treatment services.

**Answer:**

Opportunity was provided for community feedback through the RFI process.

**53) Question:**

Please define any Administrative Rules that would need to be reviewed prior to the implementation of this RFP.

**Answer:**

It is the responsibility of the applicant to review all of the requirements of the RFP and research any applicable Administrative Rules. The DIVISION will clarify any questions pertaining to specific and relevant Administrative Rules.

**54. Question:**

Please address the appropriateness of this RFP including any areas in need of Administrative Rule review, technical requirement changes, and staffing or/credentialing requirements compared to the current case management contracts for ICM and TCM.

**Answer:**

The design requirements stated in the RFP are procurement specifications and do not require Administrative Rule review. The DIVISION will clarify any questions pertaining to specific and relevant Administrative Rules, technical requirement changes, and staffing or credentialing requirements.

**55. Question:**

Does this CBCM service as defined in the RFP fall under the MRO reimbursable services?

**Answer:**

Yes

**56. Question:**

Has AMHD looked into the possibility of using para-professionals as possible solution for this issue as they are MRO reimbursable under other DIVISION contracts and would benefit areas where recruitment is challenging? It was stated that the eligibility requirement for DD para-professionals and DHS personal assistants are different, but will AMHD consider participating in a Medicaid Waiver Program?

**Answer:**

All staffing requirements remain as listed in the RFP.

**57. Question:**

Please restate the definition of QMHP, MHP and specifically define CM role and responsibilities. Under this RFP, CM will have a wider CM role, but not specifically to address therapy because therapist is different role.

**Answer:**

Case Management functions may be provided by a QMHP, MHP, or a mental health worker. Please refer to Attachment F of the RFP for the definition and qualifications of the QMHP and MHP and to Attachment M for the definition of the mental health worker. Please note the amendment on page 4 of this Addendum relating to the requirements of an RN as a Mental Health Professional.

**58. Question:**

Can applicant sub-contract with another entity to provide therapy services? What are the sub-contracting options covered under this RFP?

**Answer:**

Please refer to the sub-contracting options identified in the RFP and in the Amendments to Section 2, Service Specifications on page 3, above.

**59. Question:**

Does the MRP allow therapy reimbursement? If not, is AMHD considering pursuing this as a future option?

**Answer:**

Therapy reimbursement is limited to those types specified in the RFP to be provided by a psychiatrist or APRN-Rx.

**60. Question:**

Is there any room for negotiation between AMHD and applicant regarding consideration for a staff's time on job/direct work experience for equivalent to educational requirements for the position?

**Answer:**

Staff must meet the requirements identified in the RFP.

**61. Question:**

How is AMHD addressing the issue of excluding “qualified” CMs from performing CM duties because of lacking education requirements set by AMHD? The decision to change the definition of a CM is not meeting the needs for consumers and this is a concern.

**Answer:**

Case managers are required to meet the education and experience requirements set forth in the RFP.

**62. Question:**

Therapy services are not well defined in this RFP. Please provide more explanation on reasons for why psychologist/therapist/therapy are excluded from this RFP (versus inclusion of psychiatrist/APRN-Rx and RN and peer specialist).

**Answer:**

Community-based case management is the focus of this RFP. Since a psychiatrist is a required member of the CM team, the DIVISION will reimburse the CM psychiatrist or APRN-RX to promote continuity of care for the consumer.

**63) Question:**

Is MRO Certification required for this program? (page 2-13)

**Answer:**

Yes.

**64. Question:**

Is a Peer Specialist required? If so, do they bill under case management services? (page 2-30)

**Answer:**

A Peer Specialist is required. Billing codes will be provided through a future amendment to this RFP.

**65. Question:**

Is there a consumer ratio for the Team Leader? If so, what is it? (page 2-26)

**Answer:**

There is no consumer ratio for the Team Leader.

**66. Question:**

Is there a minimum number of consumers required for a team? (page 2-26)

**Answer:**

No.

**67. Question:**

Are nursing services provided by the RN billed under case management services? (i.e. medication administration, wound care, immunizations, etc.)  
(pages 2-29, 2-30)

**Answer:**

Reimbursement for wound care and immunizations are not included in the scope of this RFP. A RN can use the billable codes identified in this RFP for therapeutic injection or other appropriate billable codes for case management services if the RN meets the minimum requirements of a case manager.

**68. Question:**

Are psychologists and LCSWs eligible to bill for services under this program, or is the program restricted to psychiatrists and APRN – Behavioral Health? (page 2-39)

**Answer:**

Psychologists and LCSWs who meet the qualifications for, and serve as, the Team Leader or Case Manager may bill for services appropriate to those positions.

**69. Question:**

Can clinical supervision be provided by an administrative QMHP who is already on our staff (so the Team Leader can spend more time providing billable services.)? (page 2-28)

**Answer:**

Yes.

**70. Question:**

Can we bill AMHD for time spent with registered consumers who are not part of this team? For example, ICM consumers living at Safe Haven under AMHD funded beds receive services from our in-house case managers in addition to their assigned ICM case manager. Can we bill for those units if we are awarded this contract?

**Answer:**

Consumers eligible for DIVISION services will be assigned to one Case Management provider who will be the only authorized case management provider for the purposes of reimbursement.

**71. Question:**

Can the Psychiatrist on the team determine the Level of Care for consumers who have not yet been assessed by AMHD (as opposed to the AMHD Assessor)? (page 2-17)

**Answer:**

No.

**72. Question:**

Is it assumed that a CM Case Assessment is completed only one (1) time per consumer, and therefore can only be billed for once? (page 2-18 and 2-38)

**Answer:**

An initial assessment is completed only once within the time frame specified on page 2-18. However, Recovery Plan review is required and detailed in Attachment L of the RFP. The appropriate codes listed on page 2-38 should be used.

**73. Question:**

Is there a requirement for how many times the Treatment Plan (IRP) needs to be updated annually? If the requirement is more than one (1) time per year, can we bill accordingly for CM Treatment Planning? (page 2-18 and 2-38)

**Answer:**

Please refer to Attachment L of the RFP that details the AMHD Policy and Procedure regarding Recovery Treatment Planning.

**74. Question:**

Reference 2.I.C.1 Can a Peer Specialist bill for codes in Section 2 3. B. 10. (p. 2-38)? If not, how does DIVISION plan to reimburse PROVIDER for services delivered by the Peers?

**Answer:**

The billing codes for peer specialist will be provided in a future amendment to the RFP.

**75. Question:**

Reference 2.III.3.11.d what does it mean to provide services from “7:30 AM to 9:00 PM?” Note that CM services are provided 24 hours/ day 365 days / year, and, as stipulated at 2.III.A.11.a.5 (p. 2-26), there are no “office hours” because consumers are served in the community rather than at an office.

**Answer:**

Service hours shall be based on consumer needs. Therefore, while not all consumers will require services spanning this time duration, regular services should be available from the hours of 7:30 a.m. to 9:00 p.m. Crisis services should be available 24 hours a day, 365 days a year.

**76. Question:**

Reference 2.III.A.11.d p. 2-28) & 2.III.B.1 (page 2.31) It appears that bullet “i” on p. 2-31 does not match with section “d” in relation to minimum required supervision. Please clarify.

**Answer:**

Clinical supervision is required three (3) times per month.

**77. Question:**

Reference 2.III.B.1.e (p. 2-30) There is a shortage of Peer Specialists who are certified by DIVISION. Is it possible to fulfill this requirement with a Peer Specialist who does not have the AMHD Certification?

**Answer:**

No. The applicant's proposal should include the agency's plan for recruitment of peer specialists.

**78. Question:**

Does AMHD have a preference about psychiatrists being employees of the PROVIDER and paid at a rate set by the PROVIDER, or are psychiatrists independent contractors who bill AMHD at the rates indicated at paragraph B.10 (p. 2-39)

**Answer:**

The DIVISION will contract with the case management agency for case management services and limited psychiatric services as defined in this RFP. Therefore, only the case management agency contracted with the DIVISION can bill for these services.

**79. Question:**

Reference Page 1-11, XX\_. What are the specific metrics by which the performance of the PROVIDER shall be judged under each of the five criteria listed?

**Answer:**

Provider performance measures are defined on an annual basis and include provider monitoring and reporting.

**80. Question:**

Please confirm the fidelity scales developed by the DIVISION and the specific services to which they apply.

**Answer:**

The DIVISION has no fidelity scales developed for CM at this time.

**81. Question:**

Are PROVIDERS allowed to submit a bill more than once per month?

**Answer:**

Providers may invoice twice a month.

**82. Question:**

What is a reasonable time period that a PROVIDER may expect to get paid after a claim is submitted to AMHD?

**Answer:**

If a clean claim is submitted and funds are available, the DIVISION's goal is to make payment within 30 calendar days of the submission date.

**83. Question:**

We note that there is no longer a requirement that the team leader or RN assume a caseload. Is this accurate? A good change as the supervision and nursing responsibilities mitigate against assuming a caseload.

**Answer:**

A caseload is not required for the team leader, however, the ratio for RN to consumer is 1:150.

**84. Question:**

It appears that there is no longer any distinction between ICM and TCM. We are simply providing case management services. Is this correct?

**Answer:**

Yes.

**85. Question:**

On page 3-2, Section B, it states that applicant shall provide a description of projects/contacts, including references, pertinent to the proposed services. Please explain what type of references you are seeking and who might provide these?

**Answer:**

References should be able to attest to the applicant's ability to provide the services described in the RFP and to meet the program and administrative requirements stated in the RFP.

**86. Question:**

It appears that a peer specialist is optional, rather than required. Is this accurate?

**Answer:**

No. A peer specialist is required.

**87. Question:**

On page 2-18, it states that we will have “a plan to manage its waiting list.” When we reach maximum capacity, we would refer to AMHD’s UM for placement with another provider. It is not clinically appropriate to place someone on a wait list who requires case management services. How does the Division propose to handle consumers when a program has reached capacity and what justification is there for placing SPMI consumers who require care on a wait list?

**Answer:**

The DIVISION will manage all waitlists for referrals to CBCM services. See the amendment to this RFP on page 3, above.

**88. Question:**

On page 3-8, #6 "the applicant shall not refuse a referral, and that it shall not have an exclusionary policy that is inconsistent with the Division's guidelines" The provider may at times need to "refuse" a referral based on capacity to serve the consumer based on caseloads and ability to manage the consumer's level of severity. Please clarify.

**Answer:**

Please refer to the response provided to Question 27.

**89. Question:**

The RFP mentions transportation; can we get clarification regarding what is expected? We do not allow staff to transport consumers in their personal vehicles. We do provide bus passes. Is this sufficient?

**Answer:**

The case management agency must arrange for the most appropriate mode of transportation necessary to ensure the safety of the consumer and the community.

**90. Question:**

Supervision is mentioned in two places, in the body of the RFP and in the appendix. In the body it says 3 times per week by the team leader, in the appendix "once a month". Can we get clarification? Are they two separate types of supervision?

**Answer:**

Please see the response provided to Question 9 for further clarification.

**91. Question:**

Section 1: page 1-1, item I. Contract start date: 11/1/2006. How will the potential conflict of interest be addressed with the overlap of programs currently falling under DHS?

**Answer:**

This RFP is unrelated to DHS programs.

**92. Question:**

Section 2: page 2-4, item E, paragraph 2:  
Confirming it is acceptable to submit one proposal for more than one island including but not limited to more than one geographical area on one island? I.e. Leeward and Windward sides of Oahu

**Answer:**

Yes. Applicants should submit one proposal identifying every island, or specific geographical area on an island, that they propose to serve.

**93. Question:**

Section 2: page 2-9, item 10c, paragraph 1: How will eligibility and enrollment notifications be distributed to providers? How soon upon determination of eligibility will provider be notified? How often will updates be distributed?

**Answer:**

Assessment staff will assign a CM or ACT team upon eligibility determination. Providers will then receive an authorization. Initial authorizations are generally processed within forty-eight (48) working hours of the eligibility determination. There are no updates as consumers generally maintain eligibility.

**94. Question:**

Section 2: page 2-12, item j, paragraph 1:

As noted in this section, a small population of the SMI s are being provided by the behavioral health carve-out program contracted by MQD.

Will the members in this carve-out program remain with the existing program for continuity of care purposes? If not, what kind of transition plan is in place to transition existing members enrolled in this program to their new provider to ensure continuity of care?

**Answer:**

If an award is made to the MQD behavioral health carve-out program, consumers receiving services from them will be given the opportunity to continue receiving services from them. If consumers would like the opportunity to change to another DIVISION funded agency, they will be given that opportunity. All DIVISION consumers have the right to select their provider based on availability.

**95. Question:**

Section 2: page 2-13, item l, paragraph 1:

It appears all services are to be billed on a fee-for-service basis. Under what circumstance would an encounter claim need to be processed?

**Answer:**

Since all services are billed fee-for-service, an encounter claim is not applicable.

**96. Question:**

Section 2: page 2-1, item d:

Will the provider manual be distributed?

**Answer:**

The provider manual is posted on the DIVISION website at [www.amhd.org](http://www.amhd.org).

**97. Question:**

Section 2: page 2-19, paragraph 2:

Many of consumers already receive services from the private providers. How are/will the current providers included in this IRP process?

**Answer:**

Case Management agencies should invite all providers of services to the IRP meetings.

**98. Question:**

Section 2: page 2-20, number 8, a.2:

It appears the structure being described is a clinic setting which includes medication administration. How is this in line with a case management program? Often, the role of a case manager is to refer clients to a private provider of their choice for these services?

**Answer:**

Consumers may choose to receive any of these services from a private provider.

**99. Question:**

Section 2: page 2-21, number b.3:

How does this affect the clients that are already seen by a private provider?

**Answer:**

Consumers currently being seen by a private provider may continue to obtain services from a private provider.

**100. Question:**

Section 2: page 2-24, number g.4:

Will DIVISION ensure adequate training resources be made available?

**Answer:**

The DIVISION provides periodic training sessions, develops and distributes training materials and resource guides, and provides technical assistance and consultation to provider organizations upon request.

**101. Question:**

Section 2: pg 2-25, number 10, paragraph 2:

The description here is one typically associated with a clinic similar to the current MH division. How does this affect the clients who are already being seen by the private providers in the community?

**Answer:**

Consumers who are currently seen by a private provider may continue to receive services from a private provider.

**102. Question:**

Section 2., pg. 2-26, number 11, a. 2:

Ratio shall not exceed 1:30 with the majority of the consumers being relatively stable and in active stages of recovery. If you are working with higher acuity consumers particularly the dual diagnosed clients, or ACT clients, the ratio should be much lower to ensure appropriate care. Is this contract intended to only service the targeted population, or does this include ACT and ICM level of clients as well?

**Answer:**

This RFP is intended to serve consumers meeting the DIVISION criteria for case management. ACT is not a case management service.

**103. Question:**

Section 2, pg. 2-26, number 11, a. 3:

Would this ratio be the same if the clients were seeing private providers?

**Answer:**

The ratio for consumers to psychiatrist remains the same.

**104. Question:**

Section 2, pg. 2-26, number 11, a. 4:

What is the definition/qualification of a peer specialist?

**Answer:**

The peer specialist shall have, at minimum, a high school diploma, one year in recovery, and be certified as a peer specialist by the DIVISION.

**105. Question:**

Section 2, pg. 2-27, paragraph 2:

It appears that there should be some guidelines to determine the level of care that the clients will need, and for how long they would need this particular level of care.

**Answer:**

The level of care and the duration for which a consumer remains at that level of care is determined by a combination of LOCUS score, individual assessment, and the recovery plan.

**106. Question:**

Section 2, pg 2-29, item 1c:

Why would you need an RN for more than 60 clients? If the medical needs are a concern, shouldn't the CM work collaboratively with the PCP s to ensure the client gets the proper care? How was the 60 threshold determined?

**Answer:**

Case Managers may be unable to identify medical needs of consumers with co-morbid conditions. An APRN was consulted regarding the caseload.

**107. Question:**

Section 2, pg 2-32, item 2e, paragraph 1 3:

What kind of transition plan and coordination is currently underway so all parties listed are involved and working together to ensure a smooth transition?

**Answer:**

When a consumer is referred to a CM agency, the CM agency is responsible for contacting current providers of service to collaborate on a transition plan.

**108. Question:**

Section 2, pg 2-33, item 2f, paragraph 1:

Why is it necessary to submit a rate schedule when it appears all services rendered are to be on a fee-for-service basis with established rates?

**Answer:**

Applicants are required to submit budget forms detailing personnel and other operating costs in order to document that there is sufficient operating capacity to provide the services proposed.

**109. Question:**

Section 2, pg. 2-38:

There doesn't appear to be a rate for groups. What code will be used for groups and family meetings? What is the rate?

**Answer:**

Please refer to psychiatrist/APRN-RX group and family rates identified in this RFP.

**110. Question:**

Section 5, Attachment F, pg. 1, under the QMHP section:

Can we grandfather the current LSW s who function as Team Leader s into the QMHP positions?

**Answer:**

QMHP requirements as specified in this RFP must be met.

**111. Question:**

Section 5, Attachment F, pg. 1, under the MHP section:

Can we grandfather the LPN s who function as Team Leaders into the MHP positions?

**Answer:**

MHP requirements as specified in this RFP must be met.

**112. Question:**

Section 5, Attachment M:

There are many qualified care managers who do not hold a bachelor's degree. These CMs are skilled, experienced, and well trained in working with the SMI/dual diagnosed clients. If a CM is currently employed in such a position, is it possible to grandfather these CM s into the Mental Health Worker position?

**Answer:**

All staff must meet the requirements set forth in the RFP.

**113. Question:**

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

**Answer:**

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

**114. Question:**

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

**Answer:**

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

**115. Question:**

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

**Answer:**

See Question 114, above. The RFI responses were carefully reviewed by DIVISION staff, in conjunction with service requirements of the Community Plan, SAMHSA EBT Toolkits, Hawaii Administrative Rules, and MRO requirements to determine the final design.

**116. Question:**

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

**Answer:**

No.

**117. Question:**

How did the Department of Health ensure community involvement in determining the service delivery arrangements appropriate to the Wai`anae community as required by Chapter 334, HRS? Were there meetings in the community?

**Answer:**

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

**118. Question:**

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

**Answer:**

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

**119. Question:**

Please identify the service area board member(s) representing the Wai`anae community.

**Answer:**

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

**120. Question:**

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

**Answer:**

Minutes of the service area board meetings are public record and copies can be obtained through the Oahu Service Area Administrator.

**121. Question:**

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

**Answer:**

Yes.

**122. Question:**

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

**Answer:**

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

**123. Question:**

At page 2-18 of the RFP, 5. b., the applicant is required to provide a service of initial face-to-face intake contact with each consumer within 24 hours of referral. What is the fee to be charged for this service as it is not noted in the fee schedule on page 2-38 and 2-39 of the RFP? Who is the person able to perform this intake contact?

**Answer:**

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

**124. Question:**

At page 2-18, 5. d. the provider is expected to provide each consumer with a single, individualized, coordinated master recovery plan.

- a. How will this service be paid for?
- b. Who specifically will be charged with writing up the IRP?
- c. How will the members of the treatment team be paid for services in assisting in the development of the recovery plan?
- d. Will the Division prepare billing codes for this service?

**Answer:**

- a. See treatment planning billing codes
- b. The team is charged with writing the IRP.
- c. When the team is conducting recovery planning meetings, only one member of the case management team can bill for this process.
- d. Please refer to the RFP for billing codes.

**125. Question:**

Under the same subject but at page 2-19, the case manager is charged with coordinating the development of and monitoring the implementation of the IRP and shall act as the communications liaison for the CM team both internally and externally. Please identify the billing code under which the case manager will be paid for this service.

**Answer:**

There is no separate billing code.

**126. Question:**

At page 2-19, 6. Outreach, Partnering of CM team members shall be utilized as an option to engage consumers. How will the partnering members be paid for their individual service, i.e., a case manager and a nurse meets with a consumer, will both of these partners be able to bill for the same time and for the same interaction with the consumer?

**Answer:**

Only one partner may bill.

**127. Question:**

At page 2-20 7.c. the program is required to ensure that crisis services shall be provided twenty-four (24) hours per day, seven (7) days per week. Does this mean that the current crisis services such as crisis mobile outreach will not be available to the consumers who are serviced by the community-based case management services? What is the parting line between CMO and CBCM?

**Answer:**

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

**128. Question:**

At page 2-20, medication administration is called for in addition to education to the consumer. For these services, what are the appropriate charge codes, amounts of reimbursement and who the appropriate service providers? How does medication administration differ from medication management and medication monitoring?

**Answer:**

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

**129. Question:**

At page 2-20, psychoeducation is called for. For this service, what is the appropriate charge code, amounts of reimbursement and who are the appropriate service providers?

**Answer:**

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

**130. Question:**

At page 2-21, Dual Diagnosis Substance Abuse Services is addressed. How does DDC-MH service differ from MI/SA service? Is a CSAC required to be on the case management team?

**Answer:**

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

**131. Question:**

In providing the basic substance abuse identification and treatment service called for at paragraph b., page 2-21, what will be the billable code under which the practitioner will be reimbursed?

**Answer:**

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

**132. Question:**

At page 2-25, 9. c. the case manager is required to advocate on behalf of the consumer, for services that are accessible, . . . Under what billable code shall the case manager bill? H2015 U3?

**Answer:**

Yes, H 2015 U3.

**133. Question:**

The RFP calls for extensive involvement of an RN who will be expected to provide medication review and administration services, and work with the consumers and their support system. At page 2-29, the RN is required to provide medical assessments, basic health care, education, coordination of medical needs, and psychotropic and medical medication administration. The RN s ratio to consumers is 1 to 150. Yet, the RFP provide no avenue for the RN to be paid a fee for their services. Will the Division consider billable codes for the RN s services?

**Answer:**

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

**134. Question:**

The RFP calls for extensive involvement of a certified Peer Support Specialist. However, it fails to address the fee or reimbursement rate for this specialist. Is this an oversight by the Division? How will the Division reimburse the provider for this service?

**Answer:**

Billing codes for peer specialists will be published in a future amendment to this RFP.

**135. Question:**

At page 2-27, consumers who have had stability as measured by no recent hospitalization or emergency room visit are to be seen once per month. What constitutes a recent hospital visit? Once within the last week, month, quarter, year?

**Answer:**

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

**136. Question:**

At page 2-27, b. 2) crisis and emergency services are to be provided. If more than one member of a team is required to respond to a crisis, will all of the team members who responded be reimbursed for their service?

**Answer:**

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

**137. Question:**

At page 2-28, CM team members are required to meet at least two times per week for case reviews. How will these CM team members be paid for this service? Will all of them be authorized to bill? What code will the Case Manager bill under? What code will the Psychiatrist bill? What code will be used by the psychologist, the nurse, the peer support specialist?

**Answer:**

The CM team may bill for time spent conducting treatment planning with a specific consumer. Only one team member may bill for this service. Case review team meetings conducted for the purpose of internal quality management are not billable under this RFP.

**138. Question:**

When other providers attend the team meetings, how are they reimbursed?

**Answer:**

The reimbursement of providers outside the case management team is outside the scope of this RFP.

**139. Question:**

At page 2-29, under management requirements, 1. b. it is stated, In geographic areas with a demonstrated shortage of qualified psychiatrist, an APRN-Rx may assume clinical leadership and responsibility. Is the Wai`anae area considered a geographic area with a demonstrated shortage of qualified psychiatrist?

**Answer:**

A Waianae provider indicated in the RFI process and for previous RFPs that psychiatric services could be provided without difficulty.

**140. Question:**

Under that same paragraph, a psychiatrist or APRN-Rx shall also be available twenty-four hours per day, seven days per week for psychiatric crises and emergencies. How will the psychiatrist or APRN-Rx be reimbursed for being on-call for these 24 hours days, seven days per week?

**Answer:**

The psychiatrist or APRN-Rx may bill for services only if they respond to a crisis.

**141. Question:**

At page 2-29, the RN is expected to play an active role in providing case management and rehabilitation services. There are four specific services listed at pages 2-29 and 2-30. But I can find no billable codes. What will the RN be able to bill under? Can these services, which appear to be appropriate for group services, be done in groups? At what rates?

**Answer:**

A registered nurse may bill for the appropriate level of service for a position in the team for which he/she is assuming and has appropriate State licensure. The billable rate would correspond to the type of service being provided. A registered nurse may bill for case management services if the RN meets the minimum qualifications of a case manager.

**142. Question:**

At page 2-30, d., CM functions are limited to QMHP, MHP or mental health worker. In comparison with HAR Sec. 11-175-14, (l)(4) Case management services shall be provided by non-professional staff or non-certified personnel under the supervision of

professional or certified personnel. What process did the Division undergo to amend the Hawaii Administrative Rules to amend the qualification of a case manager?

**Answer:**

The DIVISION did not amend the Hawaii Administrative Rules.

**143. Question:**

At page 2-30, a peer specialist is called upon to provide an active role in rehabilitation services. Yet there is no code for their reimbursement. How will the peer specialist s services be paid?

**Answer:**

Please refer to response to Question 134 for further clarification.

**144. Question:**

Does AMHD have a model disaster preparedness plan?

**Answer:**

The DIVISION's disaster preparedness plan applies to the Department of Health and DIVISION activities only.

**145. Question:**

The RFP references fidelity scales that AMHD has for the best practices noted in the Appendix...can applicant s get a copy of these fidelity scales?

**Answer:**

Attachment K provides the AMHD Policy and Procedure regarding continuity of care, which was adopted from the transition guidelines and outcome indicators established by the AACP.

**146. Question:**

The staffing requires MH workers who are defined as individuals bachelor degree plus some specialized experience. This limits agencies from hiring individuals who have a propensity to providing these services but not have a degree. This seems unnecessarily limiting and would AMHD consider loosening this requirement up, empowering the agency to make responsible HR choices in their hiring, by saying something like...For

every two MH workers, the agency may hire a case manager who has both the aptitude and skills to provide effective case management as assessed by the agency.

**Answer:**

The qualifications for Mental Health Worker will remain unchanged as identified in Attachment M of the RFP.

**147. Question:**

There does not seem to be a requirement that each consumer must see the agency's psychiatrist. This is a positive move as many consumers have a psychiatrist they prefer to see. The agency's psychiatrist will provide psychiatric services for those consumers who do not already have an established relationship with a community psychiatrist, plus provide some of the clinical supervision and review of plans. Is this a correct interpretation?

**Answer:**

The agency's psychiatrist may provide psychiatric services for those consumers who do not already have an established relationship with a community psychiatrist or who choose to switch from another psychiatrist to receive psychiatric service from the agency psychiatrist. Active psychiatrist participation is required in recovery planning with the consumer as a part of the case management team.

**148. Question:**

On what basis did AMHD calculate the reimbursement rates? Was this rate discussed with providers? Is the rate realistic given staffing requirements?

**Answer:**

These rates were discussed with providers when initially established.

**149. Question:**

Is the definition of this community-based case management RFP services supported and/or outlined in the Community-Based Plan?

**Answer:**

The CM model, as described in the RFP, is supported by the Community Plan.