4/6/2015

TO: ALL POTENTIAL BIDDERS

FROM: H. Ryan Bolles
DSCYF – Contract Administrator

SUBJECT: ADDENDUM TO REQUEST FOR PROPOSALS (RFP) – CYF15-04 Community Based Behavioral Health Treatment and Treatment Support Services

RFP CYF15-04 Questions/Answers
ADDENDUM #1

1. Question: Can you elaborate on the "transition periods discussed at the bidders' conference?
   Answer: Two transition periods were discussed during the conference:
   a. Implementation of services resulting from the Community-based services RFP are expected to occur over the period 7/1/2015 through 12/31/2015.
   b. Adoption of an "any willing provider that is qualified" service system expected to be effective 7/1/16 and is anticipated to require a phased implementation. The comment that PBHS would have adopted an "any willing provider that is qualified" service system by 1/1/16 was not correct.

2. Can you clarify the discussion of the Medicaid reimbursement of Case Management services?
   Answer: see below
   a. Case management can be a Medicaid covered service provided that the State complies with freedom of choice and other applicable requirements. It is uncertain at this time whether PBHS will be able to fund State-wide Case management as a stand-alone service that would be compliant with Medicaid requirements.
   b. Case Management can be a reimbursable service if/when it is a component of another Medicaid service. If case management activities are an integral part of another approved service, and the State complies with freedom of choice and other applicable requirements, then that service, including the case management component, can be claimed at the service match rate.

3. Question: Can Delaware (DSCYF) bill Medicaid for tele-psychiatry services?
   Answer: Yes, in Delaware Tele-psychiatry is a reimbursable service by Medicaid, but providers must have it in their contract with the MCOs and meet the provider qualifications established for providing this service.

4. Can you provide data on how many patients under 18 sent out of state for RTC services?
   Answer: At any given time the number is estimated to be 30 – 35 in RTC MH and 5 – 10 in RTC SA. Annually the total served ranges from 60-70 in RTC MH and 40-50 in RTC SA.

5. Question: Typically for MH/SA, the process goes: assessment, treatment plan is developed, a psychiatrist signs off on treatment plan, services are delivered. In the proposed milieu change, are providers expected to develop the treatment plan and have a psychiatrist sign off, or is that all handled by PBH's assessment and authorization of services team(s), leaving the provider exclusively as the deliverer of services?
   Answer: The current process has CSM developing a service referral to a treatment provider, based on available clinical and other information. The Provider performs a comprehensive bio-psych-social and other indicated assessments. The Provider would develop the treatment plan with the client and family. A psychiatrist, when involved, would continue to be part of the provider treatment team and be a part of the treatment planning process as indicated. For those clients assigned a PBH care manager, the care manager would develop a care plan to identify needs and supports, ensure the services are coordinated and the family's multiple needs are being addressed. This role is similar to a case manager in other systems.

6. Question: What are the expected roles of psychiatrists for providers? (i.e. evaluations besides PBH's assessments; med management; treatment planning; etc.) How do psychiatric evaluations fit in with the proposed model of PBH assessment team and authorized level of care teams?
   Answer: Psychiatric services are delivered by the Provider. PBH does not provide psychiatric services.

7. Question: Does PBH have a preference for whether psychiatrists/staff who can prescribe psychotropic meds are bundled into provider services, or may a provider have a partnership with other MH agencies, and have those agencies bill for services to PBH separately? (A desire for a collaborative relationship is mentioned on page 10, but the details of how those services would be provided and billed for is not explained)
   Answer: In your response, please specify how psychiatry would be coordinated/integrated in the services you are proposing. The details of the new Medicaid State plan are not finalized which will impact billing practices.

8. Question: Can you please clarify the role of case management through PBH versus what is expected of providers? Or provide some different examples of who would be providing case management-like services in different client scenarios?
   Answer: If your agency's vision of a service being proposed includes a strong case management component, include these services (with service codes) in your service description and narrative. Modifications to CSM will occur before, after and while bids are being awarded.

9. Question: Would you like us to use the standard DSCYF budget forms for a consolidated program budget, and if so, could you post them to the bid page?
   Answer: Use of these forms is not required. Responses should clearly address service components in a way that proposed prices can be evaluated.

10. Question: May we also use creative ways to demonstrate proposed cost, depending on what reimbursement methods the provider chooses to propose? Would these be included in the budget narrative?
    Answer: Yes and yes.

11. Question: Generally speaking, what is the expectation for the credentials of staff providing services? Do all services require a Master's degree and/or a license? May some services be provided by bachelor's level staff, and would they need to be under the direct supervision of a licensed clinician?
Answer: Specific qualifications of staff will be based on the service being proposed. Reference to similar services, Medicaid standards and staff credentials in other systems may be provided to inform/support the staff qualifications being proposed for a particular service. DPBHS welcomes the proposal of new services and recognizes that past qualifications may no longer apply in all cases.

12. Question: On page 10, "Additional Treatment Support Services" describes in-home and weekend daytime respite care, skills groups, and therapeutic recreation. What credentials do staff need to have to provide these services?
Answer: Similar services and provider qualifications utilized in other systems may be consulted to inform the development of provider qualifications for a proposed service.

13. Question: Can you tell us more about the types of services DPBHS is seeking?
Answer: It was suggested that respondents review current programs in PA, NJ and MD. The RFP also refers to two SAMHSA Bulletins that include several services that have been successful in other systems.

    In addition, at the Child, Adolescent and Young Adult Behavioral Health Research and Policy Conference, DPBHS had the opportunity to attend a presentation on an Integrated Co-occurring Treatment Model, from the Begun Center for Violence Prevention Research and Education at Case Western Reserve University in Cleveland, Ohio. This is another promising integrated home-based approach for high-risk youth. It has been successful in improving home environment and achieving school attendance, reducing substance use and symptoms of mental illness. Critical has been employment of licensed staff and effective clinical supervision. Length of service is 3-6 months (3 months for youth who may have either a substance abuse or mental health issue at a serious level and 4-5 months for youth with both serious MH and SA). The presenters were Jeff Kretschmar Ph.D. and Rick Shepler Ph.D.

    While DPBHS is not specifically endorsing this program, information on its operation may be helpful. DPBHS Director, Susan Cycyk, spoke with the presenters and told them about the RFP. Both said they would be willing to speak with agencies who contact them. Jeff.Kretschmar@case.edu. Richard.shepler@case.edu

14. Question: How detailed does the narrative descriptions of client service scenarios for the service(s) being proposed need to be (pg 14 #8 under service descriptions)? Is there an outline of what to include?
Answer: Client service scenarios should be kept brief. Responses do not need to describe/duplicate what has already been stated in #'s 1-7 but highlight how what has been previously stated will apply by use of a case example. A paragraph or two depending on the service, stating how client/family needs are determined/assessed, how services will be delivered to address the child and family's needs, how the proposed service and other resources may be utilized to support the treatment goals, and when discharge criteria are met, what a proposed step down plan would be and how it would be implemented.

15. Question: What is the anticipated length of stay?
Answer: The length of services authorized for any client will be dictated by the client's needs.

16. Question: How many hours per week will youth be authorized for services? Is there an expected range?
    Answer: The length of services authorized for any client will be dictated by the client's needs.

All other terms and conditions remain the same.

If you have any questions, please contact H. Ryan Bolles at herbert.bolles@state.de.us or 302-633-2701