BHD RFP Q&A
March 2012

Overview of Programs

Crisis Respite – This is a well-established level of care that has been in the community 10 plus years. Currently there are two (2) crisis respite facilities; one is located within the CRC on 14th and Becher, which is operated by TLS, and the second is located on 57th and Silver Spring and is operated by Bell Therapy (Phoenix Care Systems). BHD is seeking an additional eight (8) bed facility.

Referrals come to Crisis Respite in one of two ways:

- Step down program – These referrals are coming from an acute hospital setting. Services are used as a means to monitor individuals for a period of time before that individual is discharged into the community. It is an alternative to inpatient treatment when an individual still needs a supervised setting, but does not require a locked facility.
- Diversion referral – These referrals come primarily from the CRC, PCS, the community, self-referrals, etc., and are considered a diversion from an acute inpatient stay.

Crisis Resource Center (CRC) – There is currently one CRC operated by TLS, which is located on 14th and Becher. It has been in operation since 2007, and is designed to assist those who are in need of crisis intervention and short-term stabilization as an alternative to hospitalization.

Community Linkages and Stabilization Program (CLASP) – This is a new program, although not a new concept. The closest programmatic concept is the "Peer Link Model" out of United Behavioral Health. The concept is to provide peer linkages to individuals as they are discharged from an acute inpatient setting to help them remain successful in the community. These peer linkages are provided via Certified Peer Specialists.

Questions / Answers

Q: Talk about the specific staff that is required for CLASP.

1. There will be one (1) Behavioral Health Emergency Service Clinician ("Clinician") who will be assigned to the program. This individual will be a BHD employee, and his/her position will be 100% dedicated to CLASP. This individual will have a Master's Degree with 3,000 hours, and will be somebody who can "sign for medical necessity" under DHS 34. This individual will be either housed at BHD along with the contracted vendor, or will go back and forth between BHD and the contracted vendor's location.
2. There will be one (1) Certified Peer Specialist Supervisor position. This individual will be an employee of the contracted vendor, and it is anticipated that this will be a full-time position. This individual will not need to have 3,000 hours. A Master's degree would be preferred but is not required.
3. There will be numerous Certified Peer Specialists depending on the agency's proposal and budget constraints. It would be ideal to see these positions be full-time, although that may not be a possibility. Staffing criteria should be met for a 40-hour work week,

however these individuals may work various hours, and be part-time positions. As this is "unchartered territory," shifts in staffing and patient population may need to be made over time.

Q: Will the Peer Specialist Supervisor be a full-time position? Is this position for a Certified Peer Specialist?

It is anticipated that the supervisor will be a full-time position. The Peer Specialists are expected to be certified through the State of Wisconsin. First shift, 40 hour/week coverage is expected in this program. There is no evening or weekend coverage required.

With regard to the location of the CLASP program, the vendor will have the option of being housed at BHD. There is room for this program, and the space allotted has previously housed 18 individuals. The vendor would not be required to pay rent, and computers and phone usage MAY be provided. This will need to be verified. Cell phones would not be covered. Currently there is no wireless internet service at BHD, although this is expected to occur by August of 2012. The BHD Clinician would be housed at BHD, and if the vendor was located elsewhere, the Clinician would travel back and forth to the vendor location as necessary.

Q: Are vendors expected to capture other sources of income for this program, which only source is Medicaid? This could be a cash flow problem for providers because of the waiting period to get Medicaid dollars from the county paid out.

The financial revenue that providers receive from Medicaid will not be a large amount, however BHD will try to capture as much as they can. There is hope that this program will work with HMOs down the line, however providers should focus on the contracted amount as that is the amount that you will be working with.

Q: Will the provider or BHD submit the billing to Medicaid?

That is not known at this point. Potential providers should spell that out in the RFP; if the agency is capable of billing Medicaid, this should be specifically stated.

Q: What is the anticipated need for individuals pertaining to CLASP services? What is the expected census?

It is suspected that the need is significant. The target population is conceptual. It is difficult at this point to identify how many individuals will need support and for how long. The goal is to touch as many lives as possible in a meaningful way.

Q: The overall bid amount, how are you defining how that's being met? It's $330,000, are you looking at that in terms of how many positions are being hired?

Yes, it's how many positions, i.e. Peer Specialists, can you hire under that budget amount.

Q: That's regardless of how much Medicaid money you can bring in, correct?

Yes, the provider can bring in more Medicaid money and as a result can expand their capacity.

Q: What is the timetable?

4/9/12 - RFP's are due by 4pm
4/29/12 - Evaluation Panels will provide scores to Jim Kubicek and Sue Gadacz
6/20/12 - Award recommendations will be made to County Board (probable date of Health & Human Needs Committee meeting)
6/28/12 - Probable date of full County Board meeting; County Executive has until the next Board meeting to sign the authorizing resolution.
7/1/12 - Anticipated program start date

Contract awards will be pro-rated for the remainder of the fiscal year.

Q: Will there be one successful bidder for each program?

The two (2) programs that are facility based, CRC and Crisis Respite, will have only one award each. There may be some flexibility with regard to CLASP, and consideration may be given to more than one provider depending upon the proposals received.

Q: What are the training requirements for the CLASP Peer Specialists?

There is training that is required to be a Peer Support Specialist, and requirements pertaining to the certification of such with the State of Wisconsin, in addition to 30 hours of required training to have the capacity to bill under DHS 34. It is possible that many individuals will meet the requirements for DHS 34 by completing the requirements to obtain certification as a Peer Specialist. In addition, the Clinician will have the ability to provide training and convey information.

Q: Is there flexibility for having Peer Specialists and a Crisis Stabilizer for support?

BHD does not want to approach a hybrid model at this point, and individuals will need to hold certification as Peer Specialists.

General Questions

1. **Will an "intent to contract" or "notice of award" letter be issued by Milwaukee County for successful applicants, and if so, when? (p.2-3)**

   A: The program director will be advised of the panel recommendations and ideally, within a week of April 29th, letters will be sent out to those who are being recommended for contract awards, and for those who are not being recommended.

2. **Does the County expect vendors to be fully operational by July 1? The RFP states "Contractor shall begin work on July 1, 2012". If not, then by what date should the programs be fully operational? (p. 2-4)**
    a. **Will the County require/request applicants to submit an implementation timeline?**
    b. **Since startup costs are allowable for the CRC component, when should it be operational? Are there 'bonus' points or consideration if startup costs are not required?**

    A: Yes, by July 1, 2012. Vendors should submit an implementation timeline with their applications. Flexibility may be given with regard to start up dates, particularly with the facility-based programs as these may require licenses and certifications to become fully operational. This will, however, be weighted against other applicants. If one provider is able to implement their program many months prior to another applicant, this could weigh in the ultimate decision of contract awards. One of the scoring mechanisms in the RFP is a fiscal score, and the agency may score higher in that particular section if no start up costs are required.

3. **Since these are new and expansion programs, will the County provide applicants information on client characteristics? If not, how will CLASP applicants in particular determine the client characteristics to fill out the required Client Characteristic Chart? (Item #37, p. 4-58)**

    A: Start with determining the number of individuals you believe you can serve, based on the program staffing you achieve within the budgeted amount. You can then apply the client characteristics you have generally served in other programs to this amount. If you do not have historical experience to draw upon, Jennifer Wittwer can provide client characteristic information from other programs such as TCM or CSP.

    Q: Would the clients in the TCM and CSP programs be serviced by the CLASP Program?

    A: No, this is a service designed to fill a gap in services for those clients who currently lack services and community assistance. In addition, there is a peer support component being added to the TCM and CSP services currently and ongoing in the future, so individuals in those programs will have access to Peer Specialist services. Total number of clients would be based on the capacity that you are able to serve. Write the proposal as if it is for a full year. It will be awarded this year, but it will be on a multi-year cycle. Start with the budget, build your staffing around that, and determine, based on how much staff you're able to afford, how many clients you'll be able to serve.

    Q: How many clients in this population have straight Medicaid?
    A: Straight Medicaid is less than 10% and 15-20% have Medicaid HMO.

Q: Is this program primarily billing Medicaid?
A: Yes, in year one it will be almost exclusively Medicaid, and it will be minimal. It will also depend on the education level of your Peer Specialists, as Masters level clinicians are reimbursed at higher rates.

Q: If clients are not on Medicaid, will they be selected into this program?
A: Yes, the agency is primarily reimbursed through the contract. This should be anticipated by the agency, and the agency should identify their unit cost this way. All of the linked budget forms are required to be completed. For scoring purposes, we need a unit rate from all proposers. The total agency budget would be increased by the contracted amount, however budget forms for all other programs should not need to be submitted.

Contract Administration's CPA Consultant, Sumanish Kalia, 414-289-6757, sumanish.kalia@milwcnty.com, is available to answer budget questions via phone or email, and an in-person meeting can also be scheduled.

Program-specific Questions

Crisis Respite

4. **Since BHD manages admission to this program, how will the vendor assure that "beds will be occupied of no less than 80% of the time overall" under 'Expected Outputs'? (p. 5-BHD-8)**

A: This is not an expectation of vendors. This is a program goal overall, but BHD will be responsible for achieving this goal. TLS is currently the contracted provider of the Crisis Resource Center, and both TLS and Bell Therapy have a contract for Crisis Respite. Proposals that are awarded with a contract become public information, and vendors may obtain copies of the proposals submitted by TLS and/or Bell Therapy. Contract Administration's Administrative Assistant, Cleo Stewart at #289-5980, should be contacted if you wish to view previous proposals.

Q: Will the Peer Specialists continue to play a role with Crisis Respite or will things change operationally?
A: Yes, the Peer Specialists will continue to interact with the new and existing Crisis Respite programs as they have done previously. There are no forecasted changes in these procedures.

Q: Will vendors have to demonstrate competency in being trauma informed and culturally competent? How are these criteria being measured?
A: There is a question in the RFP that asks something to the effect of "how does the mission of the agency coincide with the mission statement of the BHD" and the providers could possibly use that section to describe this.

Q: Is there an area of the city that is of preference for location of the new Crisis Respite?
A: It works better if it is within close driving distance to BHD – ideally as close as possible, although there is no specific location being requested.

Q: Are there increased points awarded to minority-based agencies?
A: Cultural diversity and cultural competency is weighted quite heavily on the scoring of the proposals, and this pertains to the overall competency plan and the composition of agency staff and the Board of Directors. There are no bonus points awarded to DBE agencies.

<u>Crisis Resource Center</u>

5. **Please define the geographic boundaries that Milwaukee County considers to be 'north side'. (p.5-BHD-12)**

   A: There are no specific boundaries. The "north side" is typically considered to be anywhere north of Wisconsin Avenue.

6. **Will the CRC also be able to access CLASP? (p. 5-BHD-10)**

   A: The access point or referral point for the CLASP program will be through the acute hospitals and the crisis programs such as PCS. The CRC is not currently a referral source for the program.

7. **Are the CRC residential services separate and distinct from the Crisis Respite Services? If so, how are they different programmatically? (p. 5-BHD-10)**
   a. **Who determines admission to CRC beds – the vendor, BHD or both?**
   b. **Is there a 'not-to-exceed' length of stay requirement for the CRC beds (i.e. individuals are not expected to stay for longer than 30 days)?**

   A: Yes, the CRC and the Crisis Respite programs are very separate and distinct programs. TLS has the CRC and a Crisis Respite program co-located in the same building. This is not an expectation for new providers, but it is a possibility. The CRC vendor determines admission to their program primarily, however there is an expectation by BHD that if an individual is referred to the program, they will be admitted. BHD does determine ALL admissions to the Crisis Respite programs. Individuals are not expected to be at the CRC for longer than 30 days, and generally not this long. If an individual needs more of an extended stay, the referral would most likely be made to Crisis Respite. The intent of CRC is to be a short-term crisis stabilization program.

8. **Since Milwaukee County is the payor of last resort and holds the DHS 34 billing provider number, who will retain billing revenue received? (p. 5-BHD-11 & 12)**
   a. **If the provider retains the revenue, will the County continue to withhold 5% of the revenue for its administrative costs?**

b. **Assuming the vendor's costs exceed the Medicaid-allowed per diem rate, will the County contract be utilized for the difference or is the vendor expected to accept the Medicaid rate as payment in full?**

A: There is no solid answer at this point. The CRC is one of those programs that will develop revenue numbers and those will be much greater than those of the CLASP program.

a. Yes, if there's any crisis billing that goes through our DHS 34 billing. You would still be subject to compliance, audits, etc.
b. No, Medicaid will not be considered payment in full.

9. **How long after discharge should the vendor plan for follow-up to ensure that community linkages are accessed? What kind of follow-up activities does the County envision (i.e. continuing engagement with discharged individuals until they are able to be seen by a mental health provider)? Please define type and frequency of follow-up activities. (p. 5-BHD-11)**

   A: The expectation is that there are community linkages made, however there are not currently any specific amounts or types of referrals or follow-up activities required, nor are there any specific timelines as to when these need to occur.

10. **How will the expected outcomes as identified in the RFP be measured? How will baseline data be collected by BHD? What are the targets for these outcomes? (p. 5-BHD-14)**

    A: The expected outcomes coincide with the indicators and the expected levels of outcome achievement specified in the RFP. They will be reported back in an agency report twice per year.

11. **Under performance indicators and expected levels of outcome achievement, how will clients know when they self-report that they successfully avoided hospitalization? In other words, how will individuals know if they could have been hospitalized since admission is determined by a physician/psychiatrist? (p. 5-BHD-14)**

    A: This will be based solely on client self-report, i.e. asking clients at the point of intake something to the effect of, "If you hadn't come here, where would you have gone?" to ascertain this information.

<u>Community Linkages and Stabilization Program</u>

12. **Will the face to face contacts also satisfy the general contacts requirement? Please define general contacts. (p. 5-BHD-17)**

    A: Yes, face-to-face contacts qualify as "general contacts." There should be a minimum of 4 general contacts per month, 2 of which must be face to face.

13. **The RFP states "WRAP plans developed under s. DHS 34.23(7)" (p. 5-BHD-19). Is it the County's intent to adapt the evidence-based practice of WRAP to conform to the requirements of a Crisis Plan defined within DHS 34?**
    a. **If so, who is responsible to modify the WRAP plan, the County or the vendor?**
        i. **WRAP is designed and managed by the consumer to help notice when things seem to be off balance, and help coordinate effective ways to get back to feeling their best. WRAP planning also includes Crisis Planning, an Advance Directive that lets others know how the client wants them to respond when the client cannot make decisions, take care of themself, or keep themself safe. WRAP does not require the input of others, whereas the DHS 34 Crisis Plan allows and requires input from service providers (s. DHS 34.23(7)(c)). How will the County reconcile this difference?**
    b. **If not, is the vendor responsible for developing both a WRAP and Crisis Plan?**

A: Yes, we are trying to merge these two documents, and in some cases it won't be a seamless merge. There should only be one plan, not a crisis plan and a WRAP plan, and there will be an attempt to merge these two into one even though they differ in some ways. There is some concern regarding the merge and it will take work to develop this. The crisis plan is crisis oriented, whereas the WRAP plan is a recovery plan and is something that the individual owns, and is done voluntarily.

14. **Who will approve the WRAP plan as medically necessary? (p. 5-BHD-18)**

A: The Behavioral Health Emergency Service Clinician assigned to the program. The Clinician will have a Master's Degree with 3000 hours and will be the supervisor of the program. Professional, clinical supervision will be provided for the Peer Specialists under this program, the supervisor of the Peer Specialists does not need to have 3000 hours.

15. **Under service notes, the RFP states "program staff shall prepare… assessment of the person's need for mental health services… (and) emergency mental health services provided…" (p. 5-BHD-19). This appears to be outside the scope of Certified Peer Specialists as defined by the State of Wisconsin. Who will perform these services?**

A: The BHD Clinician.

16. **For the "Community Linkage and Stabilization Program # M019 (Page 5-BHD-15) - under section entitled Program Purpose; what age group is the consumer?**

A: Adults – no other specifications are being provided.

17. **Page 5-BHD-17, #5 – The definition of Unit of Service - The RFP indicated that "the selected CLASP vendor must exhaust other governmental and private resources (e.g., Medicaid, Badger Care, private health insurance, etc.) before using funds provided by this contract".**
    a. **Does this mean the selected vendor will need to directly bill governmental and private resources as a direct means of receiving payment?**
    b. **If so, does the vendor need to have the necessary billing requirements and means or would this be done through BHD?**

    A: Yes, to the extent that it is possible it will be expected that vendors are billing for services and capturing revenue through DHS 34. As the County is the only entity that can have a billing number for this, the billing will need to be done with the County's number. Applicants should indicate in their proposal if they have the necessary infrastructure to complete the billing requirements or if they would require the billing to be done by BHD.

18. **The RFP indicates "Units of Service are defined as individual client contacts; duration of contact is documented and billed in 15-minute increments.**
    a. Will the selected vendor need to directly bill BHD for units of service performed by each Peer Specialist?
    b. How are the wages/benefits of the Peer Specialist and Peer Specialist Coordinator to be reimbursed by BHD and billed by the selected vendor (as outlined under the "Agency or staff licensure, certifications(s), and /or experience necessary to provide service" (5-BHD-16, #1))?
    c. Will non-billable time worked by the Peer Specialists be covered in the unit cost? Are these to be included in the unit cost calculation?
    d. Can travel/mileage reimbursement for Peer Specialists and the Peer Specialist Coordinator be included in the unit of service calculation? Would the selected vendor be able to bill travel/mileage expenses separate/in addition to the unit costs?
    e. How is billing completed, by the selected vendor or via the Behavioral Health Emergency Service Clinician (BHESC) provided by BHD?
    f. Will the selected vendor be responsible for creating required documentation forms to meet DHS 34 requirements or will these be provided by BHD?

    A:
    a. Yes, the selected vendor will need to bill BHD directly for units of service performed by each Peer Specialist.
    b. The wages/benefits of the Peer Specialist and Coordinator are part of the contract, and it is anticipated that those salaries will come from the contract dollars. The agency reports on a monthly basis with regard to revenue and expenses to reconcile the contract throughout the year. Information is collected via the proposals from vendors that may not be the basis for payment methodology, e.g. we may want information pertaining to units of service provided by each Peer Specialist, but whether or not we use that information on a regular basis for billing purposes has not yet been decided. Vendors will have the ability to report directly on the monthly revenue and expense reports the units that have been utilized, whether we reimburse based on units of service or not.

c. The non-billable time should be built into your rate, as it is part of the agency's overhead. Certain services are billable to Medicaid, such as travel and documentation, while other services are not billable, such as staff meetings and trainings.
d. Yes, that's part of the overall programmatic costs.
e. BHD will bill for the Clinician's time, the vendor does not submit for this individual.
f. This will be done in partnership between BHD and the selected vendor.

19. Non-Billable Activities (5-BHD-17):

a. This section indicates the "selected vendor will be responsible for the recruitment, training and retention of Peer Specialists". Will BHD or the BHESC provide any training to the Peer Specialists or Peer Specialist Coordinator?

b. Will training requirements fall under DHS 34?

A: BHD offers ample opportunities for training, but vendors should also be seeking training opportunities for their staff.

20. 5-BHD-16, #1 – Agency or staff licensure, certification(s), and/or experience necessary to provide service. Ratio of staff to clients.

a. What State certification is required for Peer Specialists?

b. Is there an available list of required job qualifications or credentials required by Peer Specialists and/or the Peer Specialist Coordinator? Has any job description been outlined for these positions?

c. Is there a desired number of Peer Specialists under the RFP bid amount? Is there a certain ratio of Peer Specialists to a Peer Specialist Coordinator?

d. Will the selected vendor be responsible for providing on-call/after hours services?

A:
a. Peer Specialists need to be certified as such through the State of Wisconsin. An exam is offered 3 times a year and is offered through UWM. More information can be provided if needed.
b. No job description has currently been outlined for these positions. Considering that the RFP is requesting this information, the vendors submitting applications should include this item in their proposal.
c. There is no set amount. This is up to the vendor to determine how many Peer Specialists they are able to support with their budget.
d. No, these services will be provided through BHD's crisis line.

21. Required Documentation (5-BHD-17):

a. Will the selected vendor have access to electronic medical record billing through BHD or will the vendor need to provide written form documentation? Will any software be needed to correspond with BHD electronic billing?

A: All documentation is in paper form at this point, however it will be integrated into the Electronic Medical Record system over the next 2 years.

Contract Amounts:

$330,000 – CLASP
$250,000 – Crisis Respite
No amount specified for CRC

Current contract for CRC is $250,000

Q: Is there a page limit for the program description?
A: A page limit has not been identified for the program description in this RFP. However, applicants are encouraged to limit their description to 12 pages or less.