

# **Community Service Agency Request for Response Frequently Asked Questions**

## **Acronym Glossary**

CANS – Child and Adolescent Needs and Strengths  
CBAT – Community-Based Acute Treatment  
CFFC – Coordinated Family-Focused Care  
CSA – Community Service Agency  
CSP – Community Support Program  
DHCFP – Division of Health Care Finance and Policy  
FST – Family Stabilization Team  
FTE – Full-Time Employee  
GED – General Educational Development  
ICC – Intensive Care Coordination  
ICP – Individual Care Plan  
IDEA – Individuals with Disabilities Education Act  
IEP – Individualized Education Program  
MCEs – Managed Care Entities  
MR – Mental Retardation  
PDD – Pervasive Developmental Disorder  
SAMSHA – Substance Abuse and Mental Health Services Administration  
SED – Serious Emotional Disturbance  
SOMWBA – State Office of Minority and Women Business Assistance  
UM – Utilization Management  
QM – Quality Management

## **Theme: Cultural Competency**

**Q: Does MassHealth have data on the racial/ethnic/linguistic make-up of their under-21 Members by city/town or region?**

*A: MassHealth does not have data on MassHealth membership by DCF area offices. We might suggest using US Census Bureau data, which is publicly available. Tell us – based on your experience serving youth and families – what the demographic make-up is of those youth. We do not have a list of demographic data for your organization against which we will be comparing your answers.*

## **Theme: CMS Approval**

**Q: What will happen if CMS does not give approval for Caregiver Peer-to-Peer Support services?**

*A: If CMS does not approve Caregiver Peer-to-Peer Support, it will be taken out of the court order/agreement, and MassHealth will then pursue possible funding of this service via state dollars..*

**Q: When is CMS approval expected?**

*A: CMS approval is expected by the end of the calendar year.*

**Theme: Master's Level vs. Bachelor's Level Care Coordinator and Family Partner**

**Q: Is there a difference in terms of the services that can be offered by a master's level Care Coordinator and Family Partner team versus a bachelor's level Care Coordinator and Family Partner team?**

*A: No*

**Q: Is it expected that both master's level and bachelor's level Care Coordinators will complete the CANS?**

*A: Yes. Non-master's level ICC care coordinators can be trained and certified in the CANS tool. EOHHS is revising the CANS policy to reflect this change.*

**Theme: Selection Committee**

**Q: We are aware that MBHP and the other MCEs will be on the selection panel. Will state agencies, such as DMH, be part of the selection panel as well? Are there other members of the selection panel?**

*A: State agency representatives and MassHealth representatives will not be part of the selection committee. A selection committee comprised of representatives from the five MCEs will review the responses received by the submission deadline and make the final selections for each of the 29 areas as well as for the three specialized CSAs. As part of the selection process, the MCEs are committed to ensuring input from families and reviewers with expertise in culturally and linguistically competent practice.*

**Theme: Volume Projections**

**Q: How was the estimated number of SED youth to be served determined for each area?**

*A: The projections were based on the number of MassHealth youth under 21 who live in each geographic area and who were recipients of any behavioral health service for more than six months. In addition, these youth met any of the following conditions:*

- Were involved with two or more state agencies*
- Were involved with Department of Mental Health*
- Were involved with Department of Youth Services*
- 60 percent of the youth were involved with Department of Children and Families.*
- Received more than \$4,800 of behavioral health claims paid*

- A case finding factor of an additional 50 percent of the number of youth who received >\$4,800 of behavioral health claims
- A case finding factor of 10 percent was included on the numbers included based on state agency involvement.

*The projections should be considered the base of unduplicated utilizers in a year, and the number served in a given month would be lower than the estimate provided. The estimated number of youth who may need these services should be considered rough estimates, as the state simply does not have the clinical data on these youth to know with certainty how many would require ICC.*

*The estimated number of youth who may need ICC reflects what we think a fully mature program may serve once completely ramped up. Experience in other states with these types of programs indicates that start-up may be quite slow, and the initial number of enrolled youth is expected to be substantially lower than the provided estimate of children with SED.*

*Selected providers will be provided with ramp-up targets for the first 2 years of service. Within the first three months of start-up, all providers will be expected to have three full-time care coordinators hired and fully enrolling families. After the first three months, each provider will be given a target range of staff hires and families enrolled for every quarter over the remaining two years. These targets will be based on estimated enrollment numbers in the provided projections by area. For example, a large volume ICC provider will be expected to hire 3-6 more staff in the 2<sup>nd</sup> quarter, while a low volume provider will be expected to hire 2-4 staff in the 2<sup>nd</sup> quarter. Providers are not expected to fully ramp-up on day one. Based on ramp-up experiences of other states, we expect providers to need 18-24 months to reach full hiring and enrollment.*

**Q: What is the expected length of stay in ICC?**

*A: The duration of ICC services is dependent on the youth continuing to meet medical necessity criteria for this service, including an assessment by the Care Planning Team that ICC is continuing to support progress towards meeting the identified goals and the youth's age.*

**Q: Without an expected length of stay (LOS) in ICC, how can I project the size of my CSA?**

*A: Because of the uniqueness of the Massachusetts ICC program, it is not possible at this time to project an average LOS. The language in the RFR asks for a budget for the geographic CSA's based on the volume figures in Appendix G of the RFR. Realizing that you would need LOS to answer this question, the RFR language will be amended to request in all geographic CSA responses a budget based on an average sized CSA with 336 ICC clients at any one time. Responses for specialized CSAs should still include a budget based on the projected size of the special population being proposed for the specific specialized CSA.*

**Q: The work of the specialized CSAs will surely overlap with the work of the geographic CSAs, and it is clear that the expectation is for these organizations to collaborate and partner. When an agency is selected as a specialized CSA, as required, that agency will have a focus on a specific area. How will this affect the estimated numbers of SED**

**children who are listed for each DCF service area, which will become the responsibility of the provider designated as the geographic CSA for that particular area?**

*A: Preference will be given to specialized CSAs located in more densely populated areas where it is expected there will be sufficient volume for more than one CSA. Once the specialized CSAs have been selected, we will work with the geographic CSAs to address any issues related to volume.*

### **Theme: Financing/Funding/Rate**

**Q: Can master's level interns bill for ICC, and if so, at what rate?**

*A: First-year, master's level interns can bill using the non-master's ICC code. Second-year, master's level interns can bill at the master's rate with the rate reimbursement varying by plan.*

**Q: How will travel to and from family homes be reimbursed for Care Coordinators and Family Partners?**

*A: Four hours of travel time a week for Care Coordinators and Family Partners per FTE was built into the rate when it was developed. This time calculation was formed by documented time studies by CFFC providers and other Systems of Care models. Travel time spent transporting a youth or caregiver to a meeting or service can be billed.*

**Q: Will flexible funds be available for the CSAs?**

*A: No. Flexible funds/spending will not be a part of the CSA. Medicaid requires that all monies be tied to a medically necessary service. However, local Systems of Care committees will be strongly encouraged to explore alternative funding for non-medically necessary services. Through the local Systems of Care committees, relationships will be built with community organizations through which community resources may be able to be leveraged. Other states with Wraparound programs (and the two Wraparound pilot programs in Massachusetts) had non-Medicaid state dollars available to pay for flexible funding.*

**Q: If a youth does not meet the medical necessity criteria for ICC, will there be reimbursement available for the assessment?**

*A: Yes, if the youth is under the age of 21 and enrolled in MassHealth Standard or MassHealth CommonHealth.*

**Q: The service definition for ICC (Appendix D of the RFR) says that "psychiatric consultation to the team" is included as a component and is billable in 15-minute increments. How is this billable?**

*A: The service definition in the RFR for ICC is wrong. Psychiatric consultation to the team is supposed to be an activity that is built into the rate and thus not billable as separate units. As stated in the RFR (page 25), .2 FTE psychiatry is built into the rate. An amendment to the RFR service definition has been made and has been posted on the MCEs' web sites.*

*Psychiatric management of individual members and customary psychiatric services are billable as usual.*

**Q: Will there be any funds available for selected CSAs as they ramp-up to provide services?**

*A: Per the RFR, "Limited funds may be made available to assist CSAs with some start-up costs."*

**Q: As a unit-rate contract, will each CSA contract have a maximum financial obligation?**

*A: No, there will be no maximum financial obligation. It is fee-for-service.*

**Q: If a contracted CSA chooses to partner with another agency for a specific CSA area, can the partner agency do its own direct billing for services, or does all billing have to be submitted by the contracted CSA?**

*A: All billing needs to be submitted by the primary contracted CSA in the situation described.*

**Q: Will there be a special rate for the specialized CSA, and/or will the specialized CSA be allowed to bill for extra costs they might incur?**

*A: Specialized CSA bidders should elaborate in the narrative response section 4.4 what specific additional costs their organizations would expect as a specialized CSA. These unique circumstances will be taken into consideration during the contracting process.*

**Q: Can you please explain the methodology behind the rate development including information on salary, overhead costs, etc.?**

*A: On November 13<sup>th</sup>, DHCFP held a hearing on the proposed floor rates. DHCFP publicly released testimony and data on how it calculated those rates. This information is enclosed as attachment 1. DHCFP is accepting written testimony about the rates until November 24<sup>th</sup>. Please go to the Mass.gov website for more information at: <http://www.mass.gov> and search for the Division of Health Care Finance and Policy. As no response from DHCFP regarding rates is expected before November 24<sup>th</sup>, we would request that anyone hesitant to respond to this RFR because of rates still submit a letter of intent by November 21<sup>st</sup>.*

**Q: Why is the rate for Caregiver Peer-to-Peer Support services lower than that of the non-master's level Care Coordinator?**

*A: The rate was based on DHCFP's analysis of salaries (see above). Providers can develop their own salary scales for Care Coordinators and Family Partners based on the total reimbursement received by the CSA for the delivery of these services.*

**Q: Will Care Coordinators and Family Partners be able to bill for support groups they might offer for caregivers and youth?**

*A: Yes. An operations manual for ICC will be made available at a later time, which will speak to operational issues, such as billing for support groups.*

**Q: To what extent have the labor market constraints been considered in the reimbursement model and performance specifications? For example, if all the overhead is built into the rates, what happens during times when the billable units are down due to vacancies (e.g., the overhead does not go down during these periods, one of which will certainly be start-up)?**

*A: Marketing these new services will be a collaborative effort of the CSA, MCEs, MassHealth, and others. The CSA will also need to monitor the productivity of their staff to ensure they are generating enough revenue to cover their costs.*

**Q: Will each MCE establish its own rates for ICC and Caregiver Peer-to-Peer Support services?**

*A: Yes. Please see page 9 of the RFR for more information on rates and contracting with the MCEs.*

**Q: Can my organization choose not to contract with an MCE if the rate established by any MCE is too low?**

*A: No. To ensure access for every MassHealth youth, organizations are expected to contract with all the MCEs. On page 9 of the RFR, it states “Each CSA will be required to contract with every MassHealth MCE for this service.” Note that the model budget organizations develop should be based upon the floor rates located on page 9 of the RFR.*

## **Theme: Caregiver Peer-to-Peer Support Services**

**Q: Are all youth enrolled in ICC required to have Caregiver Peer-to-Peer Support services as well?**

*A: No. A Family Partner must be offered to all ICC-enrolled youth and families, but if the family does not wish to work with one, then a Family Partner is not required.*

**Q: Does the Caregiver Peer-to-Peer Support program director need to be a licensed clinician?**

*A: No. However, the Caregiver Peer-to-Peer Support services program must ensure that the Family Partners are offered supervision by a licensed clinician on a weekly basis. Time spent in group supervision with a licensed clinician or dyad supervision conducted by the senior Family Partner, and the senior care coordinator would satisfy this requirement.*

**Q: Does the Caregiver Peer-to-Peer Support program director need to be a parent/caregiver of a youth with special needs?**

*A: The relationship described is preferable but not required.*

**Q: The performance specification for Caregiver Peer-to-Peer Support says that the service must be tied to a goal on the ICP. Does this mean that a Family Partner cannot work with a family for children in ICC until the ICP is developed? Family Partners are critical to the engagement model so it would make sense that they could be brought in earlier if desired by the family, at least for children in ICC.**

*A: Yes, Family Partners can be brought in earlier as they will help to inform the development of the ICP.*

**Q: Is it required for a Family Partner to be a caregiver of a youth with special needs?**

*A: Yes. A Family Partner is required to be a caregiver of a youth with special needs, preferably a youth with behavioral health needs. Serving as a foster parent is an acceptable qualification. Child care work in a residential program, day care, or other congregate care setting, however, is not an acceptable qualification.*

**Q: The staffing qualifications for Family Partner says that if they have a high school diploma or GED that they need a “minimum of two years of experience working with children/adolescents/transition age youth.” Can the time spent parenting their own child with special needs be considered “two years working with children,” or does it need to be paid work with children?**

*A: It does not need to be paid work. Time spent parenting their child is work.*

**Q: What is the expectation for the requirement that the Family Partner be supervised by both a senior Family Partner and a licensed clinician on a weekly basis?**

*A: Time spent in group supervision or dyad supervision would satisfy this requirement.*

**Q: Family Partners are an integral part of each CSA. Will other agencies, which are not CSAs, be able to develop their own team of Family Partners and bill for these services directly?**

*A: Yes. Through the network development process, other organizations interested in offering Caregiver Peer-to-Peer Support Services can do so. In the early stages of the CBHI implementation, however, it is expected that Caregiver Peer-to-Peer Support services will primarily be accessed through the CSA.*

**Q: Is it required for the Family Partner to have a driver’s license? What if the Family Partner is living in an urban area and can utilize public transportation?**

*A: Given that much of the work of the Family Partner will be community-based and not office-based, it is important that the Family Partner have a reliable means of transportation so s/he can get to Care Planning Team meetings, hospital discharge meetings, IEP meetings, etc. The CSA is responsible for ensuring, if a Family Partner who does not have a driver’s license is hired, that the lack of reliable transportation will not interfere with the usual and customary job responsibilities of a Family Partner.*

## **Theme: Medical Necessity Criteria/Youth Eligible for ICC**

**Q: When will the medical necessity criteria for ICC and Caregiver Peer-to-Peer Support be available?**

*A: The medical necessity criteria for ICC and Caregiver Peer-to-Peer Support have not yet been finalized and will not be available prior to the submission deadline date.*

**Q: Are youth with autism/PDD/MR eligible for ICC?**

*A: ICC is reserved for youth with Serious Emotional Disturbance as defined by either IDEA or SAMHSA. A youth with PDD/MR/autism would need a behavioral health diagnosis to be eligible.*

**Q: Are youth in residential care eligible for ICC?**

*A: Once a disposition plan has been agreed upon for a youth in residential, ICC can be initiated to help support the transition.*

**Q: If a youth does not have MassHealth, is s/he eligible for ICC?**

*A: No. Youth enrolled in MassHealth Standard and MassHealth CommonHealth under the age of 21 who have Serious Emotional Disturbance are eligible for ICC. However, nothing precludes the CSA from contracting with commercial payers to receive reimbursement for services delivered by the CSA.*

**Q: Who is responsible for making the SED determination for ICC?**

*A: The ICC Care Coordinator is responsible for making the SED determination based on the IDEA or SAMHSA definitions as part of the comprehensive home-based assessment.*

**Q: The state agencies serve children up to age 22. Why is the age eligibility different for ICC?**

*A: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services is a federal Medicaid statute that applies to youth under the age of 21.*

**Q: If a youth is eligible for ICC services prior to their 21<sup>st</sup> birthday, do services end when the youth turns 21?**

*A: Yes. However, planned transition to adult services is a critical component of a high quality care planning process. We would expect that Care Planning Teams are keeping the age of the youth in mind to ensure that there is a seamless transition to adult services when the youth turns 21.*

## **Theme: Provider Qualifications**

**Q: My organization is NOT a currently contracted MassHealth Managed Care provider. Can I apply?**

*A: Yes, but you must be able to demonstrate meeting the qualifications on page 7 sections a through g . Please note that the service-specific staffing requirements for ICC and Caregiver Peer-to-Peer Support services can be found in the staffing requirements section of the respective performance specifications for those services.*

**Q: My organization is only contracted with one MCE for one service. Can my organization bid to be a CSA?**

*A: Yes. If your organization is a currently contracted provider (for any level of care: inpatient, CBAT, FST, CSP, outpatient, CFFC, etc.) with one or all of the MassHealth contracted MCEs, an application to be a CSA can be made.*

*If selected for a particular geographic area, organizations are expected to contract with all the MCEs managing behavioral health care in a particular geographic area.*

**Q: Is the procurement process open to organizations that form a limited liability corporation or establish a formal partnership agreement?**

*A: Any organization that meets the requirements as specified on page 7 of the RFR may apply.*

## **Theme: Contracts and Subcontracting**

**Q: How does not having a contract with a MassHealth MCE affect a CSA applicant?**

*A: It is not required to be a currently contracted MassHealth provider in order to apply. Please refer to Provider Qualifications under Additional Requirements on pages 7-8 of the CSA RFR.*

*If selected, you will be expected to contract with all Managed Care Entities serving the MassHealth membership in a particular geographic area.*

**Q: Can a successful bidder add subcontracts after the contract award?**

*A: Yes. However, it must be stated clearly in the application how you will meet the stated requirements. Please see pages 16 and 17 for more information on subcontracting.*

**Q: Statewide contracts typically have an Affirmative Market Program plan. This RFR does not include language for bidders to develop an AMP or to utilize SOMWBA-certified vendors or subcontractors. Will there be any consideration in the bidders' evaluation for SOMWBA-certified organizations and/or subcontractors?**

*A: This procurement is not a public one. Therefore, the rules for statewide contracts for AMP and SOMWBA-certified vendors or subcontracts do not apply. However, in order to meet the*

*needs of specific linguistic or cultural groups or specialized populations, we would encourage use of SOMWBA-certified vendors or subcontractors.*

**Q: Do I need to provide copies of subcontract documents in my response?**

*A: No. A letter of intent from an organization with which you intend to contract is acceptable.*

**Theme: Specialized CSA Proposals**

**Q: How will the specialized CSAs work with the geographic CSAs? Do the geographic CSAs filter the children and families and refer them to the specialized CSAs?**

*A: Geographic and specialized CSAs working in overlapping areas will be expected to collaborate and partner in ways that strengthen services to families. Families can go to whichever CSA they choose, depending on which organization they think best meets their needs. Both the geographic CSA and the specialized CSA should make families aware that they have a choice of another CSA in their service area if that is the case.*

*Specifically, geographic CSAs do not “filter” or screen families for the specialized CSAs.*

**Q: If an applicant organization intends to submit a specialized CSA application that focuses on a primary cultural/linguistic population and there is a smaller, but significant, secondary population residing in that same geographic area, can the applicant propose to reach both the primary population and the smaller, secondary population in the same application?**

*A: Yes.*

**Q: Will the specialty CSA determine/define geographical area covered (i.e., entire city of Chelsea vs. the DCF Harbor service area)?**

*A: The specialty CSA bidders should tell us the geographic area they propose to cover. See question 6.5 on page 23 of the RFR. A specialized CSA bidder can propose to cover more than one geographic area.*

**Q: Are organizations bidding on specialized CSA contracts required to have an administrative structure that includes a medical director and/or other psychiatric clinicians (those licensed to prescribe medication) as a part of their staff structure?**

*A: Specialized CSA providers must meet the same qualifications to apply (located on page 7 of the RFR) as geographically based CSA providers. For specific staffing requirements for ICC and Caregiver Peer-to-Peer Support services, please review the staffing requirements section located in the performance specifications for those services.*

**Theme: ICC Staffing**

**Q: The number of care coordinators that the senior care coordinator is required to supervise is high at 1:8. How was this supervisory ratio determined?**

A: *The supervisory ratio was based upon experience in existing Wraparound programs in Massachusetts and other states that serve a more acute and complex population of youth, adjusted to account for the expectation that ICC will serve a population of youth with less complexity, acuity, and intensity than those served by existing Wraparound programs.*

**Q: Does the senior care coordinator need a professional license?**

A: *Yes. Staffing requirements are listed in the staffing requirements section of the ICC performance specification.*

**Q: Does the ICC program director need a professional license?**

A: *The ICC performance specifications do not require that the ICC program director have a professional license. However, it is preferred that the ICC program director be a licensed individual with commensurate experience, given s/he is responsible for all services and quality aspects of the program.*

**Q: Is the staffing model located on page 22 of 1:1 master's and non-master's care coordinators required?**

A: *No. This model is a guideline. Your response, particularly your budget should make clear what ratio you are planning.*

**Q: What is the role of the child psychiatrist in ICC? The .20 FTE (Table 1, p. 22) seems to indicate that it is a consultant role, not a direct provider role. However, the reference to a psychiatrist on page 7 suggests a different role: "Employs a psychiatrist who may fill any of the roles above and in addition, is responsible for evaluating the physiological, neurological, and psychopharmacological status of the youth served by the organization."**

A: *The psychiatry support for ICC is found in the staffing section of the ICC performance specification. It is a consultant role, **not** a direct provider role. The information on page 7 is related to the qualifications an organization (on whole) must have in order to **apply** to be a CSA, not what is expected of the ICC consulting psychiatrist. Also of note, if your organization is already a currently contracted MassHealth managed care provider, then it is assumed your organization already meets the qualifications on page 7. The qualifications to apply located on page 7, sections A through E, are for **a non-contracted MassHealth provider** that must be able to meet those qualifications in order to apply for a CSA.*

**Q: Is it expected that the CSA be fully staffed on June 30, 2009?**

A: *No. Selected providers will be provided with ramp-up targets for the first 2 years of service. Within the first three months of start-up, all providers will be expected to have three full-time care coordinators hired and fully enrolling families. After the first three months, each provider will be given a target range of staff hires and families enrolled for every quarter over the remaining two years. These targets will be based on estimated enrollment numbers in the provided projections by area. For example, a large volume ICC provider will be expected to hire 3-6 more staff in the 2<sup>nd</sup> quarter, while a low volume provider will be*

*expected to hire 2-4 staff in the 2<sup>nd</sup> quarter. Providers are not expected to fully ramp-up on day one. Based on ramp-up experiences of other states, we expect providers to need 18-24 months to reach full hiring and enrollment.*

### **Theme: Utilization Review and Quality Management**

**Q: The RFR indicates on page 36 that the “ICC provider participates in all network management, UM, and QM initiatives and meetings.” Are these separate for each purchaser?**

*A: Yes. The MCEs are working together, however, to develop efficient processes for UM and QM.*

**Q: Is pre-authorization required for ICC services?**

*A: No. Pre-authorization is not required for ICC during the initial phase of Individual Care Plan development. However, subsequent requests for continued ICC services will require concurrent review with MCE care managers.*

### **Theme: Coordination with the State Agencies**

**Q: When a youth has the involvement of both ICC and a DCF lead agency, who takes the lead on coordinating care for that youth and family?**

*A: The ICC Care Coordinator is the lead person responsible for coordination of care for youth and families involved in ICC. If state agencies are involved, they would be expected to participate on a family’s Care Planning Team wherever relevant. It is important to note that participation in ICC is voluntary and, as such, the family ultimately determines who will take the lead on coordinating their care. If a family prefers to continue working with a DCF lead agency and not become involved with ICC, that choice would be respected.*

### **Theme: RFR Response Format**

**Q: Is the audited financial statement requirement intended to come in the form of an attachment?**

*A: Yes.*

**Q: Do the responses need to be single or double spaced?**

*A: There is nothing in the RFR specifying this. Bidders should use their own discretion.*

**Q: Can the start-up budget be an attachment?**

*A: Yes.*

**Q: Can the organization chart required in question 2.1 be attached as an appendix?**

A: *Yes.*

**Q: Is question #5, for which no points are assigned, considered part of the page limit?**

A: *Yes.*

**Q: On page 16, d. i.—vii., does this question pertain to an organization’s entire staff? For example, an agency has 500 staff. Does this response require an organization to break-out all staff across i.—vii?**

A: *The response should indicate where ICC staff will be located within your organization. This question is attempting to assess the infrastructure support available for ICC and Caregiver Peer-to-Peer Support services.*

**Q: On page 17, does section 2.2.c refer to an organization’s overall supervisory support or just behavioral health services?**

A: *For behavioral health services*

### **Theme: Training**

**Q: In the performance specification for ICC, it refers to a “state required training program.” Who will be offering this? Will it be ready prior to the implementation of ICC?**

A: *During the initial implementation phase, we anticipate that initial coaching and technical assistance will be offered to each CSA to assist them in developing the competencies and skills that are necessary to implementing a high fidelity model of Wraparound. As more details emerge on training, we will make them available.*

**Q: The performance specification for Caregiver Peer-to-Peer Support says that the Family Partner must complete a 20-hour training course. Who will offer this course?**

A: *The performance specification for Caregiver Peer-to-Peer Support has been amended. This time parameter has been removed. The revised performance specification for Caregiver Peer-to-Peer Support services can be found on the web sites of the MCEs.*

**Q: How will ongoing training costs be reimbursed?**

A: *Staff training was built into the overhead to account for ongoing training costs. Please see earlier answer at the beginning of the training section about initial coaching and technical assistance .*

### **Theme: Physical Location of the CSA**

**Q: Can an out-of-state provider who otherwise meets the qualification listed on page 7 be considered to apply for CSA status?**

A: *“An established physical location within the service area is preferred. Second priority consideration will be given to provider agencies with a physical location within the service area for less than one year. Third priority consideration will be given to provider agencies with a physical location in a contiguous service area for a minimum of one year.” The spirit of the question on physical location was related to the organization knowing the service area and having familiarity with the local community resources. The provider must have an established location in the service area in order to serve children as of June 30, 2009. Please see page 19 of the RFR that asks bidders who do not already have a physical location in the service area to provide a detailed plan for how your organization will successfully establish a physical location in the service area by the expected start date.*

**Q: Please clarify what “service area” means. In Boston, there are four DCF area offices. If an organization has a location in the Park Street catchment area but wishes to be a CSA for the Dimock DCF area, would they need to have a physical location in Roxbury, or is it sufficient for the organization to be located in the city of Boston?**

A: *See page 7 of the RFR. “An established physical location within the service area is preferred. Second priority consideration will be given to provider agencies with a physical location within the service area for less than one year. Third priority consideration will be given to provider agencies with a physical location in a contiguous service area for a minimum of one year.” The spirit of the question on physical location was related to the organization knowing the service area and having familiarity with the local community resources. The provider must have an established location in the service area in order to serve children as of June 30, 2009. Please see page 19 of the RFR that asks bidders who do not already have a physical location in the service area to provide a detailed plan for how your organization will successfully establish a physical location in the service area by the expected start date.*

**Q: If an organization in Boston becomes a CSA for two or three DCF area offices, would they need to have a physical location in two or three locations?**

A: *Yes. A main office in one location and a satellite office in the proposed service area(s) would be an acceptable model. The provider must have an established location in the service area in order to serve children as of June 30, 2009. Please see page 19 of the RFR that asks bidders who do not already have a physical location in the service area to provide a detailed plan for how the organization will successfully establish a physical location in the service area by the expected start date.*

**Q: Could you clarify what physical presence in the service area means? For example, if an agency has therapeutic foster care homes in the southeast region yet the office is in Boston, would that preclude them from pursuing a CSA in the southeast region?**

A: *See page 7 of the RFR. “An established physical location within the service area is preferred. Second priority consideration will be given to provider agencies with a physical location within the service area for less than one year. Third priority consideration will be given to provider agencies with a physical location in a contiguous service area for a minimum of one year.” The spirit of the question on physical location was related to the organization knowing the service area and having familiarity with the local community*

*resources. Organizations will need to have a physical location in the service area in which you are bidding in order to serve families by June 30, 2009.*

### **Theme: Data and Information Systems**

**Q: The quality improvement process described on page 6 of the RFR requires the CSA to participate in a data-driven system. Will there be a standard web-based data system to be used by all the CSA, the MCEs, and MassHealth? If so, when will it be in place?**

*A: CSAs must enter CANS information into the Virtual Gateway. A web-based data entry system for various information collected by the CSA is a goal, but no system as been designed as of yet.*

### **Theme: Other**

**Q: Will there be standardized forms for the risk management/safety plan, ICP, and other ICC forms?**

*A: There will be a standardized ICP. There will not be a standardized risk management/safety plan.*

**Q: The ICC performance specification references an operations manual. Is this available to bidders to reference?**

*A: The operations manual will be available to assist with ramp-up and implementation.*

**Q: Will the names of the agencies that submit Letters of Intent be published on the web sites for the MCEs?**

*A: No. The names of the winners of the bid for each area and the specialty CSAs will be posted on the web sites.*

**Q: Can the state agencies offer a letter of support to my organization?**

*A: No. The state agencies have agreed not to supply letters of support to bidders as it is a conflict of interest.*

**Q: If I send in a letter of intent am I required to submit a RFR response?**

*A: No. After submitting the letter of intent, your organization can choose not to submit a response. Please note however that submission of a letter of intent is required in order to bid successfully. Please review page 11 of the RFR for more information on letters of intent.*

## **ATTACHMENT 1**

### **Introduction**

Good Morning. My name is Lucinda Brandt and I am the Pricing Manager for Ambulatory Services in the Pricing Policy and Financial Analysis Group at the Division of Health Care Finance and Policy. I am here to present testimony on proposed new regulation 114.3 CMR 52.00: Rates of Payment for Certain Children's Behavioral Health Services. This new regulation was proposed on October 2, 2008 to become effective November 1, 2008.

### **Background**

Regulation 114.3 CMR 52.00 governs the rates of payment by governmental units for certain outpatient children's behavior health services provided by eligible providers. MassHealth is implementing an overall services enhancement plan known as the Children's Behavioral Health Initiative (CBHI). The goal of the Initiative is to develop and implement a more comprehensive set of behavioral health services for eligible MassHealth members under 21 years of age.

Today's hearing concerns two distinct but sometimes related services, Targeted Case Management (TCM) and Parent/Caregiver Peer to Peer Support. TCM is a case management service, which involves the assessment of a child's needs, development of an individual care plan, coordination of planning and delivery of behavioral health services, and monitoring and follow-up activities all of which are individualized, child-centered, family-focused and community-based. TCM is provided by care managers at two staff qualification levels, Masters and Bachelors. Parent/Caregiver Peer to Peer Support is provided by a Family Partner and is offered in conjunction with TCM or certain other behavioral health services. It provides a structured one-to-one intervention between a qualified professional peer and parents or caregivers to better meet the needs of their child. Other related behavioral health services will be added to this proposed regulation at a later time.

**Description of Proposed Changes**

Because Targeted Case Management and Parent/Caregiver Peer to Peer Support services are new services implemented by MassHealth, there are no historical rates or cost report information available for these particular services. As such, the rate methodology is based on a model budget that accounts for program costs and productivity specific for the provision of these services.

Our model budgets have been developed by consulting with program staff and various data sources, such as Massachusetts Uniform Financial Reports (UFRs), data from the Bureau of Labor Statistics, and MassHealth's managed behavioral health care contractor.. Specific types of staff and relevant cost information (direct and indirect) have been obtained mainly from FY 2007 UFRs submitted by community mental health centers, as these centers currently provide behavioral health services that may have similar costs to the services provided to MassHealth beneficiaries. Maximum number of billable hours is calculated by subtracting the total non-direct (i.e. non-billable) service hours per year from the total compensable hours per year (40 hours\*52 weeks=2080 hours). Non-direct hours include vacation, sick and personal days, holidays, training, travel, supervision, and administrative activities. The unit of payment for these services is per 15 minutes. The charts identified in Attachment A illustrate the specific assumptions and calculations used to develop the proposed rates.

Based on this methodology, the proposed rate for TCM at Master level is \$15.97 per 15 minutes (\$63.87 per hour) and rate for TCM at Bachelor level is \$13.14 per 15 minutes (\$52.55 per hour). The proposed rate for the Parent/Caregiver Peer to Peer Support is \$10.49 per 15 minutes (\$41.95 per hour). The table in Attachment B lists the proposed rates along with a description and service code used for billing.

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**Fiscal Impact**

The estimated FY10 increase in spending for the provision of these new services for MassHealth fee-for-service spending is \$814,261; \$458,624 from Targeted Case Management and \$355,637 from Parent/Caregiver Peer to Peer Support services. However, it is expected that vast majority of these services will be delivered through Mass Health's managed care contracts, including MBHP, and are likely to be covered under those agreements. Purchase of these services is contingent upon Centers for Medicare and Medicaid approval of State Plan Amendments for these services.

This concludes my testimony for this morning. I am happy to answer any questions that you may have.

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**ATTACHMENT A - MODEL BUDGET FOR CBHI TARGETED CASE MANAGEMENT MASTER LEVEL**

**PROGRAM COSTS**

<b>Direct Costs:</b>		Salary/Rate	# FTEs	Cost	Source for figures
<b>Staff Salary</b>	Program Director	61,120	0.17	10,084.80	CMHCs UFR 2007
	Care Manager (master level)	45,000	4.00	180,000.00	CFFC budget -care coordinator
	Senior Care Manager	52,000	0.50	26,000.00	CFFC budget - team leader
	Psychiatrist	160,000	0.03	4,800.00	CMHCs UFR 2007
Subtotal salary			4.70	220,884.80	
<b>Taxes &amp; Benefits</b>	% of salary	19%		41,968.11	CMHCs UFR 2007
<b>Other direct costs</b>	% of salary:	12%		26,506.18	CMHCs UFR 2007
	Staff training				
	Transportation				
	Occupancy/Utilities				
	Office expenses				
Equipment/supplies					
<b>Subtotal direct costs</b>				289,359.09	
<b>Indirect Costs</b>	Overhead (% of total direct cost)	12.6%		36,459.25	CMHCs UFR 2007
	Administrative assistant	28,028	0.25	7,007.00	CMHCs UFR 2007
Subtotal indirect costs				43,466.25	
<b>Total program costs</b>				332,825.33	

**BILLABLE UNITS**

Max # of compensable hours		2080.00
Non-direct service hours	vacation (3 weeks)	120.00
	sick and personal (2 weeks)	80.00
	holidays (10 days)	80.00
	training (3 days)	24.00
	travel (4 hrs/week)	208.00
	supervision (2.1 hrs/week)*	109.20
	administrative paperwork (3 hrs/week)	156.00
	Subtotal non-direct hours	777.20
	<b>Max # productivity hours/FTE</b>	

**RATE**

Total program cost	332,825.33
Max billable hours per FTE	1,302.80
Total CM FTE	4.00
Rate per 15 min	<b>15.97</b>
Rate per hour	63.87

NOTE: \* These non-direct hours are based on the average hours of CFCC time studies (May 2007 and Sept 2007).

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**ATTACHMENT A - MODEL BUDGET FOR CBHI TARGETED CASE MANAGEMENT BACHELOR LEVEL**

**PROGRAM COSTS**

<b>Direct Costs:</b>		Salary/Rate	# FTEs	Cost	Source for figures
<b>Staff Salary</b>	Program Director	61,120	0.17	10,084.80	CMHCs UFR 2007
	Care Manager (bachelor level)	35,000	4.00	140,000.00	ICC budget
	Senior Care Manager	52,000	0.50	26,000.00	CFFC budget - team leader
	Psychiatrist	160,000	0.03	4,800.00	CMHCs UFR 2007
Subtotal salary			4.70	180,884.80	
<b>Taxes &amp; Benefits</b>	% of salary	19%		34,368.11	CMHCs UFR 2007
<b>Other direct costs</b>	% of salary:	12%		21,706.18	CMHCs UFR 2007
	Staff training				
	Transportation				
	Occupancy/Utilities				
	Office expenses				
Equipment/supplies					
<b>Subtotal direct costs</b>				236,959.09	
<b>Indirect Costs</b>	Overhead (% of total direct cost)	12.6%		29,856.85	CMHCs UFR 2007
	Administrative assistant	28,028	0.25	7,007.00	CMHCs UFR 2007
Subtotal indirect costs				36,863.85	
<b>Total program costs</b>				273,822.93	

**BILLABLE UNITS**

Max # of compensable hours		2080.00	
Non-direct service hours	vacation (3 weeks)	120.00	
	sick and personal (2 weeks)	80.00	
	holidays (10 days)	80.00	
	training (3 days)	24.00	
	travel (4 hrs/week)	208.00	
	supervision (2.1 hrs/week)*	109.20	
	administrative paperwork (3 hrs/week)	156.00	
	Subtotal non-direct hours	777.20	
	<b>Max # productivity hours/FTE</b>		1302.80

**RATE**

Assumptions	
Total program cost	273,822.93
Max billable hours per FTE	1,302.80
Total CM FTE	4.00
Rate per 15 min	<b>13.14</b>
Rate per hour	52.55

NOTE: \* These non-direct hours are based on the average hours of CFFC time studies (May 2007 and Sept 2007).

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**ATTACHMENT A - MODEL BUDGET FOR CBHI PARENT/CAREGIVER PEER TO PEER SUPPORT**

**PROGRAM COSTS**

Direct Costs:		Salary/Rate	# FTEs	Cost	Source for figures
<b>Staff Salary</b>	Program Manager	75,004	0.25	18,751.00	CMHC UFR 2007 Bureau of Labor Statistics, MA 2006 (social & human service assistants) CFFC budget -care coordinator
	Family Support Partner	30,250	8.00	242,000.00	
	Senior Family Support Partner	45,000	1.00	45,000.00	
	Subtotal salary		9.25	305,751.00	
<b>Taxes &amp; Benefits</b>	% of salary	19%		58,092.69	CMHCs UFR 2007
<b>Other direct costs</b>	% of salary:	12%		36,690.12	CMHCs UFR 2007
	Staff training				
	Transportation				
	Occupancy/Utilities				
	Office expenses				
Equipment/supplies					
<b>Subtotal direct costs</b>				400,533.81	
<b>Indirect Costs</b>	Overhead (% of total direct cost)	12.6%		50,467.26	CMHCs UFR 2007
<b>Total program costs</b>				451,001.07	

**BILLABLE UNITS**

Max # of compensable hours		2080.00	
Non-direct service hours	vacation (3 weeks)	120.00	
	sick and personal (2 weeks)	80.00	
	holidays (10 days)	80.00	
	training (3 days)	24.00	
	travel (4 hrs/week)	208.00	
	supervision (1.3 hrs/week)*	68.12	
	administrative paperwork (3 hrs/week)	156.00	
	Subtotal non-direct hours	736.12	
	Max # productivity hours/FTE		1343.88

**RATE**

Total program cost	451,001.07
Max billable hours per FTE	1,343.88
Total FP FTE	8.00
Rate per 15 min	<b>10.49</b>
Rate per hour	41.95

**NOTE: \* These non-direct hours are based on the average hours of CFFC time studies (May 2007 and Sept 2007).**

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Attachment B – Summary of Rates

Code	Service Description	Proposed Rate (per 15 minutes)
T1017-HO	Targeted case management, each 15 minutes (service provided by a Master level care manager).	15.97
T1017-HN	Targeted case management, each 15 minutes (service provided by a Bachelor level care manager)	13.14
H0038	Self-help/peer services, per 15 minutes (Parent/Caregiver Peer to Peer Support service provided by a Family Partner)	10.49