NOTICE TO ALL RESPONDERS: DHS does not anticipate that it will be necessary to meet with all responding hospitals regarding proposal review. However, we do anticipate that some meetings may be necessary and we will be holding two full days for this purpose. Please hold the following days open in the event a meeting is necessary: Thursday, October 14 and Thursday October 21, 2004.

GENERAL RFP QUESTIONS:
1. How does the Medicare cost settlement process, referenced in question 16 on page 9 of the proposal work?
   ANSWER: Most hospitals file annual Medicare cost reports which form part of the basis for future Medicare reimbursement. Under certain conditions, hospitals with exempt psychiatric units are also able to request exceptions to the established target rate if the allowable costs per discharge are significantly higher. The intent of this part of the RFP is that hospitals which are seeking a separate grant contract from DHS (in addition to the MA contract) are expected to maximize Medicare revenue before tapping into the grant contract. It is our understanding that the proposed Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) includes a better method of reimbursing hospital providers for inpatient care by trying to match the reimbursement to the higher costs incurred during the first 8 days of a patient stay. Furthermore, it appears that payment will be adjusted to reflect the length of stay, the patient’s age, rural vs. urban, co-morbidity factors, and for outliers. Of course, hospitals should consider the potential impact on their future Medicare reimbursement.

2. Does the RFP make it clear that hospitals have to provide interpreters for people who are deaf and hard of hearing?
   ANSWER: Hospitals are expected to comply with existing laws and rules regarding provision of interpreters or other specialized services for people with mental illness and hearing impairment. Unfortunately, these requirements are not always clear and have sometimes been the subject of lawsuits. Attached is a model settlement agreement which some hospitals have signed to clarify this issue.

   Note that the RFP, page 6, #12, states: "Successful responder hospitals may request additional funding in their overall per diem for specialized services for people with mental illness and hearing impairment."

FISCAL QUESTIONS:
3. Page 7, Section D: Services Not Required or Reimbursed, shall be amended and revised as follows:
   Treatment for most medical conditions, including routine lab work, X-rays and medications, is included as part of the per diem under this contract. The per diem will not include the following services, which may be eligible for reimbursement separately:
   • medical or surgical consultations or hospitalizations;
   • electroconvulsive therapy, including anesthesia and related services that may become necessary in the course of psychiatric treatment;
   • professional services which would normally be billed outside the DRG payment, including psychiatrists (or clinical nurse specialists or nurse practitioners if approved as part of this proposal) and neuropsychological testing;
   • high cost, non-elective treatments for acute or chronic illnesses, such as kidney dialysis, chemotherapeutic medications and radiation for the treatment of cancer,
The section of the sample contract relating to the above issues (see pp. 33-34 of the RFP) will be revised to be consistent with the above change in the RFP.

4. Is there a separate payment for chemical dependency (CD) counselors from a CD program under the proposal, or should CD counselors be part of the per diem rate?  
**ANSWER:** For the Integrated Dual Diagnosis Treatment provided to patients under this contract, the per diem includes this service.

5. For professional services, e.g. psychiatry, since it is now outside the per diem, should a separate rate be established – should we indicate how much the current psychiatry rate is?  
**ANSWER:** In your proposal, please indicate how much of your current per diem is spent for psychiatry. You do not need to indicate how much you plan to bill separately under the new contract for psychiatry or other professional services.

6. How will other medical illness treatment be paid for, e.g., dialysis, chemotherapy, etc.?  
**ANSWER:** Under the new contract, the per diem payment will cover most medical conditions and treatments incurred by the hospital. As indicated in Q & A #3 above exceptions include professional services which are normally billed outside the DRG and high cost, non-elective treatments for acute or chronic illnesses. Examples of treatments that fit this definition are kidney dialysis, chemotherapeutic medications and radiation for the treatment of cancer, blood clotting factor, and daily respiratory therapy. Examples of items that cannot be billed separately are routine lab work, serum toxicology screening and levels, routine and preventative examinations, and emergency room visits if provided on the same day as a contract bed day. DHS will continue to exclude ECT from the per diem payment and allow separate payment on an outpatient claim.

7. Can hospitals bundle extra charges, e.g., X-rays, general exams, into their per diem rate, rather than billing separately?  
**ANSWER:** Yes, most charges must be bundled, but unique extra charges, such as dialysis, chemotherapy, ECT, etc. can be billed separately (See #6 above).

8. PMAP payments for court holds placed after the emergency hold, and prior to commitment are inadequate, and we have been informed that MA payment constitutes payment in full. How does this impact county responsibility to pay for this period of time?  
**ANSWER:** Under current state law, the hospital must bill health plans first; in the absence of other payers, the county would be responsible for cost incurred under a court hold. DHS increased PMAP capitations to reflect the increased cost of PMAP liability for court-ordered treatment. Hospitals need to work with health plans to
ensure that health plan payments reflect the added cost of extended court-ordered stays.

9. Can a hospital expect payment from a county for a hold order without a county contract?
   ANSWER: We strongly recommend that all hospitals with a 45-day MA contract also negotiate a hold order contract with their host county. Without a hold contract, there is no basis to establish a hold order rate, to define health plan vs county vs patient responsibility, to assure appropriate notification to the county, etc. If a contract has not been negotiated and there is no health coverage, a county might still be responsible under M.S. 256G.08, but it is very difficult to work out the specifics of the county’s liability on an after-the-fact basis.

10. If contracts are renewed for additional years, as stated in the RFP, will all contract terms be the same, or will rates be renegotiated?
    ANSWER: Rates will most probably be renegotiated.

MEDICAL COVERAGE QUESTIONS:
11. Will Minnesota General Assistance Medical Care (GAMC) be part of the contract?
    ANSWER: No, the bill allowing GAMC fee-for-service to cover contract beds did not pass in the legislature. It is possible that GAMC fee-for service recipients could be paid through the separate subsidy grant (see item #16 on page 9 of the RFP instructions). The *footnote on page 4 of the RFP is revised to reflect the fact that the subsidy grant (if funds are available) could be used for a variety of situations where existing health care coverage (such as GAMC fee-for-service) does not include extended inpatient psychiatric services:

    *Depending on available funding, hospitals may also be eligible to receive a grant for patients who are uninsured, underinsured or dually eligible for Medicare and Medical Assistance.

For GAMC recipients who are in managed care plans, hospitals should work with the health plans which administer the benefits since their responsibility includes court-ordered treatment.

12. The VA will not pay for community hospital treatment of individuals who are committed and have Veteran’s Administration (VA) medical coverage – can they be paid for under this proposal?
    ANSWER: DHS staff will work with the VA to assure VA payment for medically necessary services for eligible veterans. If the VA has denied payment, this contract can be used for veterans who meet the eligibility requirements specified in this RFP.

13. For the Medical Assistance and Medicare populations (dual eligibles) referenced in the proposal, will they be covered by contracts written under this proposal?
    ANSWER: Dual eligibles are not included under the MA contract, however, there may be separate grant contracts (based on available funds) to serve this group of people. If you wish to be considered for one of these separate grant contracts, please include a reply to item 16 on page 9 of the RFP in your proposal.

PROGRAM/SERVICE DELIVERY QUESTIONS:
14. Integrated Dual Diagnosis and Treatment (IDDT) guidelines are added to the RFP as Appendix J. Below is a link to the Evidence Based Practices Toolkit on IDDT which was developed by the Federal Substance Abuse Mental Health Services Administration (SAMHSA). This Toolkit was developed to assist providers and others to implement IDDT; and will be included on the DHS Adult Mental Health Webpage by the end of August.
Additional information to assist you in operationalizing the Illness Management and Recovery (IMR) and Family Psychoeducation services specified in the RFP will be available on the DHS website listed below in late August. This link to the Evidence Based Practices Toolkits on IMR and Family Psychoeducation which were developed by the Federal Substance Abuse Mental Health Services Administration (SAMHSA). These Toolkits were developed to assist providers and others to implement IMR and Family Psychoeducation.

15. Regarding the Utilization Review (UR) document: the State Regional Treatment Centers use the LOCUS assessment – will the UR process under this proposal also use LOCUS?

**ANSWER:** LOCUS is not currently being used as part of the UR process and is not used by many community hospitals. However, this is something we can consider, and we would welcome your comments on why LOCUS would make the most sense to use. We are considering some changes to the UR process and would like your recommendations for improving the process.

16. What are the required qualifications e.g., education and training hours, for staff to lead groups?

**ANSWER:** It depends on the type of group. The proposal should outline the type of groups which will be conducted, provide a treatment program schedule, and identify the professional level of the staff responsible for providing the treatment. It should also describe how long-term individuals will be served, and describe program capability to provide active treatment 7 days per week.

17. Why is pre-petition screening necessary for accepting a voluntary patient?

**ANSWER:** The ability to serve voluntary patients is a provision that allows patients to receive these services “in lieu” of commitment. Because DHS must assure that voluntary patients need the type and level of care offered by the contract, a screening as well as a physician’s statement are required documentation for the need for treatment. DHS offers this provision because we don’t want people to be forced into commitment in order to receive appropriate care.

18. Page 8 of the RFP requires a 15-day lapse before a readmission can be counted as a new admission. This poses a problem, especially if an extension in coverage is needed which would total more than 45 days for the two admissions.

**ANSWER:** The following language is added to page 8 of the RFP (after the third paragraph of section E) to clarify that the 15-day policy will be subject to the same exceptions as are currently applied to DRG payments:

Note that Minnesota Rule 9505.0540, subpart 3, specifies four exceptions where a readmission would be treated as a new admission, regardless of the length of time between admissions. Subpart 4 of the same rule specifies situations in which a readmission would be counted as part of the initial admission. In order for a readmission to be counted as a new admission, a hospital must provide the medical review agent (currently CDMI) with a new Initial Contract Bed Review form at the time of the readmission with an attachment documenting how the readmission meets one
of the 4 exceptions listed in subpart 3 of the rule, and that it does not meet the criteria in subpart 4. For a complete copy of Minnesota Rules 9505.0540, see:

http://www.revisor.leg.state.mn.us/arule/9505/0540.html

The section of the sample contract relating to this item (see Pages 34 and 35 of the RFP) will be revised to be consistent with the above amendment to the RFP.

19. Regarding voluntary stays, if the physician indicates that a person will be on a 72 hour stay and the person agrees to voluntary treatment, will those people be covered by this proposal? Basically, who pays from day one?
   **ANSWER:** Contracts under this proposal are for days in addition to a regular MA acute care stay. However, if the individual meets the criteria for contract bed payment from day one, then the hospital should not bill for the normal DRG, and instead should just bill under the contract. For example, billing under this contract (instead of DRG) from day one would be appropriate in a situation where a patient's provisional discharge had been revoked (assuming the patient was still under commitment).

20. Does eligibility for this contract include patients who are under a continuance of a commitment proceeding, with inpatient services stipulated as part of the condition of the continuance?
   **ANSWER:** Yes, the RFP is revised on pages 4 and 30 to add a new eligibility category 7e:
   e. a continuance of a commitment proceeding, with inpatient services stipulated as part of the condition of the continuance.

If you have further questions, please contact Kelly Moch at 651-582-1829 or kelly.a.moch@state.mn.us