**HealthInfoNet’s**

**Maine State Innovation Model Testing Model Grant Request for Proposals (RFP) for Behavioral Health Information Technology (HIT) Reimbursement**

**Date of call: February 7, 2014**

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1. **Technology Related Questions:**

**Q1. Milestone 1: How is “interoperability capabilities” defined?**

**A1**: We have posted our interface specifications that will address interoperability capability requirements in detail. Please review HealthInfoNet’s Interface Specifications located on our website: <http://hinfonet.org/resources/miscellaneous/hin-interface-specifications>.

Other helpful information may be:

* At this time, HealthInfoNet only accepts inbound HL7 data feeds from EHRs.  We aggregate this information using code standardized mapping and present it in the form of a single patient record to the end user through a web portal that can only be accessed through a VPN connection.
* The EHR must be designed to ‘trigger’ an HL7 message to HealthInfoNet when certain events occur (for example, when a provider signs off on a patient record). The trigger action is what is required so that no one has to manually “click” anything to “push” the data to HIN. The trigger automates the data feed to HIN, which is why triggers are so important.
* HealthInfoNet receives many types of information from the EHR, including patient identifiers and demographics, encounter (visit) history (with procedure and diagnosis codes), lab results, vital signs, radiology reports, allergies, immunizations, and transcribed documents.

**Q2: Milestone 1: What is the objective measurement to demonstrate one has met the milestone?**

**A2:** Milestone 1 will be measured based on EHR vendor providing interface specifications capabilities.

**Q3: Milestone 2: Can you provide definitions for the HL-7 data interfaces; what exactly does this look like?**

**A3:** See A1.

**Q4: C2 (RFP page 16) asks- ‘If you do not currently have a live EHR system, do you plan to implement AND go live within 6 months from the date of this application?’, which is not consistent with the language listed under milestone one on page 6- that you ‘show project plans and timelines toward go-live in 6 months.’**

**A4:** We understand that there may be confusion about the 6 month requirement for EHR implementation for applicants that currently do not use an EHR. What we require is stated in C2, and stated in a different way would be: proof of plans that an organization will implement a live active EHR (for behavioral health services) six months from the date the application is submitted.

**Q5: Milestone 2, HIE Participation**: **What is “active clinical data”? Is it test data or live data?**

**A5:** Active clinical data is live data.

**Q6:** **Milestone 2 speaks to go-live admission, discharge and transfer (ADT) data interface. Then, attest and commit to a 6 month project plan for HL-7 Observation Result, containing lab and other lab data, data interface go-live, and then must submit the approach and plan for patient opt-in procedures and workflows.** **What are the Observation Result requirements?**

**A6:** Most importantly, assess the Interface Specifications document posted on HIN’s website with the RFP document as answered in A1 above. This has all of the technical details related to this data. Also, this data pertains to your EHR interface feeding HIN lab and other kinds of data via a VPN connection. If your organization doesn’t have lab data to send for example, then this would not pertain to you.

**Q7: Please define “sensitive information”.**

**A7: Related to the language used in item C11, page 17 of the RFP:** This question is asking about the ability for the EHR to manage access to data that may be deemed too sensitive for all EHR users (staff) in the organization to have access to it (i.e., may require a “break the glass” shield of some kind), which can include printing, downloading, and viewing this kind of data. For example, patients may request that medical information be protected, “blocked”, etc. and this often leads to a conversation about what an EHR can do to manage such data requests.

**Q8: Please explain what is meant by “ability to track versioning or mask sensitive entries for release of information”?**

**A8: Related to the language used in in the EHR security questions (C18, page 16 of the RFP):** These are Security Features in the EHR for handling categories of sensitive information that requires a different level (higher) of security for access by users (staff) than other kinds of information in the EHR.

**Q9: Please define “clinical decision support”.**

**A9**: **Related to item C13, page 18 of the RFP:** One of the benefits of using electronic systems to manage medical record information and data is to leverage the technology to “inform” the users of actions they can take in the patient’s care in an automated way. This is EHR functionality for clinicians/users that most commonly pertains to:

* Alerts and Reminders

• Diagnostic Assistance (Diagnostic Decision Support Systems - DDSS)

• Prescription Decision Support (drug-drug interactions etc.)

• Information Retrieval (information is waiting for you on the patient to be reviewed)

• Image Recognition and Interpretation

• Computerized provider order entry (CPOE) and monitoring (variance from best practices etc.)

**Q10: Is the expectation here that actual work flows be submitted for various processes? Please provide an example of a work flow.**

**A10: Related to item C15, page 18 of the RFP:** We did not intend for applicants to submit workflows. We only would like you to list the general processes (workflows) you perform that you do use your EHR for. For example, when you process a referral, do you use the EHR to support/perform that process? If yes, then you would “list Referrals” as one of the workflows you use your “EHR for”. Numbers 1-6 in C15 are intended to be examples of “process or workflows” that you might use your EHR for. Please list all major processes or workflows that you do use/plan to use your EHR for.

1. **Application Formatting Questions:**

**Q11: Do you prefer our responses to remain in a table format?  Do you want the language from each question to be included in our response or just each item number and our response?**

**A11:** We only require the “Item Number” as the reference to each answer you submit. It does not have to be in table format. We have posted the RFP document in “word” format to allow you to copy content that is helpful to you.

1. **Quality Measurement/Milestone 3 Related Questions:**

**Q12: Item B4 in the application: Can you provide additional detail as to what you mean by “Quality Measurement” programs?**

**A12:** Please let us know if your organization measures quality and, if so, how you do it. For example, do you use any quality measurement tools available through AHRQ (Agency for Healthcare, Research and Quality) as part of your organization’s internal quality program? (i.e., Partners in Care) We will be asking you to submit a quality measure as part of this project, and we’d like a current baseline as to your organization’s culture in terms of measuring quality. You may briefly describe any quality programs/measurement that you currently participate in.

**Q13: Milestone 3, p. 7, first bullet: Please clarify what the intended measures will be as it relates to the milestone requirement to “Transmit data that can be used for quality measurement and reporting for a minimum of one measure that is aligned with SIM quality measures (to be defined in workgroups and adopted by the SIM Steering Committee). For example, SIM measures as part of Health Homes quality reporting identified PTE measures under the scope of the Maine Health Management Coalition Behavioral Health work group.”**

**A13**: All awardees will be required to submit data that can be used to support the calculation by HIN for one quality measure—not yet determined. Quality reporting/eMeasurement for the SIM Grant is defined as submitting to HealthInfoNet a specific quality measure that will be supported by the SIM Steering and Data Subcommittees stakeholder process. The Language in the RFP is open ended due to the fact that the work under SIM has not yet begun. This is work for the last “year” of this RFP and it will evolve. Our intent here is to state the importance of aligning the quality measurement work of this RFP with that of the other SIM funded programs/workgroups. We will use flexibility in terms of the participation process as well as the measure/s identified as acceptable to meet the milestone within reason.

**Q14: Please confirm the composition, meeting time, etc. of the following group(s) as referenced to develop SIM measures as part of Health Homes quality reporting identified PTE measures under the scope of the Maine Health Management Coalition Behavioral Health work group.**

**A14: Milestone 3, p.7, second bullet**: Awardees may have the opportunity to participate in forums that define Behavioral Health quality measures and reporting processes within the scope of the SIM projects. In addition, HealthInfoNet may convene forums for sharing, education, and information spreading with the awardees periodically as deemed helpful and necessary to execute the program successfully. We have not determined the specific parameters of this work and ask for flexibility in understanding that this work is evolving. We aim to be reasonable with our requests as we understand everyone is very busy.

1. **Organizational Requirement Questions**:

**Q15: What does “panel size” mean? Is “panel size” actually total case load per provider? For many mental health services, bills are submitted under the name of the authorizing clinician, however, the actual service is provided by another credentialed individual (Community Integration Services are an example of this type of billing). For residential mental health services, multiple staff members serve one individual, but again, the bills are submitted under the name of the authorizing clinician. How would you like case load counts to be reported?**

A15: The number of unique clients/patients served under a clinician or credentialed provider for payment is normally how this is defined. It is important to not duplicate client numbers across multiple staff. We realize that “panel” is defined differently across services. Please do your best to define it in a way that works for your organization but also does not duplicate patients within any one service area. Please state in your answer any information that helps us understand in the section you feel is helpful.

**Q16: Why isn’t case managers listed under A6? MHRT-C’s and bachelor level staff who are qualified to work with children should be listed as those individuals provide the case management to coordinate services.**

A16: We have an “other” category intended to cover staff roles we may not be aware of. Please list out your staff and include them in such groups that make sense for your services.

**Q17: Please clarify what might be considered a major change. Has there been a major organizational change in your organization.**

**A17: Regarding item B5, page 14 of the RFP:** Examples might include significant service, strategy, or leadership changes. Please include only information you feel is relevant to the scope of the RFP. We realize not all organizational changes are relevant to this application.

**Q18: Do you want age categories served or percentages of current clients in each age group?**

**A18: Regarding B19, page 15 of the RFP:** We are looking for your current percent of clients in each age group.

**Q19: Is the broad term “severe and persistent mental illness” acceptable as a response to this question? Regarding “Define your patient population in terms of diagnosis”, is “severe and persistent mental illness” enough?**

**A19: Regarding B21:** Generally, our answer is “yes”. We are not looking for a lot of detail here, a summary or list is fine.

**Q20: “Please name the primary service counties in Maine where your patients/clients live.” Is this question seeking information regarding all counties in which the organization provides services, or the one county out of which the majority of services are provided?**

**A20: Regarding B23, page 15 of the RFP:** We’re looking for the counties where your patients and clients live, not where the services are provided. What counties do most of your patients and clients come from to receive service from you?

**Q21: Question on Procurement compliance**: **What financial reporting will be required? Funding is retroactive after milestones are met, and the agency has expended time and effort, and procured its system. Is a budget for the grant required?**

**A21: Regarding section 3. A. on page 8:** The funding for this RFP is coming from a grant from the Federal Government to support reimbursing organizations for eligible costs related to the activities articulated in the RFP. HealthInfoNet (HIN) does not require financial reporting to HIN as part of this RFP process. As part of the contract for the organization awarded, the federal procurement rules cited in the RFP will be cited. Your organization must judge reporting and documentation needs related to federal guidance and your own financial audit. HIN does not provide legal guidance.

1. **Mandatory Requirement Questions:**

**Q22: Mandatory Organizational Requirements**. **What is meant by “full implementation or optimization”? Are these the same things or different?**

**A22:** This is in reference to your EHR. If you are already fully operational (“full implementation”) with all necessary staff using your system, you are still eligible to participate in the program by your ability to optimize your EHR, for example adding technology required to include interoperability (sending HIN data as described in the Interface Specifications reference in A1). Often there are additional modules, technical work etc. that expand baseline EHR functionality to be able to send data out of the system, as well as report and measure quality data. Our intent is to support the various ways any one EHR/vendor and your organization would achieve this kind of “optimization”.

1. **General Application Questions:**

**Q23: There are no criteria or weight for any answers? Is there a reason why agencies don’t know how the applications will be scored or weighted?**

**A23: As discussed on the Q&A session on 2/7/14:**

Scoring is summarized as such:

* 10% section A
* 30% each for sections B, C, and D
* Note a 15% weight preference is provided for organizations that are Behavioral Health Homes (Stage B).

**Q24: How are awards being prioritized, for example, will those organizations that do not already have an interoperable compliant EHR be considered first? A lot of questions seem centered on agencies that already have systems in place; what is the priority versus an agency that is just beginning to make its investment?**

**A24:** The selection of the awardees will be based on the application using consistent scoring and weighting methodology based on the questions and directions described in the RFP document.

**Q25: What are the repercussions if an agency is not able to meet any of the milestones?**

**A25:** The Agency will only receive payment if milestones are met.

**Q26: Can the RFP be supplied to applicants in a format that allows it to be filled out and data entered?**

**A26:** Yes, the web posting document is now in a “word” file format so that applicants can copy any of the formatting that is helpful to you.

**Q27: Define EHR. Some agencies may have robust electronic records but they may or may not meet your definition.**

**A27: This question was answered on the Q&A call for reference.** We are asking that you answer the EHR related questions in the application the best that you and your technical resources can. Also, use the Interface specifications document on the web posted as stated in A1 as well to discuss capabilities of your EHR with your vendor or technical resource. We are not requesting that your EHR be a 2014 ONC Certified EHR.

**Q28: Milestone payments, p. 7: Please confirm if you have to participate for 3 years and meet milestones over the 3 year period to be reimbursed; or can you earn the funding at a faster pace if you achieve the milestones in advance of the deadlines set forth?**

**A28:** You will be reimbursed as you meet the milestones as described

**Q29: Can a “for-profit” organization qualify?**

**A29:** Yes

**Q30: On page 3 of the RFP document it states that the grant funding can be used as “reimbursement for activities of support behavioral health organizations that improve their Electronic Health Records (EHR) systems and supports their participation in “interoperability”, HIN’s HIE services, and shared electronic quality measurements”. In light of this expectation, is it permissible for grant funds to be used to pay for the following?**

1. **The development of specific forms within the EHR which would allow for specific data fields to be captured and shared with HIN.**
2. **The purchase and deployment of laptop computers for staff providing home based services so documentation can be captured electronically as opposed to via paper notes.**
3. **Equipment purchases related to staff training needs (computers for training labs, monitors for training demonstrations).**

**A30:** HIN’s concern for payment is related to the milestone achievement being met. We will not track or request reporting on how the payment was spent. These decisions are for your organization to make.

**Q31: I was wondering if you know of or could provide a list of existing EMR providers/systems that currently sync to the HIN system?**

**A31:** HIN does not track or report externally the EHR vendor relationships that our participants contract with.

**Questions related to the live Q&A Call on February 7th:**

**Q32: How quickly will the interface specs be posted?**

**A32:** Monday 2/10/14. The Interface Specifications can be viewed at: <http://hinfonet.org/resources/miscellaneous/hin-interface-specifications>.

**Q33: Status of EHR implementation – we use different services for different disorders – how do we address different EHR usage between different services and providers?**

**A33:** Please describe the different ways you use your EHR. One example of this would in your answer to C13 and 15.

**Q34: Regarding ‘Claim Track EHR vendor’ – if we provide both substance abuse treatment and mental health services we can separate out substance abuse data and share only (with HIN) mental health data- can we apply?**

**A34:** Yes.

**Q35: How much weighting is given for MaineCare Behavioral Health Homes (BHHO) participation? Is this a requirement?**

**A35**: You are **NOT** required to be a BHHO to qualify to apply. We are giving a 15% weighted priority for organizations that are health homes.

**Q36: If our organization is planning to apply to become a MaineCare BHH0 in the fall of 2014 when it reopens, will that count? How should we address this in the RFP application?**

**A36:** Please describe this decision and intent in your application.