Letter of Clarification #3

THE HARRIS CENTER EHR/RCM PROJECT

To: All Vendors

From: Sharon Brauner, C.P.M., A.P.P., Purchasing Manager

Cc: Nina Cook, MBA, CTPM, CPPB, Director of Purchasing

Date: September 17, 2018

RE: Letter of Clarification #3 for THE HARRIS CENTER EHR/RCM PROJECT Request for Proposal

For the benefit of all Vendors submitting responses and to avoid possible confusion, the Request for Proposal (RFP) documents are clarified as follows. Please note this Letter of Clarification is hereby incorporated into the RFP document.

Subsequent to the extension of the proposal submission deadline, The Harris Center received a clarification request that would appear to be critical information for all vendors. As such, we have elected to provide information to all potential vendors.

It is important to clarify that The Harris Center monitors and manages several hundred patients who are in contracted or state operated hospital beds. However, we do not provide or document the care being delivered in those settings. Our needs are to document the patient demographics, utilization, and other administrative data related to their stays in those contracted/state operated facilities. In short, we do not operate any acute hospital beds. However, we do operate 16 Crisis Stabilization Beds and 40 Crisis Residential beds. The definitions and regulatory requirements for these facilities are available from HHSC online sources.

We do receive and pay claims for care delivered for our patients. However, we do not have any at risk or capitated arrangements at this time.
1. PES-Psychiatric Emergency Services- Emergency Unit for voluntary/involuntary admissions- NPC number of staffed beds 37, number of patient admissions 8,938, average length of stay \( \leq 23 \) hours, annual bed days 11,045

2. AIH- Acute Inpatient Hospitalization UT HCPH contracted beds. Number of staffed beds – 165. Number of patient admissions 6,500, average length of stay 6.5 days. Annual bed days 54,411.
   - Are patients treated by billable HC providers? -NO
   - Are bed days billable by HC? NO
   - Is data captured in EMR? YES

The Harris Center monitors and manages several hundred patients who are in contracted or state operated hospital beds. However, we do not provide or document the care being delivered in those settings. Our needs are to document the patient demographics, utilization, and other administrative data related to their stays in those contracted/state operated facilities. In short, we do not operate any acute hospital beds. However, we do operate 16 Crisis Stabilization Beds and 40 Crisis Residential beds. The definitions and regulatory requirements for those facilities are available from HHSC online sources.

3. CRU - Crisis Residential Unit Short-term residential alternatives to hospitalization. Bristow Center (Caroline) 3 days to 4 weeks stay. Number of staffed beds? 18, number of patient admissions 490, average length of stay 14-21 days, annual bed days 5,402

4. CSU - Crisis Stabilization Unit - A voluntary residential program that provides person-centered, engaging, empowering, and recovery-oriented supports from peers. What is the number of staffed beds? 16, number of patient admissions 1,310, average length of stay 3-5 days, annual bed days 4,637

5. PHCRU - Post-Hospitalization Crisis Residential Unit, a Short-term (up to 21 days) residential program for voluntary adults being discharged from a MH hospital/facility. Number of staffed beds 24, number of patient admissions 491, average length of stay 8 days, annual bed days 4,745
6. Branard Street Respite Care for individuals who may need a more structured environment until stabilized. Up to 30 days. Number of staffed beds 16, number of patient admissions 315, average length of stay 24 days, annual bed days 4,380.

7. PEERS-Person-centered, Engaging, Empowering, and Recovery Support - Voluntary residential program for those in crisis who might otherwise require psych hospitalization (Hope House). Number of staffed beds 9, number of patient admissions 495, average length of stay 4.6 days, annual bed days 2,621.

8. COD - Co-Occurring Disorders - Residential treatment and intensive care coordination. Up to three months. Number of staffed beds pooled contract with 6 facilities. Number of patient admissions 153, average length of stay 56 days, annual bed days 9395.

9. CTI-Community Treatment Initiative - Intensive care coordination with up to 30 days of housing.

   We pay for transitional housing and services in the form of “rent”. We contract with four facilities and place based on facility criteria (male/female, etc.) and availability for up to 3 months. Number of admissions 149, average length of stay <30 days, annual bed days N/A.

10. Other IP monitored - State and other hospitals where HC monitors/manages patients. Number of staffed beds 45 facilities, no set number of beds; Number of admissions 400, average length of stay >90, annual bed days 119,727.

   - Do they intend to use EMR for the utilization management of their managed beds? Yes
   - Do they plan/need to create an encounter (admission/visit) in the EMR for each admission? Yes
   - Do they plan/need to document on such an encounter? Only to submit the encounter to the state – there’s no attached clinical documentation.
Does the bed management task currently get handled by Harris center using your current Managed Care System? **Partially –**

UM/Clinical functions are handled under the Managed Care system, the encounter/tracking functions are under the primary EHR system.

We are given an allotment based on population size of how many bed days we should be utilizing at the state hospitals, private contracted hospitals and HCPC on an annual basis. We are responsible for the utilization management of these beds – ensuring that we stay within our allotment or have an explanation for exceeding the allotment. To do this- we monitor usage, contact hospitals for periodic case reviews to demonstrate need for continued hospitalization and track trends (e.g. hospital A ALOS= 7 days, but hospital B ALOS =3 days with no significant difference in patient population). The Harris Center monitors and manages several hundred patients who are in contracted or state operated hospital beds.

However, **we do not provide or document the care** being delivered in those settings. Our needs are to document the patient demographics, utilization, and other administrative data related to their stays in those contracted/state operated facilities. In short, we do not operate any acute hospital beds. However, we do operate 16 Crisis Stabilization Beds and 40 Crisis Residential beds. The definitions and regulatory requirements for those facilities are available from HHSC online sources. There are 45 hospitals where we may have patients: HCPC has the majority with 200 beds. We do not bill for these bed days, but need to be able to track, report and send encounters to the state based off of them.

11. Outpatient Services- Includes Field-Based programs, intervention, homeless, and other care coordination programs.

Billable Providers **ICC 43,244; MCOT 44,232**
Non-Billable Providers HCPI 1,804; Crisis Line 129,970; 911 Diversion 5,270; CIRT 6,356; CCSI 9,572; Homeless 12,527; CTI 5,419

12. IDD: Intermediate Care Facility (ICF-ID) – 5 Homes. Number of staffed beds 30, number of patient admissions 2, average length of stay 5 years, annual bed days 10,950

13. IDD Respite Care-Out of Home-Contracted Services.
   - Nixon Respite- Number of staffed beds 1, Number of patient admissions 0, average length of stay N/A, annual bed days 0,
   - Crisis Respite- number of staffed beds 6, number of patient admissions 24 average length of stay 14 days, annual bed days 1,679.
   - The Center (West Dallas)- number of staffed beds 1, number of patient admissions 0, average length of stay 5 years, annual bed days 365

14. All other IDD outpatient programs: (All metrics below are estimates based on an annual three month sample)

<table>
<thead>
<tr>
<th>Billable Providers</th>
<th>Non-Billable Providers</th>
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<tbody>
<tr>
<td>ECI - 423,984</td>
<td>ECI - 110,604</td>
</tr>
<tr>
<td>ABA-Skip - 4,860</td>
<td>ABA-Skip - 780</td>
</tr>
<tr>
<td>Access Center - 14,592</td>
<td>Access Center - 1,116</td>
</tr>
<tr>
<td>Transition Services - 648</td>
<td>Transition Services - 756</td>
</tr>
<tr>
<td>TXHML - 29,844</td>
<td>TXHML - 1,572</td>
</tr>
<tr>
<td>Intensive - 22,860</td>
<td>Intensive - 2,316</td>
</tr>
<tr>
<td>STARS - 12,960</td>
<td>STARS - 5,988</td>
</tr>
<tr>
<td>Respite - 2,844</td>
<td>IDD SC - 4,968</td>
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<tr>
<td>IDD SC - 178,344</td>
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15. Forensics Dual Diagnosis Residential Program (DDRP), Atascocita. 150-180 day program. Number of staffed beds 100, number of patient admissions 120, average length of stay 5-6 months annual bed days 43,800

16. Harris County Jail, Infirmary. Number of staffed beds 108 beds (Will not be recorded in the EHR)

17. Harris County Jail Step Down - 244 beds (Will not be recorded in the EHR)

18. Harris County Jail Cognitive Behavioral Treatment – 20 beds (Will not be recorded in the EHR)
19. Harris County Jail Male Social Learning - **20 beds (Will not be recorded in the EHR)**

20. Children Forensics – Outpatient Only: *(All metrics below are estimates based on an annual three month sample)*

<table>
<thead>
<tr>
<th>Billable Providers</th>
<th>Non-Billable Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUPS - 5,388</td>
<td>CUPS - 13,440</td>
</tr>
<tr>
<td>CHOICES - 3,912</td>
<td>CHOICES - 2,988</td>
</tr>
<tr>
<td>JJAEP - 4,608</td>
<td>JJAEP - 1,368</td>
</tr>
<tr>
<td>TRIAD - 204</td>
<td>TRIAD - 36</td>
</tr>
<tr>
<td>TCOOMMI Jr - 2,076</td>
<td>TCOOMMI Jr - 6,168</td>
</tr>
</tbody>
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NOTE: Community Unit Probation Services (CUPS), Juvenile Justice Alternative Education Program (JJAEP), TRIAD Services

21. New Start - New Specialized Team of Advocates and Rehabilitation Therapists
   Billable Providers **14,400**, Non Billable **38,328**

22. SB1185 - Mental Health Jail Diversion Program Billable Providers – **0** Non Billable Providers **8,292**

23. Other Adult Jail Services including evaluations, general services, continuity of care, etc. Billable Providers – **0** Non Billable Providers **7, 104**

24. OutPatient Adult / Adolescent / Child Mental Health
   - Mental Health Northwest Community Service Center (3737 Dacoma, Houston), **Billable Providers 71,112, Non Billable Providers 60,468**,
   - Southwest Community Service Center (9401 Southwest Freeway, Houston), **Billable Providers 50,282, Non Billable Providers 62,400**,
   - Southeast Community Service Center (5901 Long Drive, Houston), **Billable Providers 68,496, Non Billable Providers 84,504**,
   - Southeast Community Service Center (5901 Long Drive, Houston) **Billable Providers 33,276, Non Billable Providers 52, 512**

25. MH: 16 Residential Beds *(Included in CPEP numbers)* Monitor 200/contract, *(Included in CPEP numbers)* Monitor 200/state hospital IP beds. Number of patient admissions – *(Included in CPEP numbers)*, average length of stay – *(Included in CPEP numbers)*, annual bed days- *(Included in CPEP numbers).*
The Harris Center monitors and manages several hundred patients who are in contracted or state operated hospital beds. However, we do not provide or document the care being delivered in those settings. Our needs are to document the patient demographics, utilization, and other administrative data related to their stays in those contracted/state operated facilities. In short, we do not operate any acute hospital beds. However, we do operate 16 Crisis Stabilization Beds and 40 Crisis Residential beds. The definitions and regulatory requirements for those facilities are available from HHSC online sources.

26. MCO: Are you responsible for claims intake, processing and payment to providers on a fee for service basis? We are responsible for the claims intake process and payments to providers on a fee for service basis.

27. MCO: Does a health plan or Medicaid delegate financial risk to you or outsource claims processing to you for a population of individuals? Please describe that arrangement. No.

28. MCO: Do you hold capitation arrangements with providers that you make capitated payments to? We do receive and pay claims for care delivered for our patients. However, we do not have any at risk or capitated arrangements.

29. MCO: Does the bed management task currently get handled by Harris Center using your current Managed Care system? Partially - the UM / Clinical functions are handled under the Managed Care system, the encounter / tracking functions are under the primary EHR system. We do receive and pay claims for care delivered for our patients. However, we do not have any at risk or capitated arrangements at this time.

30. Vendor Demo Criteria and Schedule

Each vendor must design their demo to demonstrate the full functionality/capability of their system for the three areas:

1. EHR Clinical – process/workflow
2. RCM – billing & MCO
3. Technical – Infrastructure, Interfaces & State Reporting

31. Vendor Demo Schedule
When the top three vendors are selected, The Harris Center will work with each vendor to determine available options. The demos will be scheduled as follows:

**Schedule: October 29th – Nov 2nd**

- **Vendor 1:**
  - 29\(^{th}\) Monday: Clinical EHR 8 – 12 & 1:30 – 5
  - 30\(^{th}\) Tuesday: RCM (billing) 8 – 12 & 1:30 – 5
  - 31\(^{st}\) Wednesday: Technical Q&A 8:30 – 12

- **Vendor 2:**
  - 31\(^{st}\) Wednesday: Technical Q&A 1:30 – 5
  - 1\(^{st}\) Thursday: Clinical EHR 8 – 12 & 1:30 – 5
  - 2\(^{nd}\) Friday: RCM (billing) 8 – 12 & 1:30 – 5

**Schedule: Nov 5th – 7th**

- **Vendor 3:**
  - 5\(^{th}\) Monday: Clinical EHR 8 – 12 & 1:30 – 5
  - 6\(^{th}\) Tuesday: RCM (billing) 8 – 12 & 1:30 – 5
  - 7\(^{st}\) Wednesday: Technical Q&A 8:30 – 12

32. Clarify Attachment D.-Notice Not to Participate

Sign and Complete Attachment D and note Not Applicable if participating.

This Letter of Clarification #3 is hereby incorporated in the RFP document and shall supersede any previous specification or provision in conflict with the Letter of Clarification #3. All responding Vendors are directed to respond accordingly. Vendors are required to add this Letter of Clarification #3 to the original RFP document.