

Continuum of Addiction Services Request for Proposals (RFP) Questions & Answers

1. South Philadelphia has a high rate of overdose fatalities, yet it seems that it is underrepresented in the identified zip codes. Can these be considered for priority location?

Yes, we will consider 19145, 19146, and 19147 priority locations.

2. Can several discrete locations be located in same program on different floors?

No. Unless the programs have separate addresses, the facility would be considered an IMD.

3. Does CBH have a contact with DDAP to help with the licensing process?

CBH is committed to working with the selected providers and DDAP collaboratively to advocate for issues related to licensure and alignment with ASAM and other procurement requirements.

For additional information on the transition to ASAM please see the following FAQ:

<http://www.ddap.pa.gov/Professionals/Documents/ASAM%20FAQs.pdf>.

4. May we attach the budget forms to the proposal as an attachment or does it have to be included in the 15-page limit (page 37)?

The provided budget forms may be completed as an attachment and will not count towards the 15 page limit.

5. In lieu of a certified corporate audit report, please confirm that for profit public companies may submit their most recent Form 10-K. If this is acceptable, may respondents provide a link to the report instead (or electronic CD version) of the several hundred page annual report?

Yes, in lieu of a certified corporate audit report a for-profit public company may submit their most recent Form 10-K electronically as part of the electronic version of their proposal on a CD or flash drive.

6. In lieu of staff names that will be providing services (RFP Appendix B), can staff positions be identified with corresponding job description submitted until hiring is complete?

Yes, positions with job descriptions are acceptable.

7. The sentence at the end of Section E 3 (pg. 31) is not complete Can it be completed?

The complete sentence is: "All staff must be culturally competent; applicants should describe hiring and training procedures to ensure culturally competent programming for populations described in section 2: Target Population."

8. Just read the announcement on changes. Other than the due date and schedule, are there other significant changes?

- The word "managed" was removed from Journey of Hope (JOH) medically monitored residential treatment (3A/B/C) throughout the document, making it clear that these services are not medically managed.
- Throughout the document, the letter "A" was added to the acronym LGBTQI = LGBTQIA.
- In Section I.D., the line "Providers must be enrolled in Medicaid and Medicare currently" was removed.

9. Due to the complexity of the RFPs and submission deadline of August 21st, could the deadline for the Q/A and RFP submission be extended?

Unfortunately we are unable to extend the question and answer or RFP submission deadline.

10. Please confirm that while the narrative portion of the response must be in 12pt Times New Roman font, respondents are permitted to utilize section and subsection headers of a distinguishing font size and type.

Yes, section and subsection headers can be in a distinguished font size and type.

11. The RFP references PCPC and ASAM. Within the specific sections of each program the reference is to follow the admission criteria, etc. for the PCPC. Should we, in our responses, cross-walk both regulations since PCPC is in effect through June 30, 2018 and programs will be operational by March 2018? If so, is it sufficient to respond to the PCPC requirements and then address a plan to meet ASAM requirements, with a launch of July 1, 2018?

PCPC should guide levels of care assessment. The RFP requirements should be used to guide program development and delivery as respondents are expected to meet the service requirements and programmatic standards as outlined in the RFP. Respondents should also indicate how they plan to prepare for the statewide transition to ASAM on July 1, 2018.

12. Should we apply for this proposal if our non-hospital based rehab currently serves more than 16 participants? If we apply, do we need to reduce our bed capacity?

Applicants with existing addictions service sites may apply to convert their existing programs to the RFP indicated programs. Existing programs will not be expected to reduce their service capacity, but may not expand services that would further exacerbate IMD non-compliance.

Additionally, all non-compliant IMD programs are potentially subject to financial penalties should IMD regulation restrictions be enforced by state or federal government. CBH has no authority to approve or waive IMD regulations.

13. At this time all of the clients who are on some type of MAT are being guest dosed by our outpatient methadone treatment program, which is located on the first floor of the building and all other treatment is done in the residential facility on the second floor. Based off of the RFP, am I correct in saying that you would prefer that the program be a separate entity? Would you prefer that the residential stabilization and maintenance program do their own induction, observation and maintenance rather than our current process?

In a scenario in which an organization is proposing to convert an existing residential treatment program into a withdrawal management and stabilization program, that program may utilize services within the same building to address treatment needs. However, it is incumbent upon the organization to include those services in the proposed residential treatment service rate as residential programs are expected to provide medication assisted treatment (and not bill for it as a separate service). Additionally, the program is expected to have the capacity to dose persons as needed, meaning the 24/7 medical monitoring and medication assisted treatment component must be in place.

14. Can any combination of the programs outlined in the RFPs (Addictions Continuum and Special Populations) be co-located?

Given current IMD requirements, non-hospital based residential programs with a total bed count greater than 16 beds cannot be co-located. The Ambulatory Stabilization program may be co-located with any of the residential programs discussed in the RFP. **Hospital based providers can deliver as many services in one location as they are not considered IMDs.**

15. Can any combination of the programs outlined in the RFPs (Addictions Continuum and Special Populations) be in side-by-side facilities, if they have their own entrances and distinct addresses?

Non-hospital based programs may be located adjacent to one another if each program has its own address and operates as a distinct program. **Hospital based providers can deliver as many services in one location as they are not considered IMDs.**

16. Does the IMD issue preclude having two 16 bed residential facilities next to each other or contained in the same building?

Non-hospital based sites may serve no more than 16 persons at a time to remain in compliance with IMD regulations. Regarding side by side locations, see response above.

17. We would like to submit a response to the RFP but are having difficulty securing a site by the submission deadline, August 21, 2017. Do you assist with this process or do you have any information to assist with obtaining property?

Applicants are expected to independently obtain their own site/s for locating programming. DBHdS does not endorse the location of any specific site. All sites chosen should meet the requirements of the RFP and state licensing code, and provide a recovery environment that meets the needs of the anticipated participants. Site control documents may include a proposal to lease a specific site (provided by the landlord).

18. Will proposing a site location that is not included in the preferred zip codes identified in the RFP affect the selection process?

Locating a program within the preferred zip codes will provide the applicant with additional consideration. All proposed programs must be located within the City of Philadelphia.

19. Can you elaborate on the RFP expectations around monitoring participant recidivism and follow up to outpatient services?

Applicants should propose a plan to ensure participants successfully step down to lower levels of care and do not remit to higher levels of care following treatment. CBH will partner with providers to share claims based aggregate data for 7 and 30 day follow-up rates to outpatient services and 30 and 90 day recidivism to all bed-based levels of care. Providers are responsible for improving these rates as part of their own continuous quality improvement process.

20. Can you provide any additional guidelines, in light of clinical and cost effectiveness, to the listed staffing requirements in each section (e.g., nursing coverage, counselor ratios and coverage)?

The staffing guidelines in the RFP reflect the Mayor's Opioid Task Force Recommendations around increasing the capacity of the workforce and CBH's recognition of the need to deliver mental health services to a complex population. Please see state regulations related to the provision of drug and alcohol services for additional staffing guidance,

http://www.ddap.pa.gov/Licensing/Pages/Licensing_Drug_and_Alcohol_Facilities.aspx

21. To meet the 24/7 psychiatric requirement, is it acceptable to have this (a psychiatrist) available within our health system but physically at a different site? We could provide a shuttle service for the client to get the care needed 24/7, but the client might need to be transported (depending on time of day) to a different location.

The staffing requirement for residential withdrawal management programs is that a physician with addictions training must be on-site 24/7 (not necessarily a psychiatrist). Please see RFP page 18. Staffing patterns outside of 24/7 on-site physician coverage will be considered, but must ensure the program has the capacity to treat immediate medical needs, admit participants 24/7, and induct medication assisted treatments when needed. Additionally, applicants'

responses should discuss the feasibility and sustainability of proposed practices that fall outside of RFP standards.

22. What are the staffing requirements in terms of medically trained personnel (nurses/techs), therapist/clinician to client ratio, and/or security personnel?

Please see DDAP regulations for staffing ratios. Of note, for programs with flex beds, staffing should align with the higher of the standards.

http://www.ddap.pa.gov/Licensing/Pages/Licensing_Drug_and_Alcohol_Facilities.aspx

23. For organizations already in the process of converting to electronic health records (EHR) where the behavioral health services won't be converted until after the March 1st deadline, can the hospital still apply to provide a service?

Conversion to an EHR can be a complex and time consuming process. Applicants who are in the process of converting to an EHR may still apply, but should submit a timeline of when the EHR will be fully implemented within the proposed program.

24. In the *Medically Managed and Medically Monitored Stabilization and Maintenance Residential Treatment (4A/4B and 3A/3B) program*, can the proposal be a well planned joint project including a hospital for 4A/4B services and a licensed residential facility for the 3A/3B services?

Yes, applicants may propose joint projects that would locate 4A/B beds at a hospital and 3A/B beds at a separate site. **Hospital based providers are strongly encouraged to submitted proposals for more than 16 beds per service.** However, the 3A/B program may have no more than 16 beds to maintain IMD compliance.

25. In level 3A/3B physician coverage- it says 24/7- do you want an actual physician on site or they just have to be available?

Programs must be able to address medical and psychiatric needs as they arise. Programs will be expected to accept participants and have the capacity to induct medication assisted treatment 24 hours per day, 7 days per week. Staffing patterns outside of 24/7 on-site physician coverage will be considered, but must ensure the above mentioned capacities are present and must not include shuttling participants around to accomplish these services.

26. For the Journey of Hope medically managed and medically monitored residential treatment (JOH 3A/B/C/ ASAM 3.7-WM/3.3), the RFP indicates that the provider must have the capacity to treat at least 45 males. Does the 45 bed capacity mean that this program must be provided in a hospital-based setting or may a bidder propose a non-hospital setting with a capacity of 16 of the 45 beds?

The Journey of Hope stabilization and maintenance program (JOH 3A/B/C/ ASAM 3.7-WM/3.3) may be provided in a hospital based setting, in a non-hospital based setting as three separate residences to meet the 45 bed capacity, or an applicant may propose a non-hospital based setting with lower capacity.

27. Does a DHS licensed RTFA fall into the category that you describe as Co-Occurring Medically Monitored Long-term intensive treatment Program (3C)?

Applicants are expected to obtain a DDAP license to provide residential treatment and rehabilitation). While an RTFA license from DHS could be an important compliment to the program, the DDAP license would also be required. Please refer to pg. 18 of the RFP for additional details around license requirements.

28. We are a licensed 3B/3C program and are not able to staff an on-site medical doctor at this time. Would networking with outside MAT providers for continuing care meet the requirements for this RFP or would we need to be actually providing these services on-site?

3B/3C is not a level of care being procured in this RFP. If an applicant is interested in proposing a 3C program, the program must be able to provide on-site physician time to ensure participants' mental health and substance use disorder needs are being adequately addressed. Please refer to pg. 21 of the RFP for additional details around staffing.

29. For the Co-occurring Medically Monitored Long-Term Intensive Treatment Program (3C), is it acceptable to have the capacity to take 3C clients, in addition to 3A/B, or do we need to hold beds for 3C specifically?

The Co-occurring Medically Monitored Long-Term Intensive Treatment Program is to be a specialized program that has expertise in treatment co-occurring disorders, specifically individuals with serious mental illness (SMI) and substance use disorder. Given the target population, the program is not expected to flex beds between withdrawal management and short term rehabilitation with long term rehabilitation. Rather, the program is expected to provide participant specific co-occurring treatment that focuses on helping individuals learn the habilitation skills necessary to successfully manage their mental health and substance use challenges.

Ambulatory Stabilization

30. What is the reimbursement methodology for the Ambulatory Stabilization Bridge Program? How are the assessments billed?

The Ambulatory Stabilization Program will be considered an outpatient program for licensing and billing purposes. Substance use level of care assessments will be able to be billed separately as an outpatient drug and alcohol service for both admitted and referred members.

31. Do you have any projections for the anticipated volume of persons that might come through the ambulatory stabilization unit in the middle of the night? If so, can you describe?

CBH anticipates great need for these services. Applicants are encouraged to reach out to their local CRC and emergency departments to discuss plans for collaboration and estimate local volume that could be generated.

32. The RFP states that the Ambulatory Stabilization Bridge Program should be a freestanding facility or located in a healthcare-specific or hospital-based facility. Is an Outpatient Center considered a healthcare-related facility? How do you define healthcare specific?

The Ambulatory Stabilization program may be free standing or co-located at an outpatient healthcare site so long as the program is able to meet the medical requirements specified in the RFP. The site will need to have staff able to be credentialed by CBH to provide behavioral health services (I.E. licensed healthcare professionals, psychiatrists, etc.). Applicants should explain how the Ambulatory Stabilization program will be integrated with the physical healthcare operations as well as identify linkages with CRCs and emergency departments. Locations near emergency departments are preferred.

33. The *Ambulatory Stabilization Bridge Program* section states that the program must be located in the designated zip codes. Our target site is located in a zip code heavily affected by substance use, and yet is not listed in the preferred zip codes. Should we still apply?

Yes, applicants are free to propose locating the Ambulatory Stabilization program at any site within the City of Philadelphia. Applicants are encouraged to locate the program in the targeted zones, see RFP p. 6.

34. In the *Ambulatory Stabilization Bridge Program* section, the RFP says that 23 - hour observation is preferred but not required (Section E-4a). Does that mean that it is preferred that each person is observed 23 hours (e.g., assessment, level of care determination, and induction process) or that the facility must be staffed and able to do 23 hours observations? Can you please clarify what tasks should occur during the observation period?

It is preferred but not required that the facility offer 23 hour observations when medically necessary. Not all persons receiving treatment at the Ambulatory Stabilization program will require 23 hour observation. For those that do require 23 hour observation, individuals should

receive the medical services necessary to ensure safe withdrawal from substances and response should include protocols for facilitating warm handoffs. For applicants not proposing a 23 hour observation component, responses should detail the extended hours available for participants to access services.

35. For Ambulatory Stabilization Services, regarding daily dosing of MAT, what are CBH's expectations? Since this would be done in an outpatient setting for 10-28 days (target duration for withdrawal management and stabilization), who can administer the medication?

The clinical expectation is that each individual is engaged by the program and receives immediate stabilization of withdrawal symptoms with facilitation of stabilization on the most clinically appropriate form and dose of MAT. Direct provision of buprenorphine and Vivitrol is strongly preferred.

We expect that many individuals may not be motivated or ready for residential treatment and or IOP, so the ambulatory program must be able to focus on physical and psychiatric stabilization, engagement, assessment, level of care determination, and linkage to aftercare. The program must be flexible to accommodate the needs of a diverse population. Examples may include someone who has employment and is looking for ambulatory stabilization with a linkage to outpatient services.

36. CBH says a comprehensive LOC assessment must be completed by a medical team. Please define what comprises a medical team and please specifically state who can complete the LOC assessment (credentials, experience, etc.).

CBH is looking for multi disciplinary teams lead by licensed clinicians and physicians. Comprehensive evaluation should include a PCPC and ASAM level of care assessment completed by a team member with the appropriate training, and should be informed by assessment of medical and psychiatric co-morbidities completed by physicians, nurse practitioners and/or physician assistants working with the rest of the team.