

# **Addictions Continuum for Special Population Request for Proposals Questions & Answers**

- 1. Will you consider the site as the licensed site, or as Mark said if you have multiple services at a site can it be considered? IE. Multiple services at one site for IMD.**
  - a. Given current IMD requirements, non-hospital based residential programs with a total bed count greater than 16 beds cannot be co-located.
  
- 2. Regarding the 16 bed limit for 2b programs, could a provider be approved for more than one 16 bed 2b program at one site?**
  - a. Non-hospital based sites may serve no more than 16 persons at a time to remain in compliance with IMD regulations.
  
- 3. If there is an existing 2b program at a particular site, would the amount of beds at that site be counted against the 16 bed limit?**
  - a. 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.
  
- 4. For the 2b/3b, are the beds 16 plus 16 or total?**
  - a. If applying for the 2b/3b flex program, this refers to 16 beds total at one site that can flex between 2b and 3b levels of care.
  
- 5. Can any combination of the programs outlined in the RFPs (Addictions Continuum and Special Populations) be co-located?**
  - a. Given current IMD requirements, non-hospital based residential programs with a total bed count greater than 16 beds cannot be co-located.
  
- 6. 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?**

- a. Non-hospital based programs may be located adjacent to one another if each program has its own address and operates as a distinct program.
- 7. Can a bed-capacity larger than 16 beds be proposed (such as 18-20 beds), especially if proposing a single facility to flex between two levels of care (e.g. 2B and 3B levels of care) and if a prospective site can accommodate the larger capacity?**
  - a. Non-hospital based sites may serve no more than 16 persons at a time to remain in compliance with IMD regulations.
- 8. Can more than 1 halfway house (2B) program be located at the same site (address) assuming that separation between programs can be maintained based on the physical layout of the facility? If yes, should separate submissions be submitted for each proposed program at the site?**
  - a. No. Unless the programs have separate addresses, the facility would be considered an IMD. Please see answer to question #14 for additional clarity.
- 9. Can an agency apply for more than one program (such as more than 1 halfway house (2B))? If yes, do separate applications need to be submitted for each site/program, or should they be included in a single submission?**
  - a. Unique proposals are required for each different specialty program. Please see answer to question #14 for additional clarity.
- 10. Do we need separate proposals for each type of half way house?**
  - a. Yes, unique proposals are required for each different specialty of halfway house.
- 11. Do we need separate proposals for the flex? 1 or 2 proposals? For flex beds, they should be submitted as one proposal? If applying for a combined/flexed Latino Halfway House (2B) and Medically Monitored Maintenance Residential (3B) Treatment program (RFP page 2), can a single RFP response (only 1 application packet) be submitted covering both levels of care to be flexed in a single facility?**
  - a. One proposal is required for the 2b/3b flex program that covers both levels of care to be flexed in a single facility. Please consider how this ability to flex will effect treatment and staffing and include these considerations in your proposal.
- 12. Is there any start-up funding available to assist with capital costs and/or staffing costs while initial census is built?**

- a. There is an overwhelming and immediate need for the services included in this RFP, therefore we are not anticipating significant 'census build up time'. We will work with selected providers during the contracting phase to discuss additional concerns about start up.

**13. Are the rates indicated in the RFPs (page 22 of RFP) negotiable? If a proposed budget indicates a higher rate than the posted rates in the RFP, can that budget and higher proposed rate be submitted for review?**

- a. The proposed budget should incorporate all the requirements of this RFP. Any deviations from the requirements and expectations of this RFP must be clearly stated along with supporting justification. If a proposed budget indicates a higher or lower rate than the posted rate ranges in the RFP, that budget along with the higher or lower proposed rate can be submitted for review. Specific program requirements and/or other innovations related to cost of services should be clearly articulated to account for requested rates outside of the described range.

**14. Can a bidder propose more than one residential program for the General Halfway House Program (2B/ASAM level 3.1)—for instance, two separate 16 bed programs at two separate locations? If so, do these need to be separate proposals with distinct separate locations?**

- a. If the program a bidder is proposing is the exact same program (in areas of clinical, staffing, training, hours, etc.), they can be submitted as one proposal and include information about both of the sites. If the program differs in any way (this includes staffing, training, hours, clinical programming, etc.), please submit separate proposals.

**15. Just read the announcement on changes. Other than the due date and schedule, are there other significant changes? If so, due to the complexity and time frame, is there any way you can let us know what they were?**

- a. Throughout the document, the age range for the youth/ young adults halfway house program was changed from 17-25 to 18-25.
- b. In Section I.D., the line "Providers must be enrolled in Medicaid and Medicare currently" was removed.

**16. Due to the complexity of the RFPs and the change in due date can there be a one week extension for questions?? Due to the complexity of the RFP, the varied program requirements, the fact that many staff and allies take vacations in August and are not available, as an organization committed to multiple proposals, would you consider rescinding the change on submission**

- a. The question and answer period and submission date cannot be extended at this time.

**17. 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 25)?**

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

**18. 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?**

- a. Yes, positions with job descriptions are acceptable.

**19. 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 185 plus page annual report?**

- a. 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.

**20. 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.**

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

**21. A question about the follow-up and recidivism requirement. Can you elaborate on the two versions of the statement and your expectations? Is this to be a formal follow-up with regular reports and analysis?**

**Page 3 and 21:**

**30 and 90 day recidivism to all bed-based levels of care**

**7 and 30 day follow-up rates to outpatient services**

**Page 14 and Page 20:**

**Agencies will be responsible for outcomes related to 7 and 30 day treatment follow-up as well as recidivism, therefore ensuring participants' engagement in treatment post-discharge is paramount.**

- a. 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.

**22. Does tobacco free include outside the facility? Can people bring tobacco on site?**

- a. Residential addiction treatment facilities shall maintain a tobacco-free environment. This includes:
  - i. CBH members may not possess or use any form of combustible tobacco or electronic cigarette devices, or possess any tobacco paraphernalia within the residential treatment facility, on the grounds of the facility, or while in a facility operated or owned vehicle.
  - ii. Residential addiction treatment facility employees, volunteers and visitors may not display any evidence of combustible tobacco or electronic cigarette devices.
  - iii. CBH members will be screened for tobacco use disorders upon admission and provided counseling and pharmacologic treatment options while residing at the facility.
  - iv. CBH members are not permitted to be taken off of campus by staff to smoke or use tobacco products.

**23. P. 3 requires programs be fully operational by January 2017 - should this read 2018?**

- a. Programs are expected to be fully operational by MARCH 2018.

**24. Can you please clarify by values outcomes specifications?**

- a. Please see RFP section II.E., page 21.

**25. Can you please clarify about "Labs"? What does this mean? What is entailed?**

- a. This mainly applies to Urine Drug Screens as monitoring tool for treatment and admission. The costs of labs should be embedded in proposed rate. The frequency of lab testing will be determined by provider based on clinical need and in accordance with best practice.

**26. Regarding EHR, is there a software our EHR needs to integrate with?**

- a. The EHR must be certified through The Office of the National Coordinator for Health Information Technology.

**27. Regarding EHR, Any recommendations for software?**

- a. CBH does not have recommendations for EHR software.

**28. Regarding EHR, Do we need to have this in place when contract starts?**

- a. 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.

**29. Need clarification on Medicaid – in meeting it was said that *applicants must enroll in Medicaid/must be able to enroll in Medicaid*. What does this mean? For what service would**

**we be Medicaid-eligible related to halfway house program?**

- a. Programs must be enrolled in Medicaid. All of the services listed in this RFP are Medicaid-funded levels of care.

**30. The staffing levels are very important – from a clinical program perspective and cost effectiveness basis. Can you provide any additional guidelines to the listed staffing in each section (e.g., nursing coverage, counselor ratios and coverage)?**

- a. 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](http://www.ddap.pa.gov/Licensing/Pages/Licensing_Drug_and_Alcohol_Facilities.aspx)

**31. 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 response to the PCPC requirements and then address a plan to meet ASAM requirements, with a launch of July 1, 2018?**

- a. Given the page limit, respondents are not expected to crosswalk PCPC to ASAM throughout their submission. However, all 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.

**32. For the Halfway House (2B), Latino Halfway House (2B), and Medically Monitored Maintenance Residential (3B) programs, the RFP refers to serving “varying genders at a time” or “serving women and/or men” (see pages 2, 7, 9, 15). However, can a single gender (male or female) model/program be proposed, especially if a site is more conducive to a single-gender model due to physical factors such as bathroom facilities or other factors?**

- a. Yes, however when restricting the program’s target population to gender, please include your plan for accepting and ensuring appropriate facilities and treatment for the transgender population.

**33. Does a halfway house have to provide outpatient treatment or can we outsource this service?**

- a. The services expected to be included in halfway housing level of care proposals are outlined in the posted RFP (see section II.A.4., Page 7-15). Services are expected to be

provided in accordance with DDAP regulations for halfway house level of care.

**34. What is the need for JOH 2b?**

- a. Currently, there is a need for one JOH 2B program serving women.

**35. Can we please get more information about the *Journey of Hope* program including goal(s), objectives, implementation, etc?**

- a. Vision:

The Journey of Hope Project offers an opportunity for individuals experiencing prolonged homelessness and behavioral health challenges to embark on a path towards recovery; improve their health and wellness; live a self-directed life, and strive to reach their full potential.

Mission:

The Journey of Hope Project is a collaboration between several innovative long-term residential treatment programs designed to serve individuals experiencing prolonged homelessness, substance use disorders, and co-occurring mental health challenges. The Project is able to admit individuals directly from the street, shelters, and Safe Havens by reducing barriers to treatment admission. Upon completion of treatment, individuals are connected with permanent supportive housing opportunities, as well as ongoing outreach and follow-up to help support long-term sustained recovery in the community.

Our goal is to have a direct impact on reducing street homelessness and reduce barriers to accessing behavioral health treatment for people experiencing homelessness and addiction. Journey of Hope (JOH) participants often have complex, multi-dimensional needs including chronic medical conditions, legal and criminal justice involvement, and histories of trauma. We seek to implement individualized, holistic, evidence-based approaches into a person's treatment in a trauma-informed therapeutic setting to be able to fully address the needs of the whole person. Journey of Hope participants may transition between levels of care while they are in "The Project"; i.e. transitioning from 3C to 2B. JOH

Journey of Hope programs work closely with many stakeholders including but not limited to; CBH, BHSI, DBHIDS, Office of Homeless Services, MAT providers, case management, Certified Peer Specialists, and others to best coordinate care for treatment needs of the person and also secure permanent supportive housing as participants transition out of treatment and back into the community. Journey of Hope programs are offered additional support from DBHIDS Homeless Services via a leadership team who oversees JOH to help support the needs of the participants, the program, and ensure the mission and vision are implemented across The Project. There are monthly JOH Project Management Meetings that bring all the JOH Directors and stakeholders together to discuss relevant issues/offer updates to The Project as it relates to our population.

**36. What qualifies as "Chronically homeless" under HUD? Does coming out of jail or prison qualify?**

- a. The Journey of Hope program requires that all members meet the HUD definition of Chronically Homeless to be eligible for services. This definition can be found in page 9 of the RFP, footnote # 7: HUD defines chronic homelessness as follows:
  - i. Has been continuously homeless for a year or more(HUD defines "homeless" as "a person sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter.)
  - ii. Has had four (4) episodes of homelessness in the last three (3) years. Details available at: <https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/>

**37. For a Latino Halfway House (2B) or Latino Medically Monitored Maintenance Residential (3B) Treatment program, please clarify the admission criteria concerning language and cultural affiliation. On page 16 of the RFP, it is noted that the program will be for individuals referred who "will be primarily Spanish-speaking and/or bicultural." Is there specific criteria that CBH has established for this standard, or will the program develop this criteria in consultation with CBH?**

- a. CBH has no specific criteria at this time around admission criteria for this populations, however are interested in proposed plans for ensuring the target population is regularly admitted to the proposed program. CBH is open to collaboratively developing this criterion with programs who are awarded the opportunity to negotiate.

**38. For a Latino Halfway House (2B) or Latino Medically Monitored Maintenance Residential (3B) Treatment program, what percentage of the staff needs to be bilingual (noted on pages 8, 15, 16, 20 of RFP)? Do the staff need to be certified/tested on written and spoken language skills?**

- a. CBH would like to see plans for ensuring that staff is bilingual. Certification and/or testing are something that is used by other bilingual services.