Delaware Health
And Social Services

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

DATE: September 12, 2014

HSS-14-027

COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT SERVICES FOR ADULTS

FOR
DIVISION SUBSTANCE ABUSE AND MENTAL HEALTH

Date Due: October 2, 2014
11:00AM

ADDENDUM # 6

Please Note:

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE ABOVE MENTIONED BID. Addendum #6 Questions & Answers

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STATE OF DELAWARE

RFP HSS-14-027
Outpatient Treatment Services for Adults
Pre-Bid Questions & Answers

1. Will you provide a draft copy of the new regulations? **Providers who attended the 8/11/14 training with Pam Baston were provided draft copies. Additional electronic copies can be obtained from the bids.delaware.gov website. Please be advised that DSAMH is currently working on this draft to update it.**

2. Services: can we provide just one or two of the services? **Yes. DSAMH will be making multiple awards to ensure the full array of services is available.**

3. Page 16: use of Meth that is orally dispensed as opposed to the injectable form—Medicaid cannot be billed for the orally dispensed Meth.

   See State Plan Certification and Reimbursement Manual. Billing code H0020 is to cover reimbursement costs for the administration of oral methadone.

H0020		**Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). (Limited to one per day.)**	**1 dose per day**
T1502	**HF**	**Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit. This code may only be used for the following medication assisted therapies: buprenorphine (SUBUTEX®), buprenorphine and naloxone (SUBOXONE®), by an alcohol and drug provider type. Frequency max 7 administrations per week (1 unit–1 administration). No modifier = oral.**	**Per service**

4. Buprenorphine is not on the benefits list and was not included in the MA RFP. **Buprenorphine is a covered benefit under this contract and under Medicaid upon CMS approval of the pending State Plan Amendment (SPA DE 13-018).**

5. Service Array: you have to include some level of outpatient, not just psycho-social. **This RFP is for the outpatient therapy services and SUD services included in the benefits list.**

6. Will you be letting us know the rates? **The Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual has been posted to the bids.delaware.gov website**

7. Are we willing to extend the dates in the RFP since the regulations and the service fee rates are not available? **The proposal submission date has been extended to October 2, 2014. The regulations and rates were previously posted to the website.**

8. If we choose not to bid on this RFP, how would that affect the existing relationship with Medicaid? **After January 1, 2015, providers not awarded a bid under this contract will not be eligible to serve Medicaid clients in the PROMISE program. Medicaid PROMISE will include all Medicaid individuals with SPMI and SUD criteria meeting functional criteria and needing services and supports to remain in the community. Medicaid beneficiaries not in PROMISE will be served solely through the Medicaid MCOs. Medicaid MCOs make their decisions regarding credentialing separately from this RFP.**

9. Will the rates be made available before the due date or well before the due date? **See the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual posted to the bids.delaware.gov website.**

10. What about if your area of expertise is for a particular age range? **If the provider specializes in providing outpatient services for a particular age range, please note that in your response (e.g., 18-25 or over 65).**

11. There are things in the RFP that are not in the current standards; such as QHP, do we have to include it in our proposal? **Yes, please refer to the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual.**

12. Pg. 12 refers to ASAM Assessment Tool; will that be made available to everyone? **The ASAM tool is available through the EEU and is currently on the DSAMH web site.**

13. If you are currently applying ASAM, as a matter of practice, can we still go by what we have in the manual? **The Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual has been posted to the bids.delaware.gov website.**

14. How is payment going to be managed? **Payment is on a fee-for-service basis. There will be no cost-settlements for either Medicaid or non-Medicaid beneficiaries.**

15. Will the billing go through HP? **Medicaid billing will be processed through HP. Non-Medicaid billing will be processed through the fiscal unit at DSAMH.**

16. Will we pre-authorize payments at level 1**? Prior authorization requirements are outlined in the Delaware Adult Behavioral Health Medicaid State Plan Certification and Reimbursement Manual. DSAMH will provide prior authorization procedures during contract negotiations with selected vendor(s)**

17. Will there be caps on the benefits? **There is an initial authorization of services under this contract as noted in the Delaware Adult Behavioral Health Medicaid State Plan Services Certification and Reimbursement Manual. Beyond that level, a prior authorization based on medical necessity is needed.**

18. What happens to the current providers after 2014 with regards to MCO billing? **Providers will need to enroll with MCOs to serve Medicaid clients not enrolled in the PROMISE program. Medicaid clients in the PROMISE program and non-Medicaid clients will need to be enrolled with DSAMH and HP for payment to continue.**

19. What is the division's position on medical necessity? **All services should meet the requisite medical necessity for service provision. There is an initial authorization of services under this contract as noted in the services manual. Beyond that level, a prior authorization based on medical necessity is needed. See the service manual.**

20. Is there an update on the Peer Specialist Certification? Will that happen in August? – **Per page 23 of the RFP, "the proposed program model will be expected to hire Peer Support Specialists (PSSMH) and Peer Recovery Coaches (SUDRC) throughout implementation and in operations, going forward. Peer Service Certification processes for both PSS and RC are in process, under the umbrella of the Delaware Certification Board. We anticipate that both of these certification programs will be underway shortly**.

21. Are under-insured clients covered by this RFP (non-Medicaid insured clients)? **This RFP is specifically for services paid for by DSAMH and Medicaid. Individuals with other third party insurance are not covered unless the third party insurance is not comprehensive (i.e., does not provide the behavioral health services in this RFP) or the behavioral health benefit has been exhausted. Third party insurance should be billed before billing Medicaid or DSAMH. Only after a denial will Medicaid and DSAMH reimburse for these services (e.g., bill Medicare prior to billing Medicaid). For uninsured and underinsured patients, patient copayments must be collected according to the department's sliding scale fee prior to DSAMH reimbursing the remaining fee.**

22. Pg. 18: breakdown of OTP clarification, RN and LPN serving no more than 15 hours per months in an OTP environment.
The State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.

23. Pg. 20: requirement for the QHP of 10 hours onsite – this needs to be clarified. If you were expected to bill with these standards, how can we be expected to build a budget?
RFP indicates "QHP (physicians, psychiatric nurse practitioners, psychologists, LCSWs, and other appropriate licensed staff) supervisors must be on site or available for phone consultation in a crisis 24/7 and supervise no more than 10 unlicensed staff" and "QHP supervisors must be on site at least 10 hours per week during hours of operation, be available for phone consultation at all times, and supervise no more than 10 staff."

24. Pg. 20: is that 2 full time staffing equivalent?
There is not enough information contained in this question to provide a response.

25. Will the rates include Peer Services and Case Managers? **This RFP includes a specific code and rate for SUD peer recovery coaches. Referral and assistance to Medicaid services should be billed as part of the service provided by the practitioner under ASAM 1.0 when the ASAM service is provided. This RFP does not include MH peer supports and PROMISE care managers. A separate RFP for PROMISE services will be released later, which will include coding and reimbursement for MH peer supports.**

The Certification and Rates manual includes the following peer recovery support coach reimbursement:

H0038	**HF**		**Self-help/peer services, substance abuse program.**	**Per 15 minute**	**$14.75**

Note: Case Management services which assist individuals eligible under Medicaid in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan is only available under the PROMISE program. Under ASAM 1.0, when referral and assistance are only reimbursed under this RFP when the following activities directly related to the SUD or SUD/co-occurring treatment and diagnosis are provided:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary has provided permission for such coordination.

If the referral and assistance is provided by a peer, the provider will bill H0038HF. When referral and assistance for gaining Medicaid services is provided by an unlicensed practitioner including licensed registered nurses, the provider will bill H0004HF. Licensed practitioners other than licensed registered nurses will bill CPT codes per the applicable AMA guidance as listed in the services manual.

26. If the current standard does not address RN Case Managers, do we respond to current standards or RDP? **See #25 regarding billing of referral and assistance.**

Note: Case Management services which assist individuals eligible under Medicaid in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan is only available under the PROMISE program. Under ASAM 1.0, when referral and assistance are only reimbursed under this RFP when the following activities directly related to the SUD or SUD/co-occurring treatment and diagnosis are provided:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
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community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary has provided permission for such coordination.

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27. Are you considering Level 1 OTP Services? **Yes.**

28. Pg. 20-21: Level of service states only 1-8 apply. Would like clarification on why it is only 1-8. **This section of the RFP lists Core Services for all ASAM Level 1 outpatient programs. However, Opioid Treatment Programs (OTPs) are not required to provide all of the listed Core Services given the unique structure and role they have. However, Office Based Opioid Treatment programs and other ASAM Level I outpatient programs must meet this expectation.**

29. When the new fee schedule comes out, will the MCO be reimbursing for RN services? **RNs are not a separately enrolled provider under Medicaid. RNs may provide unlicensed SUD services within a licensed agency. Medicaid MCO reimbursement will be negotiated between the Medicaid MCOs and each provider. This RFP is for non-Medicaid clients, as well as, Medicaid clients who will receive these services via fee-for-service. After January 1, 2015, only Medicaid individuals enrolled in the PROMISE program will receive the services via FFS.**

30. Pg. 21: regarding entitlements, at what point or what consideration will be given, to determine when the entitlement is established? **Medicaid eligibility will be determined through regular Medicaid eligibility determination processes. The provider must ensure that all third-party insurance is billed prior to Medicaid and that DSAMH funding is pursued only if the individual is eligible for Medicaid, the individual is eligible for DSAMH funding, and the sliding scale patient copayment fee has been applied.**

31. Pg. 21: regarding urinalysis (UA), is there any idea of what that would look like? Will there be a cap? **UA needs to be based on established best practices and described in full in the response. There will be no cap on UAs. Proposals should include standard panels.**

32. Hope Commission: what is DSAMH vision on how to give guarantee to the provider? **The respondent should describe access to its services, regardless of referral source.**

33. What is the current census at each existing CMHC site (active and non-active)? **About 650 admitted clients for the State run CMHC.**

34. What is the current staffing, per discipline, at each current CMHC site? **The clinics each have psychiatrists, RNs, psychiatric social workers and administrative staff. One CMHC makes use of a nurse practitioner and another of psychiatric residents.**

35. Are the current locations being used available to use as part of this RFP? **No. Bidders should include any and all locations they plan on using for this RFP. Current CMHC sites are not anticipated to provide services under this RFP.**

36. What is the current pay scale for uninsured/DSAMH clients?
DSAMH currently utilizes a cost reimbursement payment for outpatient services.

37. What will and will not be included/reimbursable by the MCO per the RFP (i.e. Peers, RNs, Case Managers, etc.)? **Each Medicaid MCO will need to contract for the specified Other Licensed Practitioner, SUD and crisis services in the enclosed services manual. Providers under the PROMISE program are not included in the MCO program.**

38. What is the average daily census at each current CMHC? **Sussex = 150, Dover = 150, Wilmington = 350.**

39. Page 10 Introduction: Which of the six sites, if any are currently operating? **All of them.**

40. Page 12 – III. Geographic Area and page 33 Capacity/Location: What is the current service configuration with the new configuration, how many clients at each site can be projected? **Unknown. This will be based on the current capacity of the current providers; however, DSAMH is not aware of their overall census as they do not report services for individuals with insurance to DSAMH. Page 12 IV. Target Population:** What resources are available to assist persons with a severe mental illness – beyond the scope of the services offered on an outpatient basis? **The provider should be staffed to treat individuals needing this level of care; medications are provided through DSAMH, Medicaid or third party insurers. Individuals requiring a higher level of care should be referred to PROMISE through DSAMH.** See the public notice for information about the additional PROMISE services.
http://regulations.delaware.gov/documents/September2014c.pdf

41. **Page 13 Comprehensive Service Array:** To plan effectively and determine if this is possible to bid, can you indicate the rates for substance abuse, mental health, and COD services at each of the three levels of care. **The Delaware Adult Behavioral Health Medicaid State Plan Certification and Reimbursement Manual has been posted to the website.**

42. **General:** If one is selected to expand into a new area, is the company expected to absorb the one-time costs into the rates or will there be an one time start-up money available. **DSAMH has limited funds available for start-up costs and will negotiate this with the successful vendor(s). Medicaid will not pay start-up costs separately.**

43. **Page 15 ASAM Level 1:** Outpatient Services: Since the program must be licensed under the new licensing regulations and will include new program and staffing standards (especially staffing standards – e.g., licensed vs. unlicensed counselors (page 16)), how can the program price the services at this time? **The draft licensure regulations and the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual have been posted to the website.**

44. **Page 17 OTP:** the medical director "on site" is not clear. Please clarify?

    RFP states "A designated medical director available on site or for consultation at all times the facility is open." The medical director does not need to be onsite as long as the Medical Director is available for consultation when the facility is open. The Medical Director can be available by phone.

45. **Page 18 OTP:** The RN and licensed practitioner requirement – is that a 15 person static caseload or see 15 clients per day? **The State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.**

46. **Page 20 – Staffing (6):** Is the Addiction Credentialed Physician indicating ASAM credentialed or another credential? And, must an Addiction Credentialed Physician be on each selected site for 10 hours per week (page 20)? **Yes and yes.**

Physicians should be certified by ASAM (prior to 2009) or the American Board of Addiction Medicine (ABAM). NOTE: In 2009, ASAM transferred the certification examination to ABAM. ABAM certification is open to physicians from all specialties who are board certified by an American Board of Medical Specialty (ABMS) member board or who have completed an Accreditation Council for Graduate Medical Education (ACGME) -accredited residency, and who meet ABAM's additional criteria to sit for and pass the ABAM certification examination. The term Addiction Credentialed Physician also applies to an Addiction Psychiatry certification bestowed by the American Board of Psychiatry and Neurology (ABPN).

47. **Page 20 – Staffing:** May the QHP (#5) and the Addiction Credentialed Physician (#6) be the same person? **Yes.**

48. **Page 23- VIII Funding and Program Capacity:** Will the fee for service be an hourly rate by professional level of the staff person (e.g., physician, peer specialist) or by the range of services (e.g., group therapy, individual therapy administrative (court or case management) or both? **Licensed practitioners will be reimbursed using CPT codes. SUD services will be reimbursed using HCPCS codes.**

49. **On page 12, under Target Population**, it states that "…any adult individual seeking behavioral health services" – would this include Maryland residents? **Not through this contract, but the provider can serve individuals with other sources of revenue.**

50. **On page 12, again under target population**, there is a statement regarding an ASAM assessment tool has been revised for Delaware – is this available now for review and inclusion in the response; and if so, how do we access that tool? **The ASAM tool is currently on the DSAMH web site.**

51. The language of the RFP uses terms not currently used or defined in licensure standards. An example of this would be on page 16, where "active" is defined as being seen every 90 days, which is in conflict with current standards. An example of this would be on page 16, where "active" is defined as being seen every 90 days, which is in conflict with current standards. At the pre-bid meetings, it was clarified to write the proposal, reflecting current standards. Will this result in any loss of points for not addressing RFP expectations that are based on unpublished licensure standards? **The providers should follow the Medicaid services manual – attached.**

52. **On page 16, #5** – how is peer support billing different than treatment billing? **Peer recovery coaches under SUD will be billed using the SUD codes outlined – See question #25.**

53. **On page 23**, at the bottom of the page, VIII – it states DSAMH will only provide payment for uninsured individuals. The current practice provides payment for under-insured individuals (extraordinary deductibles for behavioral health services) or who have

no provider within a reasonable distance from their home. As a current provider, we have seen a recent increase in the number of individuals who have insurance in this circumstance. Will this contract continue to support payment for these under-insured individuals? **Other forms of insurance must be billed prior to Medicaid and DSAMH payment. DSAMH requires that providers enforce a sliding scale fee copayment according to the individual's resources.**

54. It will be very difficult to craft a budget without a copy of the Delaware Adult Behavioral Health State Plan Service Certification and Reimbursement Manual. When will this information be available? **The manual was posted to the website.**

55. The RFP indicates that current mental health clinic clients will be referred to providers under this new program. In order to realistically project the increase in caseload, what are the numbers of clients currently being served in those clinics? Also, the number of admissions and discharges in the clinics within the last year, by county? **There are currently about 650 individuals served in the CMHC. The number of admissions and discharges this past year is significantly different than during past years because the CMHC has made a concerted effort to divert all admissions in the most recent 6 months and to discharge to other providers, when possible. This action was in preparation for this RFP.**

56. As stated in the RFP on page 23, are the certifications for PSSMH and SUDRC still scheduled for implementation in August, 2014? If not, when is it anticipated these certifications will be available? See question 20 above.

57. The parity limits restriction of services based on diagnosis. We would expect that the definition of medical necessity will become a more determiner of eligibility. What is DSAMH's position on medical necessity? **Medical necessity is the primary driver for access to services. See the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual for a listing of when authorization is required prior to payment.**

58. For the purpose of this RFP, what is the definition of a "Sub-Contractor"? Does this refer to Fee-For-Services clinicians who are contracted with the agency at a fixed hourly rate? **Yes.**

59. Will RN services be billable under the new fee schedules with the MCO's and Medicaid? **RNs are not a separately enrolled provider under Medicaid. Medicaid MCO reimbursement will be negotiated between the Medicaid MCOs and each provider. This RFP is for non-Medicaid clients, as well as, Medicaid clients who will receive these services via fee-for-service. After January 1, 2015, only Medicaid individuals enrolled in the PROMISE program will receive the services via FFS.**

60. Will Case Management services be billable under the new fee schedule with the MCO's and Medicaid? **No. See question 25. See the public notice at:**

http://regulations.delaware.gov/documents/September2014c.pdf

Note: Case Management services which assist individuals eligible under Medicaid in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan is only available under the PROMISE program. Under ASAM 1.0, when referral and assistance are only reimbursed under this RFP when the following activities directly related to the SUD or SUD/co-occurring treatment and diagnosis are provided:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary has provided permission for such coordination.

If the referral and assistance is provided by a peer, the provider will bill H0038HF. When referral and assistance for gaining Medicaid services is provided by an unlicensed practitioner including licensed registered nurses, the provider will bill H0004HF. Licensed practitioners other than licensed registered nurses will bill CPT codes per the applicable AMA guidance as listed in the services manual.

61. If Case Managers are peers, will they need to be certified for services to be billable? **See question 25 and 60 above. All peers must be certified if billing peer services.**

Note: Case Management services which assist individuals eligible under Medicaid in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan is only available under the PROMISE program. Under ASAM 1.0, when referral and assistance are only reimbursed under this RFP when the following activities directly related to the SUD or SUD/co-occurring treatment and diagnosis are provided:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary has provided permission for such coordination.

If the referral and assistance is provided by a peer, the provider will bill H0038HF. When referral and assistance for gaining Medicaid services is provided by an unlicensed practitioner including licensed registered nurses, the provider will bill H0004HF. Licensed practitioners other than licensed registered nurses will bill CPT codes per the applicable AMA guidance as listed in the services manual.

62. When will we know who the new MCO's are and when will we see the fee schedules for them? **DMMA will make this announcement when negotiations are final.**

63. When will the ASAM Form/Tool be available for use? Where will it be posted? **The Delaware ASAM used through the DSAMH EEU, is currently on the DSAMH web site.**

64. Are the caseload limits fixed for the RN's at 15 individuals and Clinicians at 50 individuals? **For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.**

For all other Level 1 outpatient treatment settings, RFP states "Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation but should not exceed 50 active individuals for each licensed practitioner and unlicensed counselor. For this standard, *active* is defined as being treated at least every 90 days." Level 2.1 intensive outpatient treatment settings require "not exceed 35 active individuals for each licensed practitioner and unlicensed counselor."

65. Section V, COMPREHENSIVE SERVICE ARRAY, STAFFING, Page 16, Item 4. Question. Is the telephone consultation described in this item a billable service? **No.**

66. Section V, COMPREHENSIVE SERVICE ARRAY, OTP, Page 17, Item 2.
Question. Does the caseload restriction of 100, apply to the Medical Director of a federally regulated clinic that provides direct administration of opioid agonists? **For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the provision of opioid addiction treatment with Subutex and Suboxone in SAMHSA certified OTPs does not require a DATA 2000 waiver. Additionally, such treatment is not subject to the 30 and 100 patient limit that applies to individual physicians and group practices providing opioid addiction treatment outside the OTP system under the authority of a DATA 2000 waiver.**

67. Section V, COMPREHENSIVE SERVICE ARRAY, OTP, Page 18 , Item 3.
Question. Does the requirement for at least one RN on site during clinic hours serving no more than 15 patients applicable when more than 15 clients are in the clinic for dispensing only? **For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.**

68. Section VI, CORE SERVICES, Pages 20 and 21, Item 4.
Question. Will methadone also be provided by the DSAMH Pharmacy for the uninsured? If not, what will be the process for the contractor ordering/receiving methadone and will DSAMH reimburse the cost of the medication? If not, who will pay for the medication? **The provider will purchase this directly.**

69. Section VI. CORE SERVICES Item # 4, Pages 20 and 21
Question. How will the costs of medical supplies and laboratory fees be reimbursed to the contracted provider? **The direct costs (staff allocation, supplies, and equipment) of the service were calculated and included in the rates as were indirect costs (any costs of operations not directly involved in providing the service) which were allocated. For**

residential rates, normal laboratory fees related to UAs were included as direct costs. However, to the extent that laboratory fees were separately billed to Medicaid or third-party insurers such as Medicare or private insurers, those costs will continue to be billed to the primary insurance and these fees do not cover those costs. Costs for medications (i.e., Buphrenorphine) would be billed in addition to the residential or outpatient services. See the State Plan Certification and Rate Manual for a list of billable medications.

70. Question. What will be the procedure for obtaining buprenorphine from the DSAMH Pharmacy? If the answer is by physician's prescription, do these prescriptions count against the 100 caseload limitation? **For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the provision of opioid addiction treatment with Subutex and Suboxone in SAMHSA certified OTPs does not require a DATA 2000 waiver. Additionally, such treatment is not subject to the 30 and 100 patient limit that applies to individual physicians and group practices providing opioid addiction treatment outside the OTP system under the authority of a DATA 2000 waiver. For patients receiving buprenorphine from a physician providing opioid addiction treatment outside the OTP system, the prescription would be filled at the pharmacy and the pharmacy would bill DSAMH. In these cases, the patient would be included in the patient limit applicable to the prescribing physician.**

71. Section VI, CORE SERVICES, Entitlements and Insurance, Page 21 , Item 5.
Question. Currently the costs of methadone and suboxone dispensed orally are not billable to Medicaid. Additionally, an administrative fee (dispensing fee) is not billable to Medicaid for suboxone dispensed orally. Will the costs for these medications and an administrative (dispensing) fee be reimbursed by DSAMH for Medicaid eligible clients if Medicaid does not reimburse these costs? **Medicaid codes will be available for the costs of and administration of suboxone. See the State Plan Certification and Reimbursement Manual.**

72. Section VI, CORE SERVICES, page 22 #15, Medical Services.
Question. The last sentence is incomplete. Will DSAMH provide the rest of the directive in this sentence? **General Medical Services – Coordination of medical and psychiatric services with local primary care providers will be required to support improved access to medical care for clients with identified health conditions. It is expected that the provider will more closely integrate and coordinate general medical care for those individuals receiving general medical care through a Federally Qualified Health Center.**

73. Section VI, CORE SERVICES, Item 18.

Question. Will DSAMH continue to employ peer specialists? **Yes for care management in PROMISE only.** If not, what is the rate of pay (hourly or salary) and how is the contractor expected to incorporate this salary into proposed budget on a fee for service payment structure? **Recovery Specialists for SUD are core services and the contractor is expected to incorporate this salary into the proposed budget and bill appropriately under the HCPCS codes as outlined in the attached services manual for services rendered.**

74. Section VII, FUNDING and PROGRAM CAPACITY, Page 23.
Question. Staff available by telephone is a requirement in this section. Will these be billable services even though no face-to-face client service is provided? **No.**

75. Section XII, page 29, last paragraph.
Question. "Preference will be given to bidders who have successfully developed an interface to an EMR system." Will DSAMH include in budget or amend contract to include cost of software at the later date? **No.**

76. The RFP stated the payment structure would be available at the pre-bid meeting, but was not. When will the reimbursement rates be available? **The Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual was posted to the website.**

77. Roseanne instructed the attendees of the pre-bid meeting to develop proposals using the current standards because the standards had not been revised and released as of that date. Is this an accurate directive? **Need to utilize the standards in the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual.**

78. If bidders are to use the current standards, will DSAMH provide a definition for QHP and QHP Supervisor since there is no definition in current standards? **Please refer to the definition in the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual.**

79. Where can the potential bidders find a list of the approved procedure codes and the associated fees? **The Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual was posted to the website.**

80. There is reference in the RFP and during the bidders meeting to a new set of licensure standards that are expected to be released. Without a release of new standards bidders are forced to write a proposal based on the current standards which, in many instances, will create a proposal that may not be what DSAMH is looking for. Can DSAMH provide direction to reconcile this? The **Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual was posted to the website.**

81. Has DSAMH considered delaying the due date of this RFP or offering a cost reimbursement payment model given the bidders do not have access to the new licensure standards or proposed fee schedule? Both of which are cornerstones of any program development. **Yes, the bid opening date has been rescheduled to October 2, 2014**

82. What level of commitment is expected for services provided at the HOPE Commission and will there be any guarantee of clientele or reimbursement given the financial exposure in a fee-for-service model? **No guarantees for clients or aggregate reimbursement will be given beyond the fee schedule in the attached services manual. The provider is not expected to provide services to individuals from HOPE without reimbursement. They will offer the same services as offered to all OP clients and be reimbursed in the same manner. This can be more fully discussed either in contract negotiations once the contract is in place.**

83. If there is more than one provider for New Castle Co will all providers will be required to provide services for the HOPE Commission? **We do not anticipate a large volume, but that is currently unknown. In addition, we do not yet know the geographic distribution of these individuals, nor their clinical needs. This will be rolled out slowly to in order to better assess the need.**

84. Can you define geographic areas served? Does that refer to the immediate area where the proposed facility will be or the areas we expect the potential clients to reside? **We are looking for at least 3 programs, one in each of the Counties, but will consider more. We do not yet know the number of respondents, and we do not know what combinations of OP services each will propose. Each of these factors will influence our final contracting decisions.**

85. Will it be acceptable for a bidder to propose ASAM Level 1 – without OBOT? Page 13 does not list that as an option. Can an OTP have OBOT program? Page 16 states must be imbedded in level 1. **Yes, this can be proposed.**

86. Can you define "appropriately licensed staff" as referenced on page 16 related to QHP? **The Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual contains the definition:** A QHP includes the following professionals who are currently registered with their respective Delaware board LCSWs, LPCMH, and LMFTs, APNs, NPs, medical doctors (MD and DO), and psychologists.

87. Page. 17, #3 states, Physical exams by program physician, PCP, or an authorized healthcare professional. Can you define an authorized healthcare professional? **See the Delaware Adult Behavioral Health Medicaid State Plan Service Certification and Reimbursement Manual including APRN or physician assistant licensed to provide physical exams under their scope of practice as defined under Delaware law.**

88. Can you clarify the statement on page 18 about RN & LPs- 1 staff per 15 patients **For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.**

89. Also on page 18 there is a requirement for 1 full time employee for referral arrangements. How does a provider get reimbursed for the time associated with this position? Will there be a reimbursable code related to this that DSAMH and the MCOs will utilize? (P. 18, #5) **Yes, this is reimbursable under the HCPCS codes for that service. See the attached manual. For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing**

patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.

90. Page 20, #6 refers to the need for an "Addiction-credentialed physician". This is not in the current licensure standards? Can you please provide clarification? **An ASAM Level 2.1 IOP setting should have access to an addiction-credentialed physician. These physicians should be certified by ASAM (prior to 2009) or the American Board of Addiction Medicine (ABAM). NOTE: In 2009, ASAM transferred the certification examination to ABAM. ABAM certification is open to physicians from all specialties who are board certified by an American Board of Medical Specialty (ABMS) member board or who have completed an Accreditation Council for Graduate Medical Education (ACGME) -accredited residency, and who meet ABAM's additional criteria to sit for and pass the ABAM certification examination. The term Addiction Credentialed Physician also applies to an Addiction Psychiatry certification bestowed by the American Board of Psychiatry and Neurology (ABPN).**

91. If an application is submitted for OTP only is their still an expectation to treat co-occurring with SM and SPMI? Are you asking if the program can exclude individuals with a co-occurring MI diagnosis? No. If the program submits only for an OTP, they must describe how they will provide services to a range of individuals, including someone with a MI diagnosis. In staffing section there is no case load restriction for OTP programs. Will an OTP only program be required to follow a 1 and 50 caseload requirement?

For the OTP programs, the State Plan Certification and Reimbursement Manual will be updated to clarify that the intent was not to radically change the current Opioid Treatment Program (OTP) model. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates. OTPs are allowed to develop staffing for their proposal with these regulations in mind and should have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have

reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.

It should be noted, however, that when OTPs adopt the recovery-oriented systems of care philosophy, their primary responsibility of dispensing medication on site to treat opiate addiction expands to include supporting patients' recovery within their own environment. In addition to forming long-term partnerships with patients and their families, other service providers, systems professionals, and community groups, recovery-oriented OTPs involve patients in all care decisions and help them identify and select the services and support they need at any point in the recovery process. The treatment program takes appropriate therapeutic measures to address the other problems identified in the treatment plan."

92. If an applicant wants to provide Core services (9 - 19) in the OTP will they have access to funding to provide the addition services? **Yes.** If no how will co-occurring opiate addicted individuals receiving methadone access these needed services?

93. Is OTP considered Level 1 and if so why do only items 1-8 apply on page 20? **This section of the RFP lists Core Services for all ASAM Level 1 outpatient programs. However Opioid Treatment Programs (OTPs) are not required to provide all of the listed Core Services given the unique structure and role they have. However, Office Based Opioid Treatment programs and other ASAM Level I outpatient programs must meet this expectation.**

94. Can you provide the number of individuals currently on a commitment that would necessitate court hearings that DSAMH expects to receive services in one of the service levels contained within this RFP? (P. 22, #14) **There are currently 32 individuals on commitment through the 3 DSAMH managed CMHCs and the program managed by Horizon House. This number has been dropping over the past two years and we anticipate it dropping further with the advent of the Commitment Statute.**

95. Will there be a reimbursement for attending Civil Commitment Status hearings? If not how are providers going to afford to send a psychiatrist? **DSAMH will consider this as part of the negotiations with the successful vendor(s).**

96. This RFP does not allow for subcontracting. How does this relate to contracted physicians given the lack of physicians with "X" numbers available to provide OBOT? **Contract physicians are allowed.**

97. Can you give direction regarding the expectation for UDS related to the criminal justice system? (P. 21, #7) UDS can be a major cost driver especially in a fee-for-service model and can greatly change the proposal. **Reimbursement is based on medical necessity criteria – DSAMH will discuss this during negotiations with the successful vendor(s).**

98. How does a provider get reimbursed for the time associated with entitlements and insurance assistance? Will there be a reimbursable code related to this that DSAMH and the MCOs will utilize? (P. 21, #5) **This is an indirect activity that was built into the rates and isn't directly reimbursable.**

99. What level of involvement is mandated related to the P&T Committee? (P. 22, #12). **This Committee meets quarterly. The program can determine who attends, as long as that individual can represent the program and its prescribers in addressing issues about formulary, possible prior authorizations, etc.**

100. How does a provider get reimbursed for the family session without client present and CJ liaison services? Will there be a reimbursable code related to this that DSAMH and the MCOs will utilize? (P. 22, #17). **So long as the visit is medically necessary and for the benefit of the client, there will be codes for family sessions without the client present in the service manual**?

101. Does a bidder have to provide location and building information if the proposed program will be located in an existing DSAMH-licensed location? (P. 33). **Yes.**

102. On page 15 when discussing the recovery environment it states "willingness to obtain such a support system in two months including 12 step sponsorship that is specific for the issues they …" Why is there a two month time limit on this? Does this include MH conditions as well? If not why is it there for SU? This is not indicated in ASAM. **It could be revised to say: Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary, or social support system but has demonstrated motivation and willingness to obtain such a support system (e.g., 12 step sponsorship) that is specific for the issues they are dealing with and is approved by their recovery team. Note: 12-step programs are not reimbursable by Medicaid.**

103. In programs with mixed payer population how will Core Service Requirements be funded (#17, #19) i.e. TASC clients with Medicaid, TASC clients with BCBS**. Providers should bill private insurance first, then Medicare, then Medicaid. For**

uninsured individuals, Individuals without a benefit will be billed through DSAMH after the sliding scale copayment is applied.

104. Is the CJ including TASC aware that this RFP covers uninsured clients only? **Providers should bill private insurance first, then Medicare, then Medicaid. For uninsured individuals, Individuals without a benefit will be billed through DSAMH after the sliding scale copayment is applied.**

105. PG 24 In the QA section "identify core performance measures for each level of service"? Are we to assume that the overall QA section would include items related to each level of service being proposed (Level 1, OTP, OBOT**…) yes, but each service does not need to be treated as distinct units. For example, one measure might be hospitalization of all admitted clients, employment, housing, meeting treatment goals, successful transition to a lower level of care with "success" define.**

106. The RFP discusses the need to submit staffing attendance information. What is the relevance of this request and in what format? **Staffing attendance information may be reviewed as part of an audit or financial review. The information must be kept on hand but will not be routinely submitted unless specifically requested.**

107. What sections of the RFP and proposal will be considered for the "capacity to meet requirements" scoring section? **Experience with the services proposed; credentials of any staff identified; accessibility of the proposed site location, etc.**

108. Does the bidder have to define static and dynamic capacity based on payer to illustrate the percentage of treatment slots that we expect to be filled by individuals being reimbursed by this RFP? **No, this is not needed.**