DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

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Commissioner

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Project SAFE Family Recovery
Request for Proposals
#190827005

Questions & Answers

1.	**With the (SAFE-FR) teams being funded, is the expectation that as much of the treatment and support happens by that team within the Area Office, under a license?**
	SAFE Family Recovery is comprised of 3 evidence-based practices: a screening protocol, an engagement intervention and recovery support. Substance use treatment services will be provided by community treatment providers as they are now, but not through a Project SAFE referral. The current Project SAFE program model will be transitioned to the SAFE Family Recovery program. The Department's expectation is as follows: ➢ Screening and Brief Intervention and Referral to Treatment (SBIRT) and toxicology screen (if warranted) occur in the DCF Area Office or a provider location; ➢ Multi-dimensional Family Recovery (MDFR) may be delivered in the home, community and/or provider location; ➢ Recovery Management Check-ups (RMC) may be delivered in the home, community, provider location, and/or using technology.
2.	**If there is follow-up care (indicated), is that (care) directed to existing outpatient providers or will that be provided in a different way?**
	Referrals for substance use treatment and other services will be directed to community treatment providers as they are now. It is the Department's expectation that should follow-up care/treatment be indicated, the provider will make such referrals and make every effort to engage the client in treatment.
3.	**Is the design (of SAFE Family Recovery) such that the majority of the work for SAFE-FR is done by the provider at the DCF office? For ECCs, a satellite location is not an ECC and there is a reduction in reimbursement.**
	See Question #1.
4.	**Are drug and alcohol testing expected to be provided in the Area Offices?**
	See Question #1.
5.	**Are you looking for quick reads (drug testing)?**
	Yes, the primary method of toxicology testing will use quick read "instant" toxicology testing so that recommendations/results can facilitate prompt referrals by DCF or SAFE-FR staff for evaluations and/or other services, although providers should possess the capability to provide more comprehensive testing, on occasion, at the request of the Department. Providers will also be expected to purchase a breathalyzer kit and to be able to conduct hair testing.
6.	**Will there still be a centralized network manager?**
	No. The centralized network manager under the current Project SAFE model will end.
7.	**Is MDFR reimbursable?**
	MDFR delivered in home and community settings is not reimbursable by Medicaid or other third party insurance companies in CT at this time. However, the Department is committed to partnering with the Department of Social Services to maximize third party reimbursement for all of its appropriate services.
8.	**What is the SBIRT fee schedule? Who can bill?**
	See the following for SBIRT reimbursement information: http://www.ct.gov/dmhas/lib/dmhas/publications/SBIRT-PB_2015-79.pdf Please note that at this time SBIRT services provided under this contract are not eligible for 3rd Party reimbursement (see Question 31).

9.	**Because there is a requirement for teams to be placed in AOs, will the region work with the selected provider to determine staffing in the region (based on volume)?**
	The first year will require collaboration between the SAFE Family Recovery team and DCF regional staff to address staffing co-location at the DCF office within each region. Currently DCF anticipates about 780 SBIRTs annually by region, with volume varying by area office.
10.	**Do you want a (SAFE Family Recovery) staff member in the DCF offices 8a-5p, M-F?**
	Not necessarily. The contractor will work with the regional office to determine the days/times when SAFE –FR staff are needed on-site.
11.	**To whom are providers reporting client engagement in services?**
	Providers will provide individual family reports directly to Area Office Social Workers and also enter date into the Provider Information Exchange (PIE).
12.	**Has every Area Office identified adequate space?**
	DCF Area Offices are currently in the process of identifying space. There may be some exceptions in some of the offices with limited available space.
13.	**Is DPH aware of the need for these licenses?**
	At this time, the staffing qualifications requested through this RFP do not meet the standard for billing requirements. Therefore, while the Department's vision remains as it is detailed in the RFP, in order to implement these services in a timely manner, providers will not be eligible to bill for services rendered on-site at a DCF Area Office and DPH licensure of the office space will not be required at this time.
14.	**Can proposal dates be adjusted to space out the deadlines of multiple RFPs?**
	The timeline for this RFP will remain as it is described on page 5 of the RFP.
15.	**Since the RFP says up to $421K of funding (per DCF region), do you expect contractors to come under the maximum amount?**
	The RFP allows respondents flexibility in developing a budget proposal for this program, up to a maximum of $421K. The Department expects applicants to submit a budget, including one that may be less than $421,000 if warranted based on the applicant's program design.
16.	**Will training be provided in MDFR?**
	Training for MDFR, and all components of SAFE Family Recovery, will be provided during the first 90 days of implementation and on an ongoing basis thereafter
17.	**In what format electronic are we required to submit proposals?**
	OPM requires an electronic submission. It does NOT replace the hard copies. You must submit the hard copies. The electronic proposal should be submitted in PDF format, to the Official Contact for this RFP, as described on page 6 (Section I.C.10) of the RFP.
18.	**In the current Project SAFE, ABH pays for some services occasionally. (e.g., Clients who do not want to use insurance) Will that continue?**
	No, the Department will be funding only SBIRT, MDFR, and RMC.
19.	**Are Letters of Agreement or MOUs allowed? Are they required?**
	You may submit LOAs and/or MOUs. If you do submit them, place them in your response as an Appendix 10. They are not required, but they could answer questions about the relationship/commitment if subcontractors mentioned in your proposal. A writeable version of the proposal outline, with the added Appendix is available on the State Contracting Portal.
20.	**Can you provide list of PS providers?**
	A current list of PS providers can be found at the following website: http://www.abhct.com/Customer-Content/WWW/CMS/files/Project_Safe/PS_Providers_-_Updated_8_23_18.pdf
21.	**Can you provide list of attendees to this bidder's conference?**
	Yes, this list has been posted on the State Contracting Portal.
22.	**Will the TOC be modified to make space for the Letters of Agreement/MOUs?**
	Yes, see Question #19.

23.	**Can you clarify what is meant by “normal” margins?**
	In Microsoft Word, “Normal” is one-inch margins.
24.	**This RFP allows for subcontractors. Are you looking for one entity to subcontract throughout the state?**
	DCF does not have a preference for a single entity to serve the entire state. Respondents are encouraged to propose the approach that best meets the requirements of the RFP and the clients served.
25.	**Can you please supply data regarding the estimated demand for service in each DCF office**
	Anticipated annual capacity per region is: ➢ SBIRT = 780 ➢ MDFR = 135 ➢ RMC = 120 These numbers are not based on anticipated number of <u>referrals</u>. They are calculated on clients who have <u>completed the service</u>. Although a client can receive a mix of any of the 3 service types, each SAFE-FR Service is counted as a stand-alone service. For example, Client #1 is referred for all 3 services, and completes only SBIRT and MDFR. In the calculations above, this counts as 1 SBIRT slot and 1 MDFR slot.
26.	**If all of our audits are on the EARS system, do we still need to include a copy of our most recent audit?**
	No. The proposal should simply indicate that copies of audits are available on the EARS system.
27.	**Can flex funds be included in the budget?**
	The RFP allows respondents flexibility in developing a budget proposal for this program, up to a maximum of $421K, but funding, once implemented, is not subject to change. DCF flex funds are not available for this service.
28.	**Which licenses are required for this contract?**
	A CT Business License is a requirement, but any other licensure is dependent on the components of the proposal. Clinical licensure may be required if the applicant is proposing such services. Zoning and/or Certificates of Occupancy might be required if services are heavily dependent on non-DCF program locations. Licensure should be proven in the proposal for any services proposed that would require licensure.
29.	**Which services are required to take place at the DCF offices and during which hours of operation are they required to work from the DCF offices?**
	The SBIRT with toxicology is expected to occur on-site at DCF offices but may be conducted in the community (e.g., at provider clinics) if it is preferred by or more convenient for clients. The contractor will work with the regional office to determine the days/times when SAFE –FR staff are needed on-site.
30.	**What agency will be conducting the QA portion on the treatment models incorporated in this RFP?**
	MDFT International will provide training and QA for MDFR. Chestnut Health Systems will provide training and QA for RMC.
31.	**Is SBIRT reimbursable by Medicaid under the provider type Clinic/Mental Health and/or DCF when conducted by a Bachelor level staff, and if so what is the reimbursement?**
	No. At this time, in order to be reimbursable, the SBIRT must be conducted by an MD, APRN or a PA.
32.	**Is MDFR reimbursable by Medicaid under the provider type Clinic/Mental Health and/or DCF, and if so what is the reimbursement?**
	No. See question #7.
33.	**Understanding that clients have choice when referring to treatment, is there a cap on how many clients can be referred to the successful bidder’s own treatment programs?**
	No, there is not a cap. The expectation is that clients will be offered and referred to programs of their choice that will meet their needs. Providers are not prohibited from <u>offering</u> treatment through their own programs. DCF will review referral data (to substance use programs) and performance measures to ensure this expectation is adhered to.
34.	**Out of the 780 assessment expected for SBIRT, can you give an estimate of how many clients would need substance abuse treatment?**
	Clients referred for SBIRT will have indicators of substance use/misuse with impact to their parenting. It is expected that some clients will decline services and others will be recommended for treatment, brief intervention, or no treatment. DCF will be using the first year of data to better inform actual need for services.

35.	**Can you give us a breakdown by city/town within each region where Project SAFE clients resided in FY18?**
	At this time, there are no Project SAFE reports with a breakdown by city/town.
36.	**For staff located in the DCF offices, will they be provided a computer and printer as well as space to conduct assessments?** **What is the frequency of the training throughout the year in case staff turnover?**
	For staff located in DCF offices, space will be provided for assessments and for drug testing, but DCF will not provide a computer. Applicants should plan to equip their staff with laptops or some other form of electronics to ensure their performance of on-site services at the DCF office. In cases of staff turnover, training will be available by the model developers.
37.	**Will it be a straight pro-rata of funding with a December start, 7 month year of the annual funding?**
	Not necessarily. To some extent, funding for the remainder of SFY 2019 will be subject to negotiation with each provider, based on implementation dates and when the program will be fully available for use. While the base funding will be pro-rated for a 7 month period, this amount may be adjusted to ensure the continuity of services to the existing population during this transition.
38.	**For the Letter of Intent, are you expecting a separate letter aside from the one-page template that was posted?**
	No.
39.	**While the minimum education level for the MDFR Specialist is bachelors, are you anticipating that we would be hiring masters level staff for this position?**
	The educational requirements for the MDFR Specialist are found on page 19 of the RFP. It is expected that providers will determine the best candidates for the positions following the minimum requirements for the position.
40.	**At the bidder's conference, it was stated that DCF would be providing training on the models used under this program. Can you please clarify which models grantees would receive training on, and what models grantees would need to seek training on separately?**
	DCF will provide initial and ongoing training on SBIRT, MDFR, and RMC. See question #16.
41.	**Is it expected that the grantee obtain an MOU/MOA with existing Project SAFE providers in the region?**
	The RFP does not require an MOU/MOA with existing Project SAFE providers.
42.	**What exact information/data is to be tracked by the providers? Can you provide the exact data outcomes expected for each service track? Are the caseloads or screening numbers expected to change year to year?**
	This is currently under development and will be finalized at the time of contract negotiation. Caseloads for screening may change year to year.
43.	**Can you identify specifically what services are billable to Medicaid and what services are grant covered? How might charting be expected to be handled for those services that are billable (i.e., following Medicaid regs)?**
	At this time, SAFE-FR services: SBIRT, Toxicology, MDFR, and RMC will not be billable under this model. The Department envisions that eventually this model will evolve to include billable services on-site at DCF Area Offices, but initially, within the Department's current resources, these services will not be eligible for third party reimbursement. While acknowledging and encouraging client choice in treatment, the Department also believes that many clients assessed to be in need of subsequent treatment services will choose to utilize the provider's treatment array, which will then allow the provider to bill for treatment services provided.
44.	**Is there a plan for relief staff should any of the team members need to be supported, or if it is discovered that more staff is needed to address demand? Would this be the responsibility of the agency to manage or will there be financial support for this process if required?**
	Contractors are expected to maintain capacity at each individual program as noted in the RFP.
45.	**As noted in the TA, the drug/alcohol screening process will remain the same, so curious as to what kind of drug screening cup is to be used? Will that be the same or is there flexibility with the screening cups, and, further, whose responsibility will it be to purchase the cups? Are any other materials required and who is responsible for supplying them?**
	Currently designed Project SAFE/RSVP/RCM services will be transitioned to the services as described in the RFP. DCF is in the process of identifying a lab vendor to be used for SAFE Family Recovery services. Once identified, it will be the responsibility of the provider to purchase the cups. All contractors will use the same screening process and materials for SBIRT. SBIRT may include a referral to community behavioral health treatment providers. Toxicology for those clients will be dependent on each

	community behavioral health treatment provider.
46.	**Are any staff required to be bilingual?**
	The team should be comprised of staff that meet the cultural and linguistic competency needs of the communities served. See page 22 in the RFP, which states that at least 1 MDFR Specialist must be bi-lingual Spanish Speaking.
47.	**How might we think about billing when all positions are expected to be Bachelor level with the exception of the supervisory role?**
	See Question 43.
48.	**The RFP notes that Medicare may not reimburse for screening services--who would be responsible for that if that is the case? Further, what happens when the person has no insurance coverage at all?**
	It is the Department's current expectation that it's funding provided as a result of this RFP will cover the costs of all screening and on-site toxicology testing.
49.	**Regarding DPH licensure, is each site expected to have only an addiction license or is the expectation that the licensure be for both mental health and substance use services?**
	See Question 13.
50.	**Is client transport required by staff? If so, how?**
	Transportation arrangements should be facilitated by the contractor for MDFR and RMC. Arrangements may consist of: coordinating with DCF staff, schedule with med cab, use of natural supports, transport client directly, among others. Budgets, where practicable, may include one-time costs to obtain a vehicle to support staff.
51.	**Are there any obligations or expectations for staff related to court?**
	Staff are expected to attend court activities as requested for the purpose of supporting the client.
52.	**Can you please put in writing which DCF offices these teams will be placed in (and if possible, clarify what is or isn't required for 'sub-offices' of the main DCF office to have licensed sites in them too)?**
	Applicants should plan a presence in each of the 14 DCF Area Offices. In the event that a specific Area Office is unable to allocate space for the co-location of SAFE FR staff, alternatives will be negotiated with the chosen provider for that Region.
53.	**Will each office have a designated testing facility (with a bathroom where the testing can be observed)?** **How should we think about chain of custody for testing that has to be sent to the lab? Is there a preferred lab provider or may agencies select their own?**
	Yes. See Question 45.
54.	**We understand that CPT codes 99408 and 99409 will be used to bill Medicaid for SBIRT Services by Physicians, APRN's, Nurse Practitioners, and Physician assistants. Is the Department aware of CPT codes for behavioral health professionals (e.g., licensed Master's level clinicians) that Connecticut's Medicaid program will pay for?**
	See Question 43.
55.	**Will DCF provide office furniture for the DCF-located staff office OR do we put this court cost in the grant?**
	Standard office furniture will be provided.
56.	**Will our staff located at DCF have access to office machines (such as copiers)?**
	See question #64.
57.	**Will our staff located at DCF have access to the Internet?**
	See question #64.
58.	**Will our staff located at DCF have access to parking?**
	DCF will do its best to allocate a parking space in each Area Office for SAFE FR staff, but cannot guarantee such at this time.
59.	**Can the SAFE (FR) program pay for incentives?**
	The RFP allows respondents flexibility in developing a budget proposal for this program, up to a maximum of $421K.

60.	**Can software costs (for our Electronic Health Record) be included as part of the budget?**
	Yes.
61.	**Can we put purchasing costs for food and water in the budget?**
	Yes.
62.	**In order to adhere to DPH Licensing requirements (and get reimbursement), the supervisor should be a licensed social worker but the RFP says that the supervisor only needs to be an MSW. Please advise.**
	See Question #43.
63.	**Will there be any cost to us to locate our staff in DCF's office? DCF will provide desks, space, etc.?**
	Standard office furniture will be provided. See question #64.
64.	**We ordinarily budget for staff to work with cell phones and HIPPA-compliant computer tablets, utilizing a secure Verizon network for email, our electronic health record system, and other needs, and cell phones for primary phone usage. Will DCF provide a fax for staff? Do we need to purchase computers that would be hard wired to another internet system, or furniture, or anything else?**
	This is DCF's preferred model for provision of equipment for staff co-located in Area Offices. DCF will not provide a dedicated fax and providers will not be allowed to hard wire computers into the DCF mainframe.
65.	**For services not provided in DCF offices, will you expect us to provide other office space, or will services be provided in client homes? (p 21. C)**
	See question #1.
66.	**If we are using subcontractors, we should complete form 3, page 30, and then include this amount as a line in our larger budget? If so under what line?**
	Yes. Funding for any sub-contracted services should be included in the Consolidated Budget Form, under the 300 Series.
67.	**Are there any reports or evaluations about prior Project SAFE, or similar work, that we can review?**
	At this time, there are no Project SAFE reports on the 3 service types of this RFP.
68.	**Will there be an updated budget form, or should we use this one, downloaded today from the state web site -- not a direct link from the RFP but accessed under "contracting documents"?**
	The path to the Consolidated Budget Form for use with this RFP is as follows: 1. From the DCF homepage, choose the 'For Providers' link from the left hand menu. 2. From the 'For Providers' link, choose the 'Contract Management' link from the center menu. 3. From the 'Contract Management' link, choose the 'Forms and Instructions' link from the center menu. 4. From the 'Forms and Instructions link, choose the 'Consolidated Budget Forms' document from the center menu.
69.	**What is the annual number of families served for the entire contract year, broken out by component – ie. RMC and MDFR? Is it 120 for the RMC and 135 for the MDFR? Do you expect that all families served will receive both components (RMC and MDFR)? If so, how would the staff serve the annual target population projections, given that RMC has a caseload of 30 clients/staff x 2 cycles/year (receiving an average of 6 months of service) x 2 staff (total N=120) and MDFR has a caseload of 15 client/staff x 3 cycles/year (4 month length of stay) x 3 staff (total N=135)? Would 15 families not receive MDFR?**
	See question # 25.
70.	**Is the attached budget form (accessed today on the state web site) the correct one to use?**
	See Question #68.
71.	**Can you confirm that SBIRT services as outlined in the RFP are eligible for third-party reimbursement? Are Recovery Support Specialists at a Psychiatric Outpatient Clinic for Adults working under a Masters-preferred supervisor actually eligible to provide SBIRT services? How will SBIRT services provided in this way meet Medicaid's "reasonable and necessary" or medical necessity criteria?**
	See Question #43.