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October 11, 2017

ADDENDUM #1

RFP # 7565508

Title: Behavioral Healthcare Link

Bid Closing Date & Time: October 24, 2017 at 10:00 AM Eastern Time (ET)

Notice to Vendors

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES. NO FURTHER QUESTIONS WILL BE ANSWERED.

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Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Vendor Questions for RFP # 7565508 Behavioral Healthcare Link

Question 1: How much money is available to be awarded under this RFP?

Answer to question 1:

The budget for the project is not available. Vendors are encouraged to offer their lowest competitive pricing.

Question 2: What will be the average amount awarded?

Answer to question 2: Not available

Question 3: Will only one vendor be chosen, or will there be multiple vendors?

Answer to question 3:

State is ideally looking to choose one vendor but will look at all options including one lead vendor with subcontracts.

Question 4: Is a fiscal match required?

Answer to question 4:

While No match is required vendors will be expected to maximize third-party billing (both commercial and public) for all billable expenses or services. It is clear that some services would not be billable through third party payors, but it is the State's expectation that third-party billing will be used to the extent possible to allay costs.

Question 5: Are you expecting that the selected agency will "take over" the Samaritan Suicide Hot Line?

Answer to question 5: No

Question 6: Will the current state detox contract and funding become part of this program?

Answer to question 6:

Yes, if the vendor does not have the capacity to provide this service they would be expected to subcontract with a vendor that does have this capacity.

Question 7: Are you expecting that there will be a full-time psychiatrist **onsite** 24/7 so that they are able to respond within 10 minutes of request? Ten minutes??? That will be quite expensive. Will you consider using PCNSs or APRNs for 10-minute response time and consulting psychiatrist available 24/7 either for consultation or to respond onsite within one (1) hour?

Answer to question 7:

To clarify, a full-time psychiatrist will not be required on site 24/7. We will consider using PCNSs or APRNs for 10-minute response time and a consulting psychiatrist available within a negotiated time requirement. Telemedicine will also be considered.

Question 8: What kinds of medications are you expecting to have onsite so that 100% of persons who need it will receive it?

Answer to question 8:

To clarify we are looking for a vendor who has the capacity to prescribe. If you are proposing to have medications on site, please inform us what your policies and procedures are for any medications that you may stock.

Question 9: Are there any State laws or police/rescue/EMT/first responders policies/ specifications/rules that would prohibit them from bring persons in crisis from the community to the BH Link site for triage, assessment, disposition/discharge planning?

Answer to question 9:

All state agencies are currently working on revising and reducing all regulations. In addition, BHDDH will work with other state agencies such as the Department of Corrections, EOHHS, the Department of Health, police, fire and rescue to assure that transportation to Behavioral Health Link is not inhibited.

Question 10: Page 7 of the RFP cites the Truven study's discussion of Rhode Island admission rates. The Truven study described 2013 data. Is more recent data available? This relates to the end outcomes described on page 8. What is the current gap between Rhode Island admission rates and national figures? If the state is successful in reducing rates by 3%, does this refer to 3% change per year? How many years might it take to close the gap between national and Rhode Island admission rates?

Answer to question 10:
The most current data has not been analyzed. We welcome any analysis provided in response to this RFP.

The 3% target is for a total reduction during the initial contract period, not a cumulative change per year.

Question 11: If a desired outcome of this program is to increase access to community-based services (page 8), wouldn't an alternative approach be to increase availability of alternative crisis services in more communities?

Answer to question 11:

The expectation is a coordinated centralized approach with at least one physical site. Multiple sites would be welcomed, but the dispatching of services and the response to crises should be coordinated through one dispatching function.

Question 12: Does this RFP anticipate one "centralized" center?

Answer to question 12:

The function needs to be centralized and coordinated at one site.

Question 13: The RFP notes that the "successful vendor must be fully licensed" by BHDDH (page 8). What level of licensure will be required?

Answer to question 13:
A current license with BHDDH. Other applicants will have the opportunity to apply and meet BHDDH licensing standards within 60 days of award.

Question 14: Page 9 discusses a "hospital affiliation mitigation plan" that seems to be directed at prospective providers who are affiliated with a hospital system. Please define "hospital affiliation." Some prospective bidders may have relationships with hospital groups that do not rise to the level of formal affiliation.

Answer to question 14:
Any affiliation with a hospital that disincentives community-based interventions for crises or incentivizes Emergency Department interventions (i.e. meets individuals in crisis at the ED) would need to address the requirement for a hospital affiliation mitigation plan as described in this RFP.

Question 15: Should a "hospital affiliation mitigation plan" include arrangements and relationships with hospitals that are not part of the bidder's hospital group? Will the State be able to take any steps to ensure that hospital outside of a successful bidder's hospital group act in ways that support the goals of this project?

Answer to question 15:

We cannot dictate the arrangements and relationships with hospitals that are not part of the bidder's hospital group. However, BHDDH will continue to work with DOH, EOHHS, managed care and BHDDH regulations and certification requirements to facilitate BH Link staff's access to individuals in crisis regardless of BH Link or the client's other service provider's hospital affiliations.

Question 16: Page 9 encourages applicants to consider texting applications as part of their plan for this program. Please provide general examples of applications that are compliant with HIPAA and 42CFR.

Answer to question 16:

The state cannot suggest a particular provider in the competitive bidding process, however, this type of service can easily be researched by vendors responding to this RFP.

Question 17: How does this RFP anticipate individuals will be transported to the BH Link? State regulations require EMS to transport individuals to the closest emergency department. Should bidders build in capacity to serve individuals who "walk in" to the BH Link?

Answer to question 17:

Yes, the vendor should have the capacity to accept all referrals including walk-ins. BHDDH has already piloted an alternative location for first responders to transport individuals to for substance use crises and will build upon those efforts to expand these procedures throughout the state.

Question 18: Page 9 discuss the requirement to track individual's participation in services for 30 days post discharge. Will this be limited to self-reported information? How often will tracking be required within this 30 day window?

Answer to question 18:

It is the expectation that BH Link will link individuals to needed services and track their engagement and follow-up with those services for 30 days. Please tell us your plan for tracking and follow up.

Question 19: Page 9-10 discusses "23 hour observation beds." How is the RFP defining this term? Is this term being used in the same way as it is defined in Medicare with the same staffing requirements?

Answer to question 19:
This program is not required to be licensed as a residential program and therefore not required to have the Medicare staffing requirements. However, it is the expectation that individuals accessing BH Link services will be linked to appropriate services along the full continuum of behavioral healthcare. Their length of stay at the program should be individualized based on need and time required for stabilization. Some clients may require a higher level of service than the program provides.

Question 20: How long are individuals anticipated to stay at the BH Link?

Answer to question 20:
Not a residential facility. It should provide, screening, assessment, and referral to or treatment and linkages to the right level of care within 23 hours. The length of stay is individualized based on client need (see above).

Question 21: Regarding all performance targets, what are this RFP's volume expectations, including volume expectations for observation beds? It is not possible to budget for staffing without that information.

Answer to question 21:

We are expecting to see start-up funding until an appropriate capacity has been reached. This capacity could be increased if the program is successful.

Question 22: Is it expected that Mobile Service Crisis Teams will be made available statewide or 24/7? If not, what is the scope and anticipated schedule of this component of the program?

Answer to question 22:

We are not expecting a 24-hour mobile treatment team. We are expecting coordination with other teams statewide for immediate access and treatment. We also expect the mobile outreach to be within a reasonable geographic distance from the location of BH Link's main walk-in facility.

Question 23: Is it anticipated that the BH Link will be able to bill for some categories of services? If so, what categories now have billing codes and for what services will the successful applicant need to work with Medicaid and insurers to open new billing codes?

Answer to question 23:

Yes. Existing billing codes should be used for services. For example, billing for crisis assessment.

Question 24: What is the call volume for the existing Help Line? Is the line staffed 24/7?

Answer to question 24:

The line is staffed 24/7. Latest data indicates about 30 calls per month

Question 25: What is the call volume for the Suicide Hot Line?

Answer to question 25:

From November 1, 2016-August 31, 2017, 630 calls were dialed to this number

Question 26: Regarding the management of the substance use residential and detox wait lists, is there any requirement that service providers provide bed availability?

Answer to question 26:

Yes. Initially weekly updates until the state has transitioned to a real time daily notification system.

Question 27: What are the anticipated staffing levels for: a) managing the waiting list for substance use residential treatment beds, b) managing the waiting list for recovery house beds, and c) managing the state detox program?

Answer to question 27:

The vendor should consider proposing two staffing patterns, one for start-up and one for when capacity is reached or utilization is maximized.

Question 28: Regarding the performance targets on page 11 requiring individuals receiving services within 10 minutes, how will this be tracked given that most EHR systems do not track client requests with a minute-by-minute time stamp?

Answer to question 28:

Will need to be developed with successful vendors.

Question 29: The performance target that 100% of individuals needing emergency medication will receive required medication seems to indicate that the BH Link program will need to include a full pharmacy. Please confirm.

Answer to question 29:

To clarify, we are looking for a respondent who has the ability to prescribe medications 24/7

Question 30: Can BH Link be located on a hospital campus?

Answer to question 30:
We will review all proposals.

Question 31: How will development of BH Link affect the regulatory requirement that CMHOs provide 24/7 emergency service?

Answer to question 31:

No changes at present.

Question 32: Will costs of marketing to raise awareness of this new level of service be an allowable cost?

Answer to question 32:

No