RFA Modifications

The metrics listed in Attachment C are the complete list of metrics providers can select among to evaluate services.

The following language is removed from RFA, Page 1 "The five-county minimum may also encourage new or expanding partnerships that embrace regional approach to services."

Correction – Wherever the RFA reads "amphetamine" should read "all stimulants".

Correction – there are two additional Prevention Coalition providers included in Attachment B: TEAM Newburgh : Orange County Council on Alcoholism : Mid-Hudson, and; Broome Opioid Abuse Council : DePauls NCADD-RA : Finger Lakes.

SOR 2 Bidders' Questions and Answers

Q.1.A. Request is made for clarification, via the specific questions below, to the following statements that appear in the RFA (bold added for emphasis/clarity):

> "The applicant may choose to focus on **one *or* more** goal areas that are of specific interest to the region." (RFA p1)
>
> "Based on the Statement of Need, and **in line with one or more** OASAS overarching goals, propose *at* ***least one*** *service* ***each*** in the areas of prevention, treatment, and recovery." (RFA p8)
>
> "In addition to at least one proposed service in the prevention, treatment and recovery areas based on the need assessment, all applicants must include the regional approach to the continuum of care as a project goal. This means every application should have a **minimum of four goals**."

A. Applicants must propose at least one treatment service, one prevention service, and one recovery service in response to the need assessment. Each of the services proposed must also relate to one of the OASAS Overarching Goals. In addition to the prevention, treatment and recovery services proposed, all applicants must include regional network collaboration as a goal.

Q1. Are we correct in understanding that an applicant WOULD be in compliance if it proposes to address *strictly* prevention in one proposed service, *strictly* treatment in a second proposed service, *strictly* recovery in a third proposed service, **and** a robust combination of prevention, treatment, and recovery in a fourth service (or set of

services) that address(es) OASAS's Overarching Goal A (Regional Approach to the Continuum of Care)?

A: Applicants must propose at least one treatment service, one prevention service, and one recovery service in response to the need assessment. Each of the services proposed must also relate to one of the OASAS Overarching Goals. In addition to the prevention, treatment and recovery services proposed, all applicants must include regional network collaboration as a goal.

Q2. Put alternatively, if an applicant designs *one* of its proposed four goal-related services to address OASAS's Overarching **Goal B** ("Addressing Gaps in the Continuum of Prevention Services"), WOULD the applicant be in compliance if the service proposed is focused directly on **prevention**, but does not as directly address treatment and recovery? (In this example, the applicant *would* address treatment and recovery, respectively, *separately* in its other proposed services, and *would* address all three parts of the continuum in its proposed service(s) aimed at meeting Overarching Goal 'A')?

A: See response to Q. 1.

Q3. Can you please explicitly define the terms "service," "strategy," "program," and "goal" *especially as these terms relate to each other* in this RFA—including as they relate to the four-goal minimum requirement stated on p8? Your provision of this definitional clarity will help assure that the program and logic model that our network designs are compliant with the context and intent of OASAS/authors of the RFA.

A: Applicants should provide services that are in response to gaps in the need assessment and tie each service to an overarching goal. Within prevention, providers can consider either prevention programs or prevention strategies as listed under Attachment G to determine and define which prevention service to propose.

Q4. Is OASAS expecting to receive a *minimum* of three budgets, corresponding the prevention, treatment, and recovery service being proposed?

A: Yes

Q5. If one provider proposes to provide grant-funded services in two separate areas (e.g., prevention and treatment, corresponding to two different OASAS over-arching goals), would OASAS expect to see two separate budgets from this same organization?

A: Yes. One for each service.

Q6. If *multiple* network leadership organizations or member organizations are proposing to *collaboratively* deliver a single, coherent grant-covered service, would OASAS expect that *each* organization that will *receive funds* pertaining to *its role* in delivering such a

collaboratively rendered service submit *its own budget*—and request funds for ONLY the *portion* of the *service* that such particular organization will be delivering?

A: Yes

Q7. If an organization is listed in Appendix B (RFA pp19-20) as one of the organizations in our region required to participate in the Network (based on its status of receiving *other* SOR, STR, or other OASAS-related funding), through what mechanism—MOU, Letter of Support, simple description in the narrative, or other—would OASAS prefer that the applicant document each such entity's **agreement** to be a part of the network?

A: Any mechanism that states a provider's commitment to participate in the network is acceptable.

Q8. If some such organizations will ***also*** be providing services that are covered under *this* Network RFA (i.e., services not covered under their other funding sources), beyond providing a separate budget from such organization(s), does OASAS have any additional preference/guidance about how to document each such members' participation commitment?

A: The application should clearly describe the proposed service, how it responds to a need identified in the need assessment, which overarching goal the service relates to and how services will be evaluated (like any other provider identified in the application).

Q9. Regarding organizations who are receiving SOR, STR or other OASAS-related funding through extension and an additional 6 months funding, can these same organizations include program additions addressing any one of the following:

a. Programs/services that would otherwise need to be reduced or eliminated
b. Enhancement of existing services to improve patient engagement
c. Expansion of existing services into new geographic target areas within the region.

A: Yes, as long as the bidder is acting consistent with the RFA, proposed service responds to the need assessment, and does not supplant existing funding.

Q10. Page 13 of the RFP indicates under "C. Formatting Instructions", "The application must be submitted using the cover sheet of the application labeled Attachment A."

a. Should that say, "Attachment K"? A: Yes
b. Is that attachment **excluded** from the 20-page limit? A: Yes

Can you please clarify our questions below with regard to the following statements that appear in the RFA (bold added for emphasis/clarity)

> RFA p33 indicates, "Year 1 fiscal period is **September 20, 2020** – **September 29, 2021**. Complete the tables below to reflect the full

requested budget."

RFA p13 indicates, "Anticipated Award: **02/01/2021**".

RFA p5 indicates, "All providers seeking funding as part of the application must include **a 12-month budget** in preparation for entering into a reimbursement-based contact with RFMH."

A. The SAMHSA SOR 2 award period is from 9/30/2020 – 9/29/21). Applicants should submit a 12-month budget based on the dollars available per county in Attachment F. Contracts will likely run from 2/1/2021 – 9/29/2021 and will be prorated based on the 12-month budget.

Q11. Would OASAS like applicants to plan a 12-month budget period that starts on 02/01/2021 and ends on 01/31/2022?

A: The budget should be for 12 months. There is no need to assign dates to the 12-month period.

Q12. In budget allocations that may especially relate to seasonality or cyclicality (for example, the start of a school year in the fall), should applicants assume that the period between 09/29/21 and 01/31/2022 CAN or CANNOT be included in planned budget allocations, if they comply with all other budget rules and guidelines?

A: The budget should reflect a 12-month period. The availability of funding beyond 9/30/2021 is subject to federal appropriation and approval of Year 1 carryover funds.

Q13. Are there any circumstances in which awarded applicants will be able to cover costs consistent with the proposed programs that were incurred between 09/30/20 and the date of award/date of funding availability?

A: No

Q14. What is the difference between (RFA p38) the allowable $30 non-cash incentive to individuals to participate in required collection follow-up and (RFA p37) the "Contingencies" that "may be used to reward and incentivize treatment compliance with a maximum contingency value being $15 *per contingency*"?

A: Participation in the GPRA interviews is voluntary on the part of the client or patient. SAMHSA allows up to $30 per person in non-cash reimbursement to compensate participants for their time completing the GPRA follow-up and discharge interviews.

The Contingencies referred to on page 37 are in reference to using Contingency Management as a behavior modification technique which requires the use of 'prizes' or contingencies to encourage and reinforce positive behaviors. SAMHSA allows the use of federal funds to cover the cost of the 'prizes' or contingencies that are used in the therapeutic approach although limits the value of any one contingency to $15 with a maximum amount of $75 spent per person per year.

Q15. What is the definition of a single "contingency" in this context (RFA p37)?

A: This contingency refers to the permissible maximum value of item given to a patient to reward or incentivize treatment compliance by promoting access to care. (See 2017 rules https://www.federalregister.gov/documents/2016/12/07/2016-28297/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-the-safe-harbors-under-the)

Q15A. The Long Island (Nassau and Suffolk) Regional Network is seeking clarification that they will be able to submit one application inclusive of both counties. The Long Island Regional Network has invested time and effort through its work with the first RFA in September and through BHCC funding have been working together to build infrastructure of Quality Oversight, Data Analytics and Clinical Integration supportive of a population health approach. This investment has supported efficiencies and economies of scale in back office operations supportive of collaborative, shared learning and program/service delivery implementation at a neighborhood, community, provider and program level. We are seeking clarification that this RFA will support a single application for Long Island, inclusive of Nassau and Suffolk counties.

A. An application that includes both Nassau and Suffolk Counties as the regional network is acceptable.

Q16. Can a Lead agency subcontract with an IPA to provide data analytic, and networking collaboration support to the network?

A: Yes, subject to an administrative cost cap, and IPA cannot charge members of the network for services under this contract.

Q17. Can an IPA that has a 501C3 be part of the application and submit a budget like other OASAS licensed programs?

A: Yes, if the 501C3 is an OASAS Certified or funded program.

Q18. Can funds be used to pay for development of data sharing capability with our RHIO, such as an enhanced portal for clinicians to view data? We view this as an improvement in patient care due to the availability of relevant treatment data. If funds can be used in this way, is there a limit to how much could be used for this purpose?

A: No

Will OASAS please provide a detailed description of why the decision to change the formula for funding levels was made?

A. Response to this question is not necessary to apply for this RFA.

Q19. How did OASAS arrive at the decision to base county funding levels on population?

a. Were other methods for determination considered (i.e., number of opioid use-related deaths, etc.)?
   A: Response to this question is not necessary to apply for this RFA.
b. Why were these other methods not selected/why was population level selected?
   A: Response to this question is not necessary to apply for this RFA.

Q20. Will OASAS detail the process for redistributing the funding for each county?

a. Did OASAS take the full pot of available funding and then remove funding for SOR Prevention Coalitions, Triple P, COTI services, and Recovery Centers; and then divide the remaining funds available based on population in each county? Or was another process used?
   A: Response to this question is not necessary to apply for this RFA.

b. The RFA notes that "the dollar amount available is calculated per county based on population size and per capita basis" (page 5). Typically, per capita is tied to a measurement (e.g., # of people with opioid use disorder) but there is no detail provided. **Please define what is meant by "per capita"?**

   A: The language included in the RFA is incorrect and should not include the "per capita basis". The calculation of dollars was based on population only.

Q21. Can the prevention logic model be included as an attachment? If so, please confirm that this will not count towards the 20-page limit.

A: The Prevention Logic Model will not count towards the 20 page limit.

Q22. Please confirm whether there is a limitation on the number of attachments that can be included.

A: There is no limit.

Q23. The definition for the Initiation and Engagement in Treatment – Initiation metric is as follows: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization,

telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. **We interpret this as new diagnoses only. Please confirm.**

A: That is correct, by definition, new diagnosis is defined as members with a 60 day negative diagnosis history, that is, a period of 60 days (2 months) before the Index episode start date (IESD) when the member had no claims/encounters with a diagnosis of AOD abuse or dependence. Note: For an inpatient stay, use the admission date to determine the Negative Diagnosis History. For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. For direct transfers, use the first admission to determine the Negative Diagnosis History.

Q24. The definition for the Initiation and Engagement in Treatment – Engagement metric is as follows: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. **Please define "initiation visit".**

A: It is the first visit following the diagnosis. In this measure, **Initiation** and Engagement in Treatment, the "initiation" visit that is the visit that was determined from the first part of the measure.

Q24a. The definition for the Continued engagement in Substance Use Disorder Treatment (CET) metric is as follows: The percentage of individuals with a new episode of Substance Use Disorder (SUD) treatment within the intake period and at least one subsequent SUD treatment every 30 days through 180 days from the date of the initial SUD treatment. **The way this is written implies that there is no course of care that is less than 6 months. The metric should be modified to state "…treatment every 30 days through 180 days or completion of the episode from the date of the initial SUD treatment."**

A. The literature supports 6 months of engagement. Of course, there will be exceptions even in the highest quality care and therefore, there is no expectation of 100% numerator compliance.

Q25. The definition for the Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N) metric is as follows: The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid dependence. **Please define "index visit".**

A: IESD is Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.

Q26. The definition for the Use of Pharmacotherapy for Opioid Dependence metric is as follows: The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time

during the measurement year. **The metric name implies this should measure opioid dependence, but the definition only notes alcohol use or dependence. We assume this is a typo in the definition given the focus of the grant is opioid use and should be revised from "alcohol use or dependence" to "opioid use or dependence". Please confirm.**

A: It is a typo – it should read Opioid use or dependence.

Q27. The definition for the Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) metric is as follows: Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment. **How does a patient with 1) a shorter than 180-day course of care to completion in a non-OTP 822 setting and 2) who receives also bupe or vivitrol continuously during the treatment episode impact performance here?**

A: A person who utilized medication for less than 180 days would not be numerator compliant. All three FDA approved medications are included in the calculation and it also includes people who were on any medication over that time, so if they transitioned from methadone to buprenorphine but otherwise met the criteria they would be numerator compliant.

Q28. The definition for the Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 day metric is as follows: The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge. **Please define high intensity care – should it be 816, 818, and/or 820 stabilization?**

A: Only part 816 (detox) and 818 (inpatient rehab) episodes are included in the denominator. Part 820 stabilization or rehabilitation after discharge within the 7 days would be included in the numerator and would be counted as compliant. Note: A visit from one 818 to another 818 in the time period is numerator compliant, however a visit from an 818 to an 816 is not numerator compliant.

Q29. The definition for the Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 30 day metric is as follows: The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. **Please define high intensity care – should it be 816, 818, and/or 820 stabilization?**

A: See Question 28.

Q30. Will OASAS please provide more clarity on how they envision the GPRA data collection process being implemented across the different networks? For example, will OASAS be responsible for overall monitoring to ensure that follow-up and discharge GPRAs are being completed in order to achieve SAMHSA's 80% follow-up rate (as required per SAMHSA's SOR RFA)?

A: OASAS will monitor all providers responsible for completing GPRA data collection. Providers will be trained in the administration of the GPRA, tracking and data entry into the WITS system.

Q31. Will OASAS ensure that each funded agency (those that have contracts with RFMH) will be given access to SPARS? If not, how does OASAS envision ensuring that this data gets entered into SPARS?

A: SAMHSA does not allow individual provider access to the SPARS. OASAS will utilize a GPRA data collection module in a web-based application into which all providers will enter data. The data is uploaded to the SPARS system on a regular basis.

Q32. If a funded agency provides a subaward to another agency to support program activities, would the subawardee gain access to SPARS, or would it be the responsibility of the lead to manage GPRA data collection and entry into SPARS?

A: The funded agency is responsible for all compliance activities as required by the grant.

Q33. Is GPRA data for prevention clients required as SOR funds are through CSAT and not CSAP?

A: No.

Q34. Will networks be given access to both the CSAP and CSAT SPARS database?

A: No.

Q34a. RFA page 2 indicates, "In order to do this, the Regional Network will be guided by a Network Advisory Committee comprised of diverse stakeholders and perspectives... that will meet **monthly** to provide feedback, share best practices, and review data to ensure data driven decision making."

RFA page 9 indicates, "The lead management team will convene regular meetings with the Regional Advisory Committee, **no less than quarterly**, to share information and resources; address referrals to and coordination of care; problem solve around barriers to services; discuss quality improvement opportunities and metrics in addition to other collaborative activities.

A. The Regional Advisory Committee must meet at least quarterly.

Q35. Is the Network Advisory Committee and Regional Advisory Committee one and the same entity? (Or do they differ?)

A: The same.

Q36. Is OASAS' intent that such Committee(s) meet amongst themselves (without the lead-management team) **monthly**, but/and that the *lead management team* convene/co-lead these meetings at least **quarterly**? Or is the intent that this Committee, including representatives of the lead management team, simply meet either monthly or quarterly, based on the discretion of the grantee and its regional needs?

A: The lead management team will convene meetings with the Regional Advisory Committee at least quarterly.

Q37. Does the proposal need to include written confirmation from all proposed Network Provider Members in the form of letters or MOUs, or will it be sufficient to produce such documentation upon award?

A: Upon award and during contracting.

Q38. Bottom of p8, it states 'Additional network members **may** include social service, transportation...' The paragraph goes on to list 'Local hospitals, FQHCs, [...] and/or other youth/family services agencies **should** be included as network partners.' Does 'should' mean 'would ideally' or 'must be included'?

A: Ideally

Q39. Do current clients and family members to be included in the Regional Advisory Committee need to be named in the proposal?

A: No

Q40. Does the proposal need to include written confirmation from all proposed Regional Advisory Committee members in the form of letters or MOUs, or will it be sufficient to produce such documentation upon award?

A: Upon award and during contracting.

Q41. Does each provider submit a separate budget? We anticipate that at least 12-14 providers will be involved, so 12-14 separate budgets would need to be prepared. Is that correct?

A: Each provider seeking funding will need to submit a budget to cover their cost of service delivery.

Q42. Can each provider include 10% indirect cost on their individual budget?

A: Yes

Q43. We are considering having our RHIO (HIXNY) develop an application that will allow individual providers to view information (primary care data, and other medical information) for their client in real time, subject to the client's allowance under a release. Would the cost of this development be allowed as a contractual expense? If so, would each provider that submits a budget include a portion of the cost in their budget?

A: No

Q44. Page 9 of the document, #3. Regional Advisory Committee- references "PRC Representation." Would you please explain what this is?

A: Prevention Resource Center

Q45. Is a logic model required only for the Prevention piece? A logic model is not discussed as a requirement for Treatment and Recovery.

A: Yes

Q46. Are consultant costs included in the MTDC?

A: Yes

Q47. Is there any flexibility in extending the due date a few days given that January 4 is the first day back after the holidays? (Reference: Section V. Proposal Submissions, A. Expected Timetable for Key Events)

A: No.

Q48. Does the budget submitted need to precisely allocate $ allotted to the counties as specified in Attachment F only to providers geographically located in that county? Or can capabilities developed for the regional network leverage funds designated to a single county for the benefit of multiple counties in the network? Example: Strategy to develop a peer training, mentoring/coaching and management service is funded to be developed and delivered by a provider in a smaller county for deployment across all the counties in the network. (Reference: Section III. Administrative Information, A. Available Funding, and Attachment F)

A: The Regional Network can leverage funds from a single county to benefit all counties in the network.

Q49. Can multiple networks be awarded funds designated to a specific county? For example, if a county is allocated $200,000 can Network A be awarded a portion and Network B be awarded a portion with the total not exceeding $200,000 even though Network A applied for the full $200,000 and Network B applied for less than $200,000? (Reference: Attachment F)

A: Yes; OASAS will determine allocations after awards, if necessary.

Q50. A statement on page 3 under Provide EBT as Overarching Goal is "The network will address access to MAT for substance use disorders (alcohol, opioids, and tobacco), and especially for OUD, as it is currently available within the region, identify gaps in care, and provide a plan to address gaps." Even though the RFA says that only one overarching goal must be focused on, does this mean that every application must include identifying and addressing same day MAT across their selected region? (Reference: Section II. OASAS Overarching Goals for the Continuum of Care, D. Provide Evidence Based Treatment)

A: Applicants must include one treatment service, one prevention services and one recovery service in the proposal in response to the need assessment. Each of the services proposed must relate to one of the OASAS Overarching Goals. If the need assessment identifies access to MAT, the applicant can propose a service to increase access and it would relate to this overarching goal.

Q51. Must we propose 1 service in Prevention, Treatment and Recovery for each county or 1 service in each for the network as a whole? (Reference: Section IV. Application Proposal and Scoring, A. Program Narrative, iii. Project Goals)

A: One prevention, one treatment, one recovery service for the region as a whole.

Q52. In the RFA are listed the required partners to include in the Networks ("Attachment B: Required Network Partners Receiving SOR Funding Outside of Regional Network RFA"). If one of the listed agencies chooses not to participate in your application but is in one of your region's counties, does that weaken or disqualify your application? Even if you have another OASAS-funded provider doing the same service in that county? (For example, a SOR-funded Recovery Center chooses not to participate but another OASAS-funded agency operating a Recovery Center is a Network member. (Reference: Attachment B)

A: Providers identified in Attachment B will be required to work with awarded networks.

Q53. What information is required from network providers in the Letter of Interest (e.g. Tax Id, MMIS, # members served annually)? (Reference: III. Administrative Information, B. Eligible Applicants)

A: The letter of interest from non-funded collaborative partners can include any of this information.

Q54. Are there specific measures that OASAS would like us to address in our grant application? (Reference: N/A, just a general question)

A: See RFA page 11 Evaluation plan for description of measures.

Q54a. One of the overarching goals of the RFA is the establishment of a regional network of care that "will evaluate and monitor the impact of the services provided at a regional level," and "will ensure that collaboration and integrated services continue past the grant cycle." In order to do this, "cost and resource sharing are encouraged." Yet, on the bidder's conference call OASAS indicated that all grant funds must be used for direct service only. What portion of the grant funds can be used to provide for network functions (i.e. sharing and analyzing data, ensuring and improving quality, managing referrals, and developing technological solutions for these functions)? Should those expenses be separate budgets, or should they be included as line items within each individual provider program budget?

A: Costs for these activities will be subject to a budget cap as part of the 10% indirect cost cap on all grants.

Q55. Given the geographic size of the three-county region known as the Tug Hill/Seaway Region, would it be possible for this region to apply, even though it is only three Counties?

A: Yes.

Q56. For clarification, each applicant seeking funding under this RFP will create their budget and receive a contract through RFMH?

A: Each provider who receives an award will have a budget and contract with RFMH.

Q57. I am familiar with the GPRA data collection process. If a prevention program has a youth focus, will the GPRA still be required with this population?

A: No.

Q58. The RFA says that "the applicant must submit an MOU among providers seeking funding through the RFA". If several behavioral health IPAs (funded by OMH/OASAS with Behavioral Health Care Collaborative grants) and a hospital system are collaborating to form a regional network, can the IPAs (all BHCCs) and hospital system sign an MOU on behalf of their providers so long as the MOU specifies the participating providers, the services they will provide and the commitment to collaborate on the network goals? Also, does an MOU among the participating providers need to be executed before the award and be submitted with the proposal?

A: Eligible applicants include OASAS certified or funded providers. The MOU is among the funded providers and may be submitted with application or upon contracting.

Q59. The RFA specifies that each provider receiving funding for a service from the regional grant has to submit a budget using Attachment I and the provider is limited to 10% indirect costs. A regional network like this one also has network-level administrative costs for training, data collection and analysis, quality improvement activities, coordinating/staffing the Leadership Management Team and Regional Advisory Committee, reporting to OASAS, etc. If the Regional Network contracts with one or several Behavioral Health Care Collaboratives (BHCCs) that are also IPAs to provide these functions, would they submit a Budget Form as well and contract for funding with OASAS. Is there a percentage limit to the county grant award that can be used for network administration, coordination, training, evaluation and support?

A: These services would be included in a funded provider's budget included in the application. The costs will be subject to a budget cap.

Q60. If an academic partner supports the network with respect to evaluation and training, for example, does the individual or organization complete a Budget Form as well and contract directly with OASAS?

A: No. A funded provider within the network would need to contract expenses for associated service and include in their respective budget.

Q61. Can you clarify which goals are required and which are choices based on regional needs. The RFA says that Goal A. Regional Networks of Care is required and that "the applicant can focus on one of more goals specific to the region. The goal or goals must include a continuum of prevention, treatment and recovery services in the proposed approach." Can you clarify that applicants can choose 1 or more from B through I so long as at least 1 new prevention, treatment and recovery service is provided with grant funds tied to 1 or more of the goals? Is that a correct understanding of the RFA?

A: Regional Network coordination is a required goal and, based on the need assessment, the applicant must propose one prevention, one treatment and one recovery service which tie to one or more from B. through I.

Q62. Can the Regional Network include Art 28 DTCs and Art 31 Mental Health Clinics that offer MAT and other substance use treatment services? Can the network include harm reduction programs with Art 28 Medicaid waivers that may have collaborative relationships with MAT treatment providers?

A: Yes, the network can include these entities, but they are not eligible for funding.

Q63. Related to the frequency of Advisory Committee meetings, we noticed a discrepancy in different parts of the RFA. Specifically, on page 2, we see that the Advisory Committee "will meet monthly to provide feedback…", while on page 9, it reads the Advisory Committee will meet "no less than quarterly." Please clarify which frequency will be required by OASAS.

A: The lead management team will convene meetings with the Regional Advisory Committee at least quarterly.

Q64. Can funds be used to purchase Tele/Video equipment for a jail setting to place in a correctional facility?

A: No

Q65. Are all RCOC's (SOR and non-SOR) eligible for funding if service in RFA are new to the workplan of the RCOC?

A: Yes

Q66. Due to the geographical size of our area, is it possible to use a tri-county approach when setting our region? (Jefferson, Lewis, & St. Lawrence Counties)

A: Yes

Q67. Are successful applicants required to monitor progress on all the regional metrics listed in Attachment C?

A: No. The Regional Network must select at least one metric to monitor. Based on the prevention strategy selected the provider must identify ways to measure program effectiveness (i.e., pre and post-test).

Q68. These metrics vary somewhat from the metrics tracked in PSYCKES. Are we permitted to use the PSYCKES analogs or must we use the metrics in Attachment C?

A: The calculations for these measures are consistent with PSYKES.

Q69. Will OASAS provide grantees with the baseline data for the Attachment C metrics by county/borough and how frequently will the data be refreshed.

A: Yes. Due to the claims lag and the need for complete data, it is likely that we will only be able to rerun every 6 months.

Q70. Attachment I: Budget Format: Can full-time direct care professional staff be hired as contractors for extra work on this project if the extra work is above and beyond their normal schedule and/or normal scope of work? For example, can a five day a week M-F employee that is doing work not related to the grant, work on Saturday mornings as a contractor as long as the Saturday mornings are on a as needed basis to provide flexibility to respond to grant funded program activities? If yes, should this employee be listed under contractual?

A: Yes, however, any such arrangement needs to be in compliance with wage, hour and labor laws.

Q71. D. Sustainability Plan: The Prevention workplans are on a July-June year and are usually due in the spring. How can the proposed grant activities that can only begin in

February be incorporated into the workplan when there will only be one or two months of grant funded activities and the workplan can't be modified once it's submitted? Similarly, without knowing if there will be a no-cost contract extension, how can prevention providers submit a budget for funding for formerly funded grant activities if the grant has been extended?

A: Workplans are a plan for the delivery of services. Changes to workplans may be reported in WITNYS as unplanned services.

Q72. Do the projected numbers of people served have to be reported by County for each activity or can the numbers be reported for the region as a whole?

A: By county.

Q73. Can PSYCKES metrics and data be used in lieu of the metrics identified in Attachment C of the SOR RFA?

A: They are the same measures and PSYKES is a great way to help the network track them.

Q74. Can outcomes metrics data be reported based on region as opposed to reporting based on County or Burroughs? For example, metrics in PSYCKES can be difficult to filter by County or Burroughs and if a network is using PSYCKES data then this may not be manageable.

A: Yes – the state will also provide this data at a county level for the network after awards are made.

Q75. Assuming the existing RCOC services funded through the previous SOR grant will be integrated into this new regional initiative, we are concerned about preserving the clear and vitally important distinction between clinical treatment and peer recovery. While the two approaches are undoubtedly complimentary, peers are far more than clinical helpers, capable of playing key roles prior to, during and following intensive services. The flexible, holistic, community-based support provided by certified and well-trained Peer staff at every stage can profoundly affect probable recovery outcomes, providing personal strategies that can reduce unnecessary service dependency, address the needs of the whole person and facilitate connections with sustaining circles of natural support. Our question is the extent to which the potential of peers as contributing professionals are being recognized, encouraged and fully embraced through this new and transformational approach to service amalgamation and delivery?

A: The RFA is consistent with the goal of maintaining the integrity of the peer role in recovery centers as well as outpatient settings and recognizing the unique contributions peers can make from initial outreach and engagement through long term support for recovery.

Q76. What percentage of the funding dollars can be used for things essential for network development and sustainability including activities related to administration, project management, data analytics, quality improvement and oversight, developing value-based payment arrangement models for contracting with managed care payors, referral systems and technological solutions?

A: Yes, up to the admin cap and the combined total cannot exceed 10%.

Questions from Bidders' Conference Call

Q81. I heard that agencies can participate in more than one application. Thank you. Is that also true for the lead agency (e.g. the lead agency could lead an application and apply as a participant on another application)?

A: Yes

Q82. Can an applicant be part of 2 winning applications or would only 1 win?

A: Yes, an applicant can be part of multiple successful applications; however, an applicant's budget and/or scope may be modified to meet the needs/fiscal requirements as deemed necessary by OASAS.

Q83. Can an agency that participates in 2 applications submit budgets for both of those applications?

A: Yes

Q84. Must dollars allocated for each county stay in that county or can the network decide to allocate dollars across the network?

A: Dollars can be allocated across the network.

Q84a. The metrics on page 12 do not match the measures listed in Attachment C.

A. The complete list of metrics is listed in Attachment C.

Q85. Will all projects be required to track and make improvements on all measures, or a selected set that relate to the interventions chosen by the network?

A: Selected set that relate to the chosen interventions.

Q86. 20 pages single or double spaced?

A: Spacing is at the discretion of the applicant; either is allowed.

Q87. Can funding be used to continue/build on services that were started under SOR but are no longer funded?

A: Yes, as long as such services are accounted for in the need assessment.

Q88. Can the providers and collaborating entities in the Long Island region -- Nassau and Suffolk Counties -- decide that in the best interest of the whole Long Island region, it will be most effective to submit a single application for the bi-county region. Can we go ahead and submit a single application for the total Nassau-County region? We ask because these counties (and the boroughs of NYC) seemed to be described slightly differently in the RFA.

A: Yes

Q89. Are organizations in the 5 boroughs excluded from this opportunity?

A: No

Q90. For the Initiation and Engagement in Treatment - Initiation measure, is this for new diagnoses only?

A: There is a 60-day period where there are no SUD claims in order to establish a new episode. It is possible that a person received treatment prior to that period, yes, this is to measure how quickly a person who has a “new” diagnosis initiates and engages in care.

Q91. There were some significant shifts in the amounts of resources available in some counties. Significant decrease in Richmond County, significant decrease in the Bronx, etc. Could you explain genesis of these shifts? What variables were considered?

A: Response to this question is not necessary to apply for this RFA.

Q92. Can you elaborate on what attachments are allowed?

A: Any attachment specifically referenced in the RFA and others as needed to respond to the RFA.

Q93. For the Initiation and Engagement in Treatment - Engagement measure, can you please clarify how you are defining "initiation visit".

A: See question 23.

Q94. Can Nassau and Suffolk Counties be combined into one regional network or do we have to submit separately? The RFA states that there will be at least one award for each Nassau and Suffolk counties.

A: Nassau and Suffolk can be combined under one network.

Q95. Are applicants allowed to include the required prevention logic model (one-page, landscape visual) as an attachment that is excluded from the 20-page limit on the total narrative.

A: Yes

Q96. Measure selection - will the State be selecting these measures for the network?

A: The Regional Network must select at least one metric to monitor from the list in Attachment C. Based on the prevention strategy selected the provider must identify ways to measure program effectiveness (i.e., pre and post-test).

Q97. The Use of Pharmacotherapy for Opioid Dependence measure is defined as "The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year." Should this include alcohol dependence or is this a typo?

A: See question 26.

Q98. Are the regions specific in the RFA?

A: No

Q99. First, Please share more about what you desire for a community needs assessment. Second are you expecting the needs assessment to be part of the application or completed as part of the award?

A: The need assessment is part of the application and applicant should propose services that respond to the identified gaps in services. The need assessment should be thorough enough to identify gaps in services.

Q100. Within the narrative application, are applicants allowed to use 10-point font within diagrams, tables, and footnotes/endnotes? And is it okay for the applicant to include all endnote references on a separate page (an attachment that falls outside of the 20-page limit)?

A: Yes

Q101. There are many existing current IPAs and other regional networks developed, but since there is basically a one month turn around period to apply; can the network include and recruit providers or additional partners after the application is submitted if it enhances the continuum of care?

A: Yes, however there can be no additional requests for funding.

Q102. How does OASAS envision the Regional BHCCs (Behavioral Health Care Collaboratives) fitting into this effort? We understand they can't be the lead applicant as the BHCC itself is not a service provider. The BHCCs can assist in other, administrative ways.

A: The BHCC can be paid for administrative services per limits but cannot be an applicant or receive a contract. Funded network provider would have to include costs in their respective budget.

Q103. What if a county refuses to work with a network because they have a competing application?

A: The identified regional network is not required to have participation by every county identified as part of its region for purposes of application development. One LGU representative is required to be identified to serve on the Regional Advisory Committee and applications should include a plan on how a successful applicant will communicate throughout the award with the LGUs in each county in the identified regional network.

Q104. Can you clarify focus areas: RFP says opioid and stimulants and page 2 says opioid and amphetamine? Can you clarify if the focus is all stimulants or amphetamines only?

A: This program also supports evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

Q105. Can you advise on the time frame for startup? You mentioned submission and award, but I don't think it was clear when we start and end year 1, and if we are to include any subsequent budget years.

A: We anticipate that the start date of the contracts will be 2/1/21. Year 1 ends 9/29/21.

Q106. If there are costs for administering the regional network, and a network determines to use an external entity (such an IPA, or CCBHC or other entity), can that entity contract directly with RFMH after award if the costs are budgeted for and included in the RFA response or is it the responsibility of the lead applicant to include these costs as part of their budget?

A: See question 102.

Q107. Do all entities who budget is included as part of the RFA submission have to be OASAS certified? Do they have to be providers of service? i.e. - could the regional network sub award data collection and analytics to an external group and budget for that?

A: OASAS certified or funded program are eligible to receive funding through this RFA. See Question 102.

Q108. It is clear that Opioids and stimulants are a focus of the grant. In some areas, the data shows that alcohol is a greater identified need than Opioids. In this grant in addition to Opioids and stimulants, could attention be given to the use of MAT for alcohol?

A: No.

Q109. Can you provide additional clarity regarding the roles of Recovery Centers whose funding is currently extended? Will there be a separate RFA or will they be funded through this award?

A: SOR funded recovery centers will receive funding separate from this RFA that will extend funding for the year. That funding is not included in this RFA. These recovery centers must be included in the network of SUD providers in the proposed regional network. They are eligible to also receive funding through this RFA for new or expanded services and that will be handled in a separate contract

Q110. It is perceivable that a county is represented in more than one application. If two applications for regional networks were receiving an award and had one overlapping county how would the dollar allocation for the overlapping county be determined?

A: see Q82

Q111. Can other members be part of the Leadership Management Team such as behavioral health IPA leaders or is it limited to reps from the 3 types of providers?

A: The leadership team is limited to one representative from each provider type – prevention, treatment and recovery.

Q112. Can you speak a little bit more about the type of needs assessment you are looking to see as a true in depth needs assessment takes months to prepare well beyond the timeframe we have to submit RFA?

A: See Question 99.

Q113. We understand that LGU participation in the network is required. Are letters of support from participating LGUs required? Or can this agreement simply be documented in the narrative based on conversations with the relevant LGUs (county governments).

A: Agreement can be documented in the narrative.

Q114. Will all SOR recovery centers be included in regional networks? Will some not? Will any of the original recovery centers be included? Could any non-OASAS funded recovery centers be included in the application?

A: Yes

Q115. As there are many networks already developed working on state BHCC goals and objectives together-members of that network are intricately woven into the existing CQI work, data analytics and performance outcomes to more rapidly lift goals and objectives of grants and add to the existing infrastructure. Can several different networks apply for a portion of the dollars from one county without competing with another network of partners/providers from that same county?

A: This is an open competitive award process.

Q116. Is it possible that a county may be in more than one approved award?

A Yes, OASAS may allocate funds between two awards to meet the needs and goals of the RFA.

Q117. Can a BHCC be the delegated administrator of the regional network to provide functions such as financial management, training, data collection, reporting, etc. Is there a limit on amount of funds used to coordinate and facilitate network collaboration?

A: Costs for these activities will be subject to a budget cap as part of the 10% indirect cost cap on all grants as part of a funded provider budget.

Q118. Will OASAS contract with each funded provider in the network?

A: Each provider who receives an award will contract with RFMH.

Q119. Would OASAS like applicants to plan a 12-month budget period that starts on 02/01/2021 and ends on 01/31/2022?

A: See Question 11.

Q120. If one provider proposes to provide grant-funded services in two separate areas (e.g., prevention and treatment, corresponding to two different OASAS over-arching goals), would OASAS expect to see two separate budgets from this same organization?

A: See Question 5.

Q121. We are in Buffalo Rebecca Rose Recovery Centers in the Lovejoy communities. WE are dealing in the sober living. How do we become with for use with this treatment and recovery network?

A: Only entities that are certified and funded by OASAS may apply.

Q122. As a follow up to the community needs assessment question, given there are existent Needs Assessments on many LGU county plans or other state agency reports. Can part of the proposal include development and update of a new logic model and needs assessment, and include focus groups, surveys and other community data collection efforts post award.

A: No. Need assessment is a required part of the application.

Q123. Would 42CFR part 2 privacy regulations apply to all clinical service providers that look to join an application?

A: 42 CFR Part 2 applies to any covered entity. An accurate response to this question cannot be provided because the application of 42 CFR Part 2 depends upon the nature of the clinical service provided and information being disclosed.

Q124. Are we required to have an LGU on the advisory committee from each county we are applying for?

A: One LGU administrator among the counties included in the network must participate.

Q125. If the counties selected by the applicant overlap PRC regions - would the applicant select which PRC would be part of the Regional Advisory Committee or would both PRCs need to be represented on the Regional Advisory Committee?

A: The decision on whether to include one or both PRCs is at the discretion of the applicant.

Q126. Can established provider networks that serve multiple NYC boroughs apply as one regional application?

A: Yes.

Q127. Are we correct in understanding that an applicant WOULD be in compliance if it proposes to address strictly PREVENTION in one proposed service, strictly TREATMENT in a second proposed service, strictly RECOVERY in a third proposed service, plus some COMBINATION of prevention, treatment, and recovery in a fourth service that address(es) OASAS's Overarching Goal "A" (Regional Approach to the Continuum of Care)?

A: See question Q1.