

**PHILADELPHIA DEPARTMENT OF BEHAVIORAL HEALTH
AND MENTAL RETARDATION SERVICES**

**BEHAVIORAL HEALTH DAY SERVICE TRANSFORMATION
REQUEST FOR TRANSFORMATION PLANS**

BIDDERS CONFERENCE QUESTIONS & ANSWERS

September 22, 2006

The questions below have been raised by provider agencies in reference to the current Day Service Transformation Request for Transformation Plans (RFTPs). Responses are being forwarded to all applicant agencies, via this question and answer summary. Applicants are encouraged to review and consider these responses with regard to the development of their pilot or phased transformation plans.

1. Will DBH dictate the type of billing structures to be used? If a proposed model has a sound rationale should providers simply budget DBH revenue equal to cost and assume that DBH is prepared to work out the funding mechanism with the provider and the state?

DBH will collaborate with pilot agencies to discuss the viability and advisability of a variety of reimbursement mechanisms.

2. What type of billing models will be used?

DBH is open to the prospect of employing a variety of creative funding strategies including case rates or other alternative reimbursement mechanisms on a limited pilot basis. DBH will work with agencies to explore various financing structures, within Medicaid reimbursement guidelines, with the intention of maintaining service model integrity. DBH also intends to employ performance based incentives subsequent to the establishment of baselines for a limited number of prioritized outcomes and measures.

3. The RFTP asks for budget costs to be shown separately for mobile and site-based services. Does DBH need to see site/mobile costs separately or is a single budget OK for an integrated service approach?

For the purposes of the Transformation Crosswalk Form, it is required that mobile and site-based costs be shown separately. These funds may, however, be combined in a single budget for presentation of the detailed Expenditure Summary.

4. A start up budget is requested and the RFP indicates that an implementation period of up to 1 year may be required. Should start-up costs extend across two fiscal years, beginning March 1, 2007?

It is likely that the actual allocation of startup funds will extend across two fiscal years (FY 07 & FY 08). However, only a single startup budget is required, based upon the initial 12 months of operation.

5. How will pilot programs be reimbursed during the start up year?

DBH will work closely with each pilot provider regarding reimbursement procedures and mechanisms.

6. Should agencies propose plans that are essentially budget neutral, based upon the allocations and revenues currently received for day services, or should plans be driven by consumer need regardless of cost? Under what circumstances might DBH waive neutrality?

Agencies should plan their transformations based upon budgets equivalent to the dollars they currently receive for day services (PHP, soc rehab & voc rehab). Note that budget neutral plans do not necessarily have to be rate neutral (some rates may be higher than PHP) and that a few exceptions to budget neutrality may be considered based upon the following:

- A limited number of services targeting persons with exceptionally high levels of acuity (heavy users of acute care & crisis services).
- A limited number of services specifically intended to address the needs of populations that are currently unserved or dramatically underserved (behavioral health disparity populations).

7. Will providers be given a FFS rate for mobile services?

All approved programs will have a mobile service component. Mobile services will be reimbursed either by FFS, by an integrated rate that includes mobile and site based services, or by a case rate. It should be noted that the mobile services associated with this initiative are not the mobile treatment services that the State is planning to add to HealthChoices.

8. Will mobile services include case management?

Mobile staff will be involved in providing treatment services and will address recovering persons' goals in various life domains. Some of these supports may be similar to case management. In addition to linking functions, these staff may assist recovering persons with the supervised practice of a variety of social, interpersonal and instrumental skills in community settings.

9. Can providers begin to develop volunteer specialists in existing programs or do agencies need to wait until the peers are trained or certified?

Certified Peer Specialist (CPS) is a specific, formal job description and role that requires training and certification, per the OMHSAS draft bulletin. However, there are many ways to develop peer support within programs and peers helping peers is strongly encouraged.

10. Does DBH have a definition of what constitutes an underserved or acute population?

There is no standard definition, however it is expected that programs targeting acute or behavioral health disparity populations will specifically recruit individuals needing these services and that DBH will play a role in the authorization of referrals/admissions. DBH will collaborate with providers to establish eligibility criteria for these services.

11. Could the focus on reducing acute service use include funding for a crisis specialist to work with consumers at home, in the community or at the agency?

DBH is open to a variety of ideas and suggestions to address the goal of reducing the use of acute services. A 24/7 mechanism for intervening and deescalating persons served by agencies is desirable if feasible.

12. DBH did not mention the utilization of the Montgomery County IOP model in the RFTP. Is this model seen as viable? Can providers consider this response when responding to the RFTP?

DBH assumes that IOP is a potentially viable model, but that it has a number of limitations. The IOP model does not include funding for either mobile services or community integration activities. Consequently, an IOP model might be proposed as a site-based service coupled with a mobile services component. It is, however, unlikely that IOP programs will be selected as pilots.

13. Must proposed models severely curtail psychiatric oversight?

There is no requirement or expectation that psychiatric oversight will be diminished. Preferred models will have both strong treatment and community integrated rehabilitation components.

14. How will individual agencies be able to access the pool of certified peer specialists?

Proposals should indicate where peer specialist positions are needed (programs) and how these positions will be used. Subsequent to DBH approval of an

agency's transformation plan, the provider will be invited to hire peer specialists from a group of recovering persons who will have already received certification training.

15. Will mobile services be used to transition people to non-billable, community based activities?

Yes. The goal of the entire transformation is to promote recovery that enables people to live and actively participate in their communities.

16. Can billable temporary support be provided for people who are transitioning to independent (non-billable) activities? e.g. Staff accompanying an older adult to a senior center for a few days until the individual is comfortable enough to attend by themselves. Can this occur even if the transitional support is not considered to be skill teaching in nature?

Yes, temporary mobile support can be provided to people who are transitioning from site based to independent activities in the community. It is anticipated that virtually all of these supports will involve some level of skill teaching and skill supervision.

17. How do site based, county funded, social rehabilitation services factor into the day program transformation?

Social rehabilitation dollars that currently support day services should be considered an additional source of transformation funding. The application of these funds to transformed services may include blending them with PHP revenues or they may be used separately. In either case, it is anticipated that social rehabilitation dollars currently supporting discrete day services will be used to fund recovery oriented programs.

18. How will supported employment and educational activities be funded?

Medical Assistance will not provide reimbursement for the direct provision of vocational or educational services. Consequently, educational and employment related objectives should be pursued largely through the utilization of community based resources such as job training programs, colleges, Adult Basic Education and GED, health care and alternative therapy resources etc. Agencies may support the advancement of these goals via the provision of MA billable services such as psycho-education and psychiatric rehabilitation. These MA funded services can be used to equip, encourage and support recovering persons related to their participation in mainstream educational and employment opportunities.

DBH is aware that accessing such resources is a substantial task. It is hoped that as we move through this transformation process, provider agencies will establish collaborative partnerships with mainstream providers of vocational training and

educational services, and develop models to support recovering individuals while they are utilizing such resources. Peer specialists and/or professional staff functioning in a mobile capacity may be employed to provide this support.

Onetime funding will be made available to assist pilot agencies to develop collaborative relationships with community organizations that provide vocational, employment and educational services (as well as other community integrated resources). Accessing community resources and supporting the effective utilization of these opportunities, via mobile staff, is the preferred approach (rather than the provision of these services onsite at agencies).

Efforts should be made to tap diverse funding streams to cover tuition and other costs related to enrollment. E.G. OVR. DBH will work with Pilots who develop such partnerships to locate funds needed to access these resources whenever mainstream avenues have been pursued and are either unavailable or insufficient.

DBH/MRS program funds currently used by agencies to provide vocational services must continue to be dedicated to employment related supports subsequent to the recovery transformation. The preferred application of these dedicated funds will involve their use to provide Supported Employment services that are not reimbursable with MA dollars (job coaching, etc.). It is also recommended that consideration be given to the use of current social rehabilitation funding to support the provision of vocational and/or educational services.

19. Are phased agencies eligible for start up funding?

The phased approach will not involve the literal transformation of programs during the pilot startup period. Rather, phased agencies will devote their attention to the preliminary steps needed to prepare for the later transformation of their existing services (orienting recovering persons, staff and family members, establishing a peer culture, etc.). Subsequent to the later submission of a full plan (pilot format), including a detailed startup budget, DBH will consider limited startup funding (transformation support) requests from phased agencies. These funds will be allocated based upon availability.

20. Is it mandatory that all day programs make this transition?

Yes, with the following exceptions, providers should consider how each of their day programs can be transformed to become more recovery focused and community integrated:

Existing day services excluded from major transformation:

- Clubhouse programs
- Community Living Room
- Friends Connection

21. Has there been discussion with the state regarding licensing, especially related to the startup year? How will licensing reviews conducted by the state be affected?

Yes, DBH has initiated preliminary discussions with the state regarding the licensure implications for transformed services. Further discussions are planned to address this issue in more detail. It is intended that pilot agencies will not be negatively impacted during the pilot period when these issues are being resolved. The transformation process is a partnership with OHMSAS, DBH and providers.

22. Describe the review process for determining pilot programs?

A committee comprised of DBH staff, consultants, recovering persons, family members, OMHSAS and OVR representatives will be convened to review the RFTP pilot submissions. The review committee will score and rank the proposals and make recommendations based upon these findings to the DBH Executive Committee for final selection.

23. What supports will you provide for phased agencies (as opposed to pilot programs)?

In phased plans providers should, on the basis of their self assessment, identify the supports they anticipate needing during the period prior to full implementation of the models they select. Requested supports will be considered by DBH in discussion with providers.

24. How can what is learned from the pilots be used to inform phased applicants when both pilots and phased providers are expected to start in March 2007?

Pilot agencies will begin the actual transformation of their services in March 2007. Simultaneously, phased providers will begin to prepare their agencies for program transformations that may not begin until late in calendar year 2007. Phased agencies will not be expected to begin the literal transformation of their programs until they have submitted full plans (pilot format) that have been reviewed and approved by DBH. Full plans will likely be required from phased agencies in October of 2007. Consequently, phased applicants will be able to benefit from the lessons learned via the transformation startup experiences of the pilot agencies.

25. If agencies are not selected as pilots do they default to a phased approach?

Yes. Pilot applicants who are not selected as pilots will be required to revise and resubmit their plans in October 2007. These agencies will have a phased status until their resubmitted plans have been reviewed and approved.

26. Has there been any consideration to the individuals who are not covered by CBH?

The primary population for the new services will be persons who qualify for HealthChoices. Individuals who are not eligible for Medicaid may also be served on a limited basis, based upon funding availability (program dollars). Consequently, providers may consider using their existing County dollars to serve non-CBH eligible individuals.

27. The Coalition and Alliance identified a number of consumers in the existing partial system with acute care needs. Should proposals address these needs as well as focusing on community integration and recovery?

Yes. Strategies to address individual needs should be outlined in the program design. Acute needs are considered part of the total recovery process and should be addressed. Recovery focused programs should be designed to address a range of both treatment and rehabilitation needs.

28. How will transportation be dealt with? What about people who can't use public transportation?

Based on preliminary discussions with the State, all HealthChoices reimbursed pilot services, will be medically necessary and eligible for transportation reimbursement. This coverage is applicable to both site based and mobile service locations, in keeping with the goal to promote genuine, community integrated recovery.

Non-HealthChoices reimbursed services such as supported employment will not have access to Medical Assistance reimbursed transportation, as is currently the case.

It is additionally important that all individuals receive training and support in the utilization of Public Transport. This is an essential step in the movement towards recovery.

Furthermore it is highly desirable that individuals receiving Medical Assistance transportation funds, receive sufficient dollars to support the purchase of transpasses. In those instances in which individuals cannot access sufficient funds to purchase a transpass, they will require access to additional funds to implement the independent community based elements of their recovery plans.

29. Subsequent to the transformation of day services, will Partial Hospital Programs (PHPs) as we currently know them cease to exist?

Yes, with the exception of Acute PHPs and PHPs that serve specialized populations. The central focus of this initiative is to transform PHPs to more recovery oriented alternative services. It should also be noted that the State has

indicated their intention to eliminate PHP as a billable service at some point in the future.

30. To what extent might DBH share ideas proposed in applications that are not selected as pilots?

A central theme of the transformation is the desire to promote mutual learning and system-wide collaboration. This means that innovative ideas conceived by agencies may be shared with other providers in an effort to establish a recovery focused system of care.

31. The timeline presented in the bidder's conference called for implementation of full phased plans to begin 12/14/07. The RFTP indicates that implementation of major service components is to start no later than July 2008. Is there a difference in definition? Which is the date to be used in the response?

Note that start dates are approximate and are expected to vary by agency in terms of actual implementation. It is expected that most agencies will undertake a staggered startup approach to the transformation of their services. i.e. not all programs will be transformed simultaneously. Consequently, it is intended that phased agencies will begin to transform some of their programs by the end of calendar year 2007, but that it may take until later in CY 2008 to initiate the conversion of all day services. Consequently, phased providers should assume an initial start date of December 2007.

32. How will licensed and non-licensed boarding homes receive training in this process and by whom?

Agencies should actively engage their communities including providers of residential and personal care home services. The inclusion of recovery transformation content is also planned in future trainings for personal care home operators.

33. How essential are peer specialists? What is the salary range for peer specialists?

Peer specialists are a vital and essential part of the recovery transformation initiative. While reimbursement rates have not been set, rates currently paid across the state range from \$9-15 per hour based on location and level of care. These positions can be part time (20 hours/wk) or full time based on individual and agency need.

34. Are there plans to transform behavioral health services for adolescent populations?

The entire DBH funded system is in the process of transformation. Initiatives and projects will continue to expand over time and will eventually include all populations.

35. Will the DBH monitoring team be assigned and provide technical assistance to the selected pilots?

Not at this time. Initially all pilot agencies will be partnered with a consultant who will provide technical assistance and support.