ASAM 2.1 RFP: Q&A

1. **When submitting for regions, does it mean we cannot treat members living outside those regions?**

   The intention is a regional footprint to minimize access challenges for members, therefore, the provider awarded the region should treat those within geographic proximity. We also recognize member choice and will honor member's request for a program outside of the region.

2. **How many providers per region may be awarded opportunity to provide 2.1 services?**

   There will be one ASAM 2.1 provider per region. There will be consideration for 1 provider to be awarded for up to 2 regions.

3. **How many programs are being awarded in each geographical region?**

   There will be one program per region.

4. **LOC 1.0 covers 9 hours of services a week. What would the authorized service hours be for 2.1?**

   ASAM 2.1 LOC will be defaulting to 9-19 hours of an intensive outpatient model. The level of care will be actively care managed with utilization reviews expected at some intervals to verify medical necessity of services delivered.

5. **If you are still in the process of applying for your license, can you still submit a proposal stating anticipated date of licensing?**

   Only providers with a current DDAP license should submit a proposal.

6. **What are your plans to address the specialized needs of certain populations, such as LGBTQ+ when you're only awarding 4 regions?**

   Providers are expected to be culturally competent and should be able to service all members including specialized populations. Proposals are an opportunity to highlight provider strengths in servicing specialized populations and will be taken into consideration.

7. **Will all providers be required to provide childcare so that IOP is accessible to all individuals?**

   Childcare is not a requirement but will enhance the proposal and consideration for childcare is preferred.

8. **Would a program that only treat individuals who identify as "women" not be eligible to apply since they do not service "all members"?**

   Providers who treat specialized populations are eligible to submit proposals. We will consider, in the proposals submitted, the ability to service people in the ASAM IOP level of care comprehensively.

9. **For each provider will there be an expectation as to how many clients they can maintain in active services? Is there a concern regarding accessibility? If a provider is awarded a region, can they operate multiple sites within the region?**

   The expectation is that the awarded providers will bring up and maintain 30 slots within each of the four ASAM 2.1 programs. This is a new level of service in the network and is considered an enhancement. This program will take time to ramp up and the system will aim to be flexible and can address needs as we move forward. There will be four total programs, one program per geographical region awarded.

10. **If no MAT (methadone) programs are awarded IOP services, will members be able to attend MAT outpatient and IOP services at a non-MAT program?**

    CBH will ensure that members who are currently receiving Methadone maintenance treatment can continue to receive dosing with their current methadone provider if the awarded ASAM 2.1 programs do not provide Methadone maintenance treatment. RFP applicants are expected to provide a plan to implement direct provision of Medication Assisted Treatment (MAT) for members with substance use disorders that have evidence-based medication approaches such as opioid use disorder, alcohol use disorder, and tobacco use disorder.

11. **Can you please provide more detail on the type of value-based payment model you are anticipating? Specifically, will reimbursement be based on clinical outcomes? Process outcomes? Or are we getting reimbursed by legacy system, unit based, hourly based, etc.?**

    It is anticipated that the funding for ASAM IOP will be under an alternative payment structure such as a case rate, and eventually that will become a value-based payment model, but the details of this have not been finalized. Any VBP structure will most likely have clinical outcome measures but may also include process outcomes. Until this APA (and eventual VBP) is finalized there is likelihood that the reimbursement may first be under a fee-for-service model, which will help gather utilization and other data to inform the APA/VBP.

12. **What do timeframes for payment look like under this value-based reimbursement structure?**

    Value-based reimbursement structure timeframe has yet to be determined.

13. **For providers with an existing case rate for their continuum services, will IOP consumers be billed under the case rate, or will this be a completely discreet and separate service that will be billed outside of the case rate?**

    ASAM IOP is a separate service from ASAM SUD Outpatient, so will not be included in that case rate (or other rates in the SUD continuum). It will have its own, stand-alone funding structure.

14. **Do staff have to be dedicated solely to the IOP or can they be shared between another program?**

    ASAM 2.1 programs should follow state regulations regarding staffing and staff should have the appropriate credentials to deliver the service.