OUD COE FAQs
April 21, 2016

Question	Answer
Q1. An organization provides a wide range of services across several programs. One of those programs provides substance abuse treatment and counseling specifically related to opioid addiction. When completing the application, should it show both the organization and the specific substance abuse treatment program? Should the application show the range of services, or information specific to the substance abuse treatment program?	The larger organization and the individual program should be listed as the applicant (organization/individual program). The information in questions 1-13 of the application can apply to the broader organization, but questions 14-24 should be specific to the services of the substance abuse treatment program
Q2. The Center of Excellence (COE) cover letter states "Completion of this application is the first step in becoming a COE" - are there additional steps not explained in the cover letter?	Additional steps would include the normal process of application review, obtaining input and feedback from counties and MCOs, selection of providers, completion of the readiness review, and contracting.
Q3. The press release talks about $50 million for opioid services. How will the other $25 million be used if you are funding $500,000 to 50 centers?	The $34.2 million listed in the press release is the overall **state funds** requested in the Governor's budget to implement services to combat the opioid crisis in Pennsylvania. Some of the budgeted dollars will be used for direct care services through the HealthChoices program. These direct care services are eligible for federal Medicaid matching funds.
Q4. Are applications to be submitted by May 6 even for the phase 2 (2017) group as well, or is this first submission open only to currently DDAP licensed OTPs?	The application is for both phase 1 and phase 2. Question #3 on the application is to obtain information about providers that are not Department of Drug and Alcohol Program (DDAP) licensed outpatient treatment programs (OTPs).

Q5. Will there be a separate RFP process for the creation of opioid use disorder (OUD) COEs for peri-natal women or should interested providers apply through the current issued RFP?	The physical health MCOs are required to contract with 20 high volume obstetrical providers/health systems to put into place a COE like program **during 2016**. The MCOs have been directed to use current capitation rate funding for maternity care and community based care management (CBCM) funding already provided to them to develop these programs. So funding of those programs is not contingent on the 16-17 budget request for $34.2 million by the Governor. There will be no application process for those 20 COEs, nor is DHS being as prescriptive in the requirements. The expectation from the Office of Medical Assistance Programs (OMAP) is that 20 obstetrical OUD programs must be in place before the end of 2016. Providers can use the 50 OUD-COE funding opportunity to develop an obstetrical focus on OUD treatment but must also treat other individuals with OUD.
Q6. Where can we find a document/site for PA's "current healthcare reform initiatives"? Is there a strategic plan?	A critical healthcare reform initiative for PA was Medicaid expansion. Both physical health and behavioral health are moving to alternative payments structures with an emphasis on values based purchasing. In addition, DHS is currently planning to implement Certified Community Behavioral Health Clinics, which will adopt innovative approaches to community-based behavioral health services.
Q7. Can a non-DDAP licensed medical facility develop an arrangement with another organization to provide the MAT?	A non-DDAP licensed facility should apply with the intention of providing the medication piece of MAT, and referring individuals to drug and alcohol treatment centers for the treatment portion (wraparound services/counseling).

Q8. Can we have more detail about the information which would be reported (e.g track aggregate and standard outcomes)?	Each COE will be expected to track and internally report the following metrics at an individual and aggregate level: • The number of individuals initiated in treatment and engaged for 30, 60, 90,180, 365 days • The percentage of individuals evaluated within 1 business day of referral; • The percentage of individuals diagnosed and referred for mental health conditions; • The percentage of individuals receiving drug and alcohol counseling; • The percentage of individuals referred for comprehensive pain management treatment • The percentage of individuals concomitantly taking benzodiazepines or prescription opiates • A time series survey for quality of life and movement towards recovery for each individual • An annual validated patient satisfaction survey
Q9. Since Medicare/Medicaid Duals have much of their substance abuse care through the BHMCO (as will Community Health Choices participants), can those members count in the expectation for 300 new patients at the COE?	The 25 COEs funded under the Single County Authorities and the 5 COEs funded under BH HealthChoices will be expected to render and coordinate care for MMEs (duals). They would be included in the 300 new patient count. For the 20 COEs funded under PH-MCOs, they will render direct care services and coordinate care for only those covered by the current PH-HealthChoices program. This would include duals under the age of 21 but not those duals 21 and older.

Q10. Does a COE align with one MCO for the flow of the money? There is no field on the application to identify who that is. Would they just pick one after being awarded the grant?	The first step is for the Department to pick the COEs. The PH and BH MCOs will be involved in providing input into the final selection process of all 50 COEs. Once they are picked, the MCOs will contract with the selected 50 COEs. The BH MCOs would contract with those selected 30 COEs in the counties in which they do business. The PH-MCOs will contract with all COEs based on the HC region in which each COE is located.
Q11. I understand you cannot commit to funding beyond this fiscal year but you suggested you anticipated it would continue. If it does, do you see that as continued support for care management services at the locations supported in this round of funding, or will the money in the next fiscal year be for additional new or expanded sites?	Funding for this initiative is contingent on the budget being approved and nothing should be put in place until that occurs except, unless an SCA has current funding they are willing utilize to start the program. Future funding requests would ask for continued support for the first 50 COEs for at least an additional year. Potentially additional funding could be requested for new COEs in the second year to support expansion beyond the original 50 COEs. Some funding for the COEs will become a part of the HealthChoices capitated rates as these services and supports are developed for the Medicaid population.
Q12. There is biggest confusion regarding implementation. In the cover letter, it states it is for Methadone Clinics (SCA/BHMCO) and Clozaril Clinics (PHMCO), but then the application reads as if it could be anyone who meets the noted criteria, or at least implied criteria.	DHS is expecting the applicants to be either methadone clinics or other outpatient treatment programs that currently or plan to provide buprenorphine and/or naltrexone treatment. The services provided by the COEs are detailed in the application.

Q13. What is the role of Drug and Alcohol provider in the learning network? In reviewing the model noted from UNM it is consultation for folks who do not hold specialty in areas, but as a way to increase support to assist with availability of services by non-specialist. This would benefit a medical community in implementing MAT. Would this entail being a member of one in a consultative role for providers that specialize in Drug and Alcohol or as a way to educate local PCP?	The learning network is an opportunity for all of the participating entities to provide support and consultation with regard to their particular area of expertise. All 50 COEs will be required to participate. The Drug and Alcohol providers can share best clinical practices, best operational/management practices, discuss the handling of tough clinical issues (pregnancy, benzodiazepine tapering/avoidance) through case based learning, and serve as a "hub" resource to primary care providers, emergency departments, and others for screening and referral.
Q14. If an applicant that is selected to be a COE is a provider that the SCA has not contracted with will the SCA be required to contract with that provider?	A part of the DHS review of the COE applications will include a conversation with the SCA to understand any concerns, or reluctance, in contracting with a particular provider.
Q15. For the funds that will flow through the SCA, is the state or SCA responsible for the contract and expectations of the provider?	The SCA will initiate and be responsible for managing the contract with the provider. This expectation would be similar to any other state funding that the SCA receives and utilizes to contract for services from a provider. The DHS will set expectations of the use of funds allocated under the initiative.
Q16. Can funding be utilized for SCA administrative services?	The funding is primarily focused on the implementation of the care management team; however the DHS is aware of the financial constraints of the SCAs. Conversations can be requested by individual SCAs who may find the management of this initiative challenging.

Q17. Can part of the funding be utilized for Electronic Health Records?	The funding is primarily focused on the implementation of the care management team and is not to be utilized for EHR purchase. Funds may be utilized to support the tracking of quality metrics within the EHR. DHS will be making funds available to BH providers for linkage for HIE in the next year.
Q18. Must the “300 new patients” all be Medicaid eligible?	On the physical health side, all the participants must be Medicaid eligible since the funding will be through the HealthChoices Physical Health MCOs. On the Behavioral Health Side, non-Medicaid eligible individuals can also be served through the funding to the SCAs.
Q19. Can you further define the role of the care management team?	The Community based care management team will consist of licensed and unlicensed professionals. The care management team is focused on initiation of appropriate treatment and supports the engagement of the individual in continued treatment. The care management team will work within their local community to accept warm hand offs of individuals with OUD from local emergency departments, state and county corrections facilities, and from primary care providers. It will also work with inpatient and outpatient residential drug and alcohol providers to assure individuals living with OUD transition from that level of care to the COE for ongoing engagement in treatment. The CBCM team will motivate and encourage individuals with OUD to stay engaged in both physical health and mental health treatments. Team members will facilitate recovery by helping individuals find stable housing and employment, and helping them reestablish family/community relationships.

Q20. Can the funding be utilized for additional treatment services?	The funding is primarily focused on the implementation of the care management team, but may also be utilized for treatment services for individuals not covered by insurance. Additional treatment services would be funded by HealthChoices for Medicaid eligible individuals.
Q21. If a provider has four offices in different parts of Pennsylvania are they eligible to qualify for four COEs?	All four would be eligible if they are in different physical locations, and can all expand care for 300 patients at each office.
Q22. How does the funding work. Will the funding be distributed directly to the qualifying COE or will it be paid through a third party such as a managed care organization or OMHSAS / SAMHSA?	For the current licensed D&A facilities, OMHSAS will provide funding to the SCAs which will contract with the providers. For those practices that are not a licensed D&A facility, they would be paid through the HealthChoices MCOs in two payments as described in the application.