

Allegheny County Department of Human Services Q&A for RFP for Residential Services, aligned with American Society of Addiction Medicine Standards, for Individuals with Substance Use Disorder

Thursday, April 9, 2026

1. Is there a budget available, or should respondents submit their own budgets?

Respondents should submit their own proposed budgets.

Thursday, April 16, 2026

2. How should providers report data in the required spreadsheet? Should the information reflect only Allegheny County clients, or the provider's full patient population?

Existing providers that serve Allegheny County clients should only report data specific to Allegheny County, which will be compared against DHS records. Providers that have not previously served Allegheny County clients may submit data for the client populations that they have available.

Thursday, April 23, 2026

3. When reporting numbers on the RFP Data Template, should data include all facility residents or only Allegheny County residents?

Report data only for Allegheny County residents. Do not include clients from other counties.

4. Should providers use Community Care Behavioral Health (CCBH) data that only goes through 2024 for the Residential RFP Data Template, or should Calendar Year (CY) 2025 program data be used?

Use the data from the CCBH benchmarking report or the CCBH Value-Based Payment (VBP) report (for readmissions) for Allegheny County when responding to the questions on 7 or 30-day follow-up rates or readmission rates. However, you may use additional data sources when responding to either follow-up rates or readmission rates. For example, you can use your own data when describing how you plan to improve one of the rates (follow-up or readmission).

For new applicants not in the Allegheny Contract (HealthChoices or ALDA), you can use data from another CCBH contract, data from other Behavioral Health Managed Care Organizations (BH-MCOs) on follow-up rates (the VBP readmission measure may not be available for non-CCBH contracts), or other data sources.

5. Should data include commercially insured Allegheny County residents that were treated in CY 2025?

Yes. Include your most recent data for commercially insured and self-pay Allegheny County residents when responding to relevant data fields.

6. How is an “episode of care” defined?

An episode of care is the total number of consecutive days within one residential level of care. For example, if a client enrolled in a 3.7WM program for four days and then transferred to a 3.5 program for 21 days, all in CY 2025, the person would have two episodes of care, one for 3.7WM with a Length of Stay (LOS) of 4 days and one for 3.5 with a LOS of 21 days.

7. Is there a standard definition of “co-occurring serious mental illness,” or may providers define it themselves?

Serious mental illness typically includes DSM-5 diagnoses such as schizophrenia, bipolar disorder, major depression, PTSD, severe anxiety disorders (e.g., panic disorder or OCD), and borderline personality disorder. Other diagnoses may qualify if symptoms and course are severe.

8. For the client-to-staff ratio, should providers report counselor-to-client ratio or all staff?

Use the client-to-staff ratio reported in your American Society of Addiction Medicine (ASAM) review for each level of care.

9. What is included in an “unplanned discharge”?

Unplanned discharges fall into three categories:

- Client-directed (e.g., leaving against medical or facility advice)
- Administrative (e.g., policy violations)
- Medical (e.g., transfer due to medical complications)

10. For staff-to-client ratio, should we report the standard facility ratio or Allegheny County-specific ratios? And for bed utilization, should we use only Allegheny County data, or should we report our overall facility wait-list data for all counties served?

Use the standard facility ratios reported in your ASAM review. For waitlist and bed utilization, overall facility data is sufficient.

11. How should providers define “medically complex conditions”?

Use recognized categories such as pregnancy, physical disability, chronic health conditions (e.g., diabetes, hypertension, heart or lung disease), or medical needs related to Substance Use Disorders (SUD) (e.g., wound care). Provide specific counts when reporting.

12. Can individuals be counted in multiple demographic or clinical categories?

Yes. Individuals may be counted in multiple applicable categories (e.g., race, veteran status, Medications for Opioid Use Disorder (MOUD), serious mental illness).

13. For ASAM alignment, do providers need to submit documentation?

No documentation is required. If all ASAM dimension scores are 1s, simply indicate alignment. If any dimension is scored a 2, describe your plan to achieve a 1.

14. Do current network providers need to respond to this RFP to continue contracting with CCBH Allegheny?

Yes. All current residential providers must apply through this RFP to be considered for a 2027 contract. Providers that do not apply will be removed from Allegheny Health Choices and ALDA contracts, without cause, effective 12/31/26.

15. We have several Memoranda of Understanding with some community partners. Would these satisfy the requirement for Partner Commitment Letters?

Yes, existing MOUs would meet the requirement.

16. Does a provider have to be MWDBE certified to contract with Allegheny through this new RFP process?

No, MWDBE certification is not required to apply for this RFP.

17. How should providers answer the question “Total dollar amount requested”? Is this the contract amount or actual program expenses, and is rate-setting part of this RFP?

The “Total dollar amount requested” field on page 2 of the Response Form does not need to be completed. Current providers should include actual program expenses and/or current contract amounts in the financial stability section. Rate-setting is a separate process outside of this RFP process.

18. Should providers submit one application per level of care, or can levels of care within the same physical location be combined?

We strongly recommend submitting separate applications for each level of care, so providers have more space to fully address the scored sections.

19. If multiple applications are submitted, do providers need different applicant names and email addresses in Bonfire?

Yes. Each application must be submitted separately using unique contact information (name and email). Proposals should only be combined if they are intended to be a single application.

Thursday, April 30, 2026

20. On the Data Template, under Discharge Planning (below the 2022, 2023, and 2024 reporting years), should the following items be reported using CY 2025 data?

- Total number of discharges
- Total number of unplanned discharges
- Percentage of discharges that were client-directed

- Percentage of discharges that were administrative
- Percentage of discharges that were medical or psychiatric

Yes. Please use CY 2025 data to complete all five items.

21. The RFP states: “Providers who score a ‘3’ or ‘4’ must either achieve a score of ‘1’ or ‘2’ or develop an explicit, agreed-upon performance improvement plan before the application will be considered for contracting.” If an applicant’s 3.1 program has received a score of 3 from another BHMCO and is currently implementing a Quality Improvement Plan (QIP) with a re-review pending, how should this be addressed in their application? Can an applicant request that their materials be reviewed before submission to ensure they are addressing this part adequately? Should applicants submit any additional documentation (such as the QIP) with their 3.1 application?

We cannot review documents before the official evaluation process. However, applicants with a score above 1 may want to consider the following when explaining how they plan to improve their score. Applicants are competing with agencies that have perfect ASAM scores—scores of 1 across all categories. The goal is to provide the reviewer with a clear, logical, and, if helpful, data-driven plan for how the applicant will also achieve a score of 1 in the relevant category in CY 2026. The reviewer should be able to understand how the applicant intends to address the issue based on information gathered from the ASAM review and other data sources. Applicants may use any sources when preparing this summary, but should keep the description clear and straightforward, and should not assume the reviewer is familiar with a QIP or other funder-specific formats.

22. In the Q&A sent yesterday, providers were instructed to use the client-to-staff ratio reported in their ASAM review for each level of care. Can you specify where this information appears in the ASAM review sheet?

You can also use your rate reported to DDAP for each level of care, based on your DDAP contract and licensing agreement, if you are not required to report it on your ASAM review. We are looking for your program's staff-to-client ratio reported for licensing or funding.

23. It is our understanding that the RFP for ASAM Level 3 services applies to both existing and prospective HCAL and ALDA providers. Does this include adolescent 3.5 programs, and how should adolescent providers complete the application if ASAM assessments have not yet occurred and no scores are available?

For adolescent 3.5 programs, applicants may simply state that ASAM reviews have not yet occurred. We are aware that ASAM review tools for adolescent programs have not been developed.

24. When gathering and reporting data for each level of care, should an episode be included on both the 3.7WM reporting tool and the 3.5 reporting tool? For example, if a patient is admitted to 3.7WM and then transfers to 3.5 during the same episode, should pregnancy be reported in both the 3.7WM and 3.5 templates?

Yes, when completing the data template, summarize data for each level of care, including separating 3.7WM counts from 3.5 counts. In your scenario, a pregnant woman would be counted in both 3.7WM and 3.5, even though the person attended both programs. If your 3.5 program served 200 people in CY2025 and 100 of them went through your 3.7WM prior to entering 3.5, you would include 100 in your 3.7WM data template and 200 in your 3.5 data template.

Thursday, May 7, 2026

25. For the budget and Narrative, are you looking for our organization's overall budget for 2025? Or are you looking specifically at a budget for Allegheny County? And are there some more details/guidelines as to what ought to be included?

For the financial stability question, proposers should focus their answers on Allegheny County when possible, not the organization's overall budget. Proposers should communicate the costs (personnel, facility/capital, operating, and administrative) required to run the program for each level of care that they are applying to. Budget information should be as detailed as possible to give evaluators a clear understanding on what it costs to operate the service and what is included in those costs. Proposers should also explain what the minimum volume of clients required to ensure the service is viable are. Additionally, proposers should define what their ideal client volume is for their proposed model, and how they will operate in an environment of high or excessive client utilization.

26. What are providers expected to submit for the MWDBE and VOSB sections of the RFP? Do all providers need to complete every part of these forms, even if they are not certified as MWDBE or Veteran-Owned?

Allegheny County has MWDBE goals of 13% participation for Minority Business Enterprises, a 5% goal for Veteran Owned Small Business, and 2% participation for Women Enterprises and expects that Successful Proposers will make a “good faith effort” in assisting the County in meeting these goals. The good faith effort means to pass on those percentages to the organizations you subcontract with for inventory and services such as office supplies and janitorial services. Only organizations that are certified meet those percentages. If you do not meet those percentages, you should request a waiver. For more information, visit the Allegheny County Equity and Inclusion Department website.

All providers must complete the MWDBE and VOSB forms by filling out the sections that apply to them.

- On the MWDBE form, indicate whether your organization is certified, and list any MWDBE subcontractors you solicit, if applicable. Providers that are not

MWDBE-certified should still complete the form and note “No” in the certification section.

- On the VOSB form, list any VOSB subcontractors you solicit, if applicable. Providers that do not solicit VOSB subcontractors should complete the applicable portions of the form and follow the VOSB waiver instructions.

27. Can providers transitioning beds from Levels 3.5/3.7WM to Level 3.1 receive exceptions to operate Level 3.1 beds in a non-freestanding building or a setting that is not a stand-alone “home”?

Providers should follow all applicable DDAP licensing regulations for Level 3.1 programs. DHS cannot grant exceptions to DDAP requirements. Questions regarding facility type, freestanding structures, or whether exceptions may be granted must be directed to the provider’s DDAP licensing representative. For more information, please read Chapter 709: Standards for Licensure of Freestanding Treatment Facilities.

28. In the data template, when reporting the percentage of episodes under categories (e.g., medically complex, Megan’s Law), should percentages be calculated within each subcategory or across all episodes?

Percentages should be calculated within each subcategory. For example, for “medically complex,” report the percentage of medically complex episodes that were under 7 days, under 21 days, etc.

29. Who evaluates the submitted RFPs, and how are conflicts of interest handled?

RFPs are reviewed by a committee that includes DHS staff across departments, County representatives, community members, and treatment professionals. All reviewers must complete a conflict-of-interest disclosure before reviewing application materials. Anyone with a conflict will not be permitted to review application materials. Multiple reviewers score each application.

30. How should unplanned discharges be categorized if they do not fit into client-directed, administrative, or medical/psychiatric categories (e.g., discharge due to criminal justice involvement)?

Count the discharge in the total number of unplanned discharges, but do not assign it to one of the three percentage subcategories if it does not fit. It will not affect scoring if the count is small.

31. What should providers do if they cannot obtain their 7-day or 30-day follow-up data from CCBH?

If a provider does not have a CCBH benchmarking report, they may use their internal data. In the narrative, note that a CCBH report was not available and identify the source of the internal numbers. This will not negatively affect scoring.

32. Should 7-day and 30-day follow-up data be reported as numbers or percentages for 2022–2024?

Use percentages, consistent with the format in the CCBH benchmarking reports.

33. What should providers do if they only recently started tracking waitlist length and do not have full 2025 data?

Report the data you have and explain in the narrative when tracking began and how waitlist length is monitored. DHS does not have this data independently; internal data is acceptable.

34. How should “postpartum” be defined in the data template?

Providers may use their organizational definition of postpartum (commonly up to one year after delivery). Include the definition in the narrative for clarity.

35. For “women with children,” should programs report only mothers whose children reside with them in the program, or all mothers?

Providers should define in the narrative how they are reporting this category (e.g., only mothers whose children reside with them, or all mothers with children under 18). DHS will evaluate based on the clarity of the provider’s definition.

36. Are these population categories likely to appear in future RFPs? Should providers consider updating their internal data systems to track them?

Categories related to medically complex conditions and unplanned discharges are aligned with DHS’s focus on continuous quality improvement. Providers may choose to strengthen internal tracking, but the RFP primarily evaluates how organizations use available data and understand patterns in their population.

37. For the question about submitting multiple applications, do providers need different names and email addresses in Bonfire for each application?

Yes. Bonfire requires unique contact information for each submitted application. Using the same name and email for multiple submissions will prevent the system from accepting them.

38. For the discharge data on the template, should providers count only clients admitted on or after January 1, 2025? For the total number of discharges in 2025, should providers include only clients who were both admitted and discharged in 2025?

Include all enrollments and all discharges that occur between 1/1/25 and 12/31/25, recognizing that these two sets of numbers will likely differ. For enrollments, include only clients admitted on or after 1/1/25 and up to 12/31/25. For discharges, include all

clients discharged on or after 1/1/25 and up to 12/31/25, even if they were admitted prior to 2025.

However, it is acceptable if you choose to report the same individuals for both counts—meaning only those who were both enrolled and discharged in 2025—based on your capacity to analyze your data. These approaches will produce totals close enough to align with DHS data sets.

Thursday, May 14, 2026

39. The RFP asks for a “description of your policy for enrolling individuals who are already receiving methadone in an Opioid Treatment Program (OTP) and seeking residential treatment for another SUD. Please include data noted in the Excel spreadsheet.” What does “seeking residential treatment for another SUD” mean?

This question was directed toward 3.5 or 3.7 residential programs, not halfway house (3.1) programs. The intent is for providers to describe how they work with individuals who may already be receiving treatment for, or managing, their opioid use disorder through MOUD and related services, but who also need residential treatment for a different substance use disorder, such as alcohol use disorder or stimulant use disorder.

40. For the Data Template, providers are asked to report follow-up rates for several years. Some providers do not see these reports in the CCBH e-portal. How should these rates be obtained, and should providers submit data for 2022–2024?

Organizations already enrolled in a CCBH contract—whether in Allegheny County or another HealthChoices region—should have received a benchmarking report that includes the follow-up rates for 2022, 2023, and 2024 required for the data template. Providers who cannot locate these reports in the portal can contact their CCBH representative to request another copy.

Benchmarking reports are typically available for 3.1, 3.5, and 3.7 providers and may also include readmission data for organizations participating in VBP. The only exception is when a provider had a low number of enrolled CCBH clients in those years, in which case benchmarking data may not have been produced. Providers should complete the required fields for 2022–2024 using the benchmarking report.

41. On the RFP Response Form, page 2, it asks for a "Total Dollar Amount Requested". Are you able to offer some guidance on what you are looking for here? Is this an amount based on what we anticipate based on number of Allegheny County residents we plan (or project) to serve in a given year? And if so, would we simply use our current contracted rate amount and use number of episodes projected?

The 'Total Dollar Amount Requested' field on page 2 of the Response Form does not need to be completed. As noted in Question 17 of the published Q&A (above), current providers should include their actual program expenses and/or current contract amounts in the financial stability section instead. Rate-setting will occur outside of this RFP process.

42. Do we need to provide the full address for each location represented on our data sheets? For example, if we have multiple locations that offer 3.7 WM, 3.5, and 3.1 services, should each location be listed separately in rows 9–11 on the data sheets? Is it acceptable to list only the county?

Yes, you can use rows 8–10 to identify the location of the residential program on the Data Template. If multiple levels of care operate on the same campus, you may copy and paste the same address into the corresponding datasheets within a single template.

43. How should providers report their ASAM alignment scores, particularly if their score is 1?

Providers should report their ASAM alignment review scores exactly as they were received. As noted in Question 13 above, if all scores are “1,” simply list them; no additional narrative is required. Providers with any score of “2” should describe how they plan to move that score to a 1. Regardless of ASAM scores, all providers must still respond to the full RFP.

44. Are partner letters required, and is there a limit to how many may be submitted?

Partner letters may be included to support your proposal, but reviewers primarily focus on the content of your response. There is no set limit; providers may submit as many letters as they feel are useful, whether that is a few or several.

45. What attachments are required?

Please read the RFP for all required attachments.

46. CCBH claims data for 2024 does not separate 3.5 and 3.7 levels of care for certain medication-related metrics (e.g., percent receiving MOUD). How should providers report this information?

Providers should enter the most accurate data available in the data template. If CCBH claims data combines 3.5 and 3.7 medication-related metrics and cannot be separated, providers should report the combined values in the applicable rows. In the narrative section of the RFP—particularly the question about the provider’s approach to offering medications for AUD, OUD, and TUD—providers should describe this limitation and explain how these data were obtained. This helps guide the reviewer’s understanding of how the information was organized.

Thursday, May 21, 2026

47. In the Q&A document, the answer to question 16 states that MWDBE certification is not required for this RFP, while the answer to question 26 states that all

providers MUST complete the MWDBE and VOSB forms. The submission form lists these as optional, but the RFP posting document lists them as required attachments. Can you please clarify whether both forms must be completed and attached for each RFP submission?

MWDBE certification is not required for this RFP. This is what is stated in Question 16 and refers specifically to whether a provider must **hold** MWDBE certification in order to be eligible to apply.

Question 26 addresses a different requirement: even though certification is not required, all applicants must still complete the MWDBE and VOSB forms as part of the application. These forms must be completed for each submission, with applicants filling out the sections that apply to them.

48. On the Response Form, it indicates that ASAM Certifications are to be attached, but in the RFP posting document they are not listed as a required attachment. In the Q&A document, the answer to question number 13 states that no documentation is required. Please confirm the confirmation review letters are not to be attached.

You do not need to include a copy of your ASAM letter, as we have the ASAM scores for all ASAM 3.0 programs. The goal of the narrative is to describe how an agency will reduce its score from a 2, 3, or 4 to a 1.

49. In the Q&A document, question number 42 states that multiple LOCs on the same property may be listed on the same data sheet with the same address. However, our question relates to data for a single LOC (e.g., ASAM 3.5) that is compiled across multiple addresses. We also asked whether counties could be used instead of full addresses. Adding rows may be necessary depending on what is required. Please advise what you would like to see.

Each 3.5 residential program needs to submit an application with a unique data template for each location. The RFP is based on a specific residential program, not an overall organization. Thus, if your organization has three ASAM 3.5 programs located at three different locations, your best option is to submit three applications with a data template for each location. You can include multiple ASAM 3.0 levels of care on one campus in a single data template, such as 3.5, 3.7wm, and 3.7, as long as the address is the same for all levels of care. If reviewers cannot identify the location of the program, and if the data in the template does not align with DHS/CCBH claims data for a specific location, the applicant will receive a lower score on sections where data are used in the summaries. We don't need the data to be exact; however, reviewers will be looking for data summaries within the ballpark of our data sets.

50. The Data Template includes 2022, 2023, and 2024, but the guidance indicates that 2024 benchmarking data should be used for the seven-day and 30-day follow-up rates. Should we still be using 2024?

Yes. Please complete the Data Template for all three years—2022, 2023, and 2024—using your CCBH benchmarking report. For the narrative questions, please use 2024 data, as it is the most recent year included.

51. Where should providers upload the Data Template in Bonfire, given the single-file upload limit for the RFP Response Form and that no dedicated Data Template field is available?

Providers may upload the Data Template to either of the following locations:

- As a separate, clearly labeled section/appendix within the RFP Response Form (this attachment will not count toward the page limit), or
- Under the “Budget and Budget Narrative” upload area.

Either location is acceptable. Please ensure the file is clearly labeled as “[Organization Name] – Data Template” so it can be easily identified during review.