Solicitation Information
7 April 08

Continuous Recruitment #22

TITLE: Access to Recovery – Clinical Treatment

Submission Deadline: Continuous Recruitment through 31 DEC 09

PRE-BID/ PROPOSAL CONFERENCE: NO

Questions concerning this solicitation may be e-mailed to the Division of Purchases at questions@purchasing.state.ri.us . Questions should be submitted in a *Microsoft Word attachment, n*o later than **1 Dec 09** @1**2:00 Noon (ET).** Please reference the CR # on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No
BOND REQUIRED: No

Jerome D. Moynihan, C.P.M., CPPO
Administrator of Purchasing Systems

Vendors must register on-line at the State Purchasing Website at www.purchasing.ri.gov.

NOTE TO VENDORS:

No offer will be considered that is not accompanied by a completed and signed Bidder Certification Cover Form.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

SUBSTANCE ABUSE CLINICAL TREATMENT SERVICES

The State of Rhode Island, Department of Administration / Division of Purchases, on behalf of the Department of Mental Health, Retardation and Hospitals (MHRH), Division of Behavioral Healthcare Services (DBH) is seeking to develop and maintain a network of licensed substance abuse treatment agencies to participate in Accessing Recovery in Rhode Island (RI ATR), a Federal grant from the Substance Abuse and Mental Health Services Administration—SAMHSA, in accordance with the terms of this solicitation and the State's General Conditions of Purchase, which is available on the internet at www.purchasing.ri.gov. All agencies that desire to be included on this list must meet all of the bid criteria listed below.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

Potential offerors are advised to review all sections of this Request carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

Potential offerors are advised that the Department of Mental Health, Retardation and Hospitals has drafted a *Providers Handbook* that will be posted at www.MHRH.RI.gov.

Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this Request will be rejected as being non-responsive.

All costs associated with developing or submitting a proposal in response to this Request, or to provide oral or written clarification of its content shall be borne by the offeror. The State assumes no responsibility for these costs.

Proposals are considered to be irrevocable for a period of not less than sixty (60) days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.

Proposals misdirected to other State locations or which are otherwise not present in the Office of Purchases at the time of opening for any cause will be determined to be late and will not be considered. The official time clock is located in the Reception area of the Department of Administration / Division of Purchases, One Capitol Hill, Providence, RI.

It is intended that an award pursuant to this Request will be made to a single contractor, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered, but subcontracts are permitted, provided that their use is clearly indicated in the offeror's proposal, and the subcontractor(s) proposed to be used are identified in the proposal.

In accordance with Title 7, Chapter 1.1 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the state until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401 222-3040). *This is a requirement only for the successful vendor(s).*

Bidders are advised that all materials submitted to the State of Rhode Island for consideration in response to this Request for Proposals will be considered to be public records, as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception, and will be released for inspection immediately upon request, once an award has been made.

Bidders are required to complete and submit both the Master **Certification Application—Clinical Treatment Services** and a **Treatment Services Addendum** for each site; and, in addition, submit other required documents specified in the applications.

PURPOSE

On September 20, 2007, Governor Donald L. Carcieri was informed that the state of Rhode Island was being awarded an Access to Recovery grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Access to Recovery (ATR) program is part of a Presidential initiative to provide client choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. Through the ATR grant, states have flexibility in designing and implementing voucher programs, consistent with proven models, to meet the needs of clients in the state. The key to successful implementation of ATR and the voucher program is the relationship between states and the clients receiving services, to ensure that clients have a genuine, free, and independent choice among eligible providers.

ACCEPTANCE CRITERIA:

Substance abuse treatment agencies seeking to be a member of the ATR clinical treatment services network must certify that they will meet all of the following criteria:

1 All clinical treatment services providers participating in this initiative must be a licensed Behavioral Healthcare Organization.
2 The Provider must enter into a one-year agreement with DBH. That agreement will automatically renew for successive one-year terms thereafter, terminating on September 29, 2010, unless terminated sooner by either the Provider or DBH. Either party may terminate the agreement at any time without cause by giving at least 45 days prior written notice to the other party. If either party defaults in the performance of any of their obligations under the agreement, and such default continues for thirty (30) days after receipt of notice from the non-defaulting party, the non-defaulting party shall have the right to terminate the agreement.
3 An understanding that they may be required to collect Government Performance and Results Act data on clients at their discharge from the voucher and/or six (6) months post discharge from the voucher.
4 An understanding that DBH will monitor outcomes, track costs, and prevent waste, fraud and abuse to ensure accountability and effectiveness in the use of Federal funds.
5 Participating providers must accept the general client placement and clinical assessment conducted by the ATR Screener/Assessor.
6 Participating providers understand that participation in the ATR requires use of and data entry into the ATR Voucher Management System (VMS) and that maintaining the ability to access the VMS is a required component of membership in the ATR treatment services network.
7 Participating providers understand that client service information must be entered into the ATR Voucher Management System (VMS) within 14 calendar days of service provision in order to receive full payment for service provided.
8 Participating providers understand that client service information must be entered into the ATR Voucher Management System (VMS) within 45 calendar days of service provision in order to

receive any payment for the service provided.
9 Participating providers understand that only the services listed in the VMS for each individual client are the only services for which reimbursement will be allowed.
10 Participating providers understand that only individuals presenting with an active voucher for services can be served under this program
11 Participating providers understand that they will be reimbursed only for eligible services provided to an eligible client.
12 Participating providers understand that clients have choice in the decision of a treatment provider.
13 Participating providers understand that if no eligible services are provided for 30 consecutive days, the voucher may become inactive and unavailable to the provider.
14 Participating providers understand that they may be required to collect additional data as determined by DBH.
15 Participating providers understand that all residential treatment beds available for ATR are covered under a license issued by MHRH or able to be licensed at the time of use.
16 Participating providers understand that the appended Clinical Treatment Service Rates (see Attachment B) are the only applicable rates for services provided to eligible clients by providers participating in the ATR clinical treatment network.
17 Participating providers understand that ATR funding is contingent on service provision and that ATR funding will not supplant state or Medicaid or other federal funding.
18 Participating providers agree that accepting a voucher from the Department with the client's ID will act as the vehicle to begin treatment. Unless a voucher is received, the provider will not be reimbursed for the services provided.
19 Participating providers understand that all provider records are subject to review by the Department for a period of three years from service date.
20 Participating providers will be required to provide the Department with an annual audit in accordance with the terms and conditions of the contract.

This is a continual enrollment process through 31 Dec 09. The Division of Purchases will forward all applications received to the ATR Implementation Team for evaluation.

Responses (**an original plus one copy**) should be mailed or hand-delivered in a sealed envelope marked " CR 22 – Access to Recovery – Clinical Treatment" to

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time may not be considered. Proposals misdirected to other State locations or which are otherwise not presented in the Division of Purchases by the scheduled due date and time will be determined to be late and may not be considered. Proposals faxed or emailed to the Division of Purchases will not be considered. The official time clock is located in the reception area of the Division of Purchases

RESPONSE CONTENTS

Responses must include the following:

1. A completed and signed R.I.V.I.P. generated bidder certification cover sheet (downloaded from the RI Division of Purchases Internet home page at http://www.purchasing.ri.gov

2. Evidence of a current license as a behavioral healthcare organization (acceptance criteria # 1)

3. A proposal narrative not to exceed 5 pages in a font no smaller than 12 point

4. A completed and signed Certification Application (see Attachment A)

5. A completed Addendum Certification Application—*Treatment Services* (see Attachment A)

6. Other required documents specified in the Certification Application and Addendum.

7. A completed and signed Taxpayer Identification Number Form (W-9), which is available form the Purchases website at www.purchasing.ri.gov For assistance, call the Help Line at 401 222-3766.

ATTACHMENT A
MASTER CERTIFICATION APPLICATION AND ADDENDUM

STATE OF RHODE ISLAND ACCESS TO RECOVERY (ATR) PROGRAM

Department of Mental Health, Retardation and Hospitals
Division of Behavioral Healthcare Services
14 Harrington Road- Barry Hall Cranston, Rhode Island, 02920
www.mhrh.ri.gov (401) 462-4680

MASTER CERTIFICATION APPLICATION
Clinical Treatment Services

Instructions: If you are interested in participating in the Access to Recovery (ATR) program please fill out this application and check the clinical treatment services your entity is applying to provide at each program site listed on page 2. Complete one Clinical Treatment Services Addendum for each program site at which you are applying to provide ATR services. Attach your completed Clinical Treatment Services Addendum to each respective site's Main Application. This information is necessary for the provider directory.

1. Organization Name
_____

2. Program Name (if different)
_____

3. Site Address
_____
_____

4. Billing Address (if different)
_____
_____

5.City_____ State_____ Zip_____

6. Phone_____
Secure Fax (for Authorizations) _____

7. Contact Person _____
E-mail_____ Phone_____
Fax _____

ATTACHMENT A
MASTER CERTIFICATION APPLICATION AND ADDENDUM

8. Federal Tax ID (TIN) ☐☐☐☐☐☐☐☐☐ 8.a. 501(c)(3) ID Number_____

9. Submit a copy of the organization's IRS W-9 Form

10. Submit a copy of the declarations page of your commercial liability insurance policy.

11. Submit the names of your Board of Directors.

12. One aspect of this program is a focus on reaching out to the faith-based community. Is your organization faith-based or denomination-sponsored/supported? Yes ☐ No ☐

13. Individuals served
Please complete the following regarding your typical clientele:

Age Range	*Gender:* M- Male F- Female B-Both	*Capacity*	*Average Length of Stay*

AGENCY REQUESTS APPROVED STATUS FOR THE FOLLOWING TREATMENT SERVICES <u>AT THIS SITE</u>.	
☐ Adolescent Residential Treatment ☐ Aftercare/Continuing Care ☐ Co-occurring Enhanced IOP* ☐ Day/Partial Hospitalization Treatment ☐ Intensive Outpatient Treatment	☐ Outpatient Treatment – Group ☐ Outpatient Treatment – Individual ☐ Medication Assisted Treatment ☐ Residential Treatment ☐ Urinalysis

* Applicants seeking to provide this service must submit a plan for how they will provide a best practice model of Co-occurring Enhanced IOP

14. Client Grievances/Customer Complaints
Please attach your policy regarding the manner by which your organization addresses grievances or complaints.

15. Any action taken against your license by the State or Federal Government?
If so, please describe, in detail.

16. Pertinent, relevant service staff will be required to attend MHRH trainings/meeting regarding, but not limited to the following topics: ATR eligibility criteria, documentation requirements and authorization and billing procedures.

17. ATTESTATION STATEMENT:

ATTACHMENT A

MASTER CERTIFICATION APPLICATION AND ADDENDUM

MY SIGNATURE BELOW INDICATES THAT ALL OF THE INFORMATION PROVIDED FOR THIS SERVICE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. MY ORGANIZATION AGREES TO THE REQUIREMENTS AND TERMS OF PARTICIPATION IN THE ACCESS TO RECOVERY PROGRAM.

NAME:

_____

SIGNATURE:

_____

TITLE:_____DATE:_____

We require any revisions to the above information be reported to the Rhode Island Department of Mental Health, Retardation and Hospitals within 30 days of the change (ex. Change of location, contact person, phone number, etc.).

FOR INTERNAL USE ONLY

Date Received: _____

☐ Approved ☐ Pending ☐ Denied

Assessment:

Reviewed By _____

STATE OF RHODE ISLAND ACCESS TO RECOVERY (ATR) PROGRAM

Department of Mental Health, Retardation and Hospitals
Division of Behavioral Healthcare Services
14 Harrington Road- Barry Hall Cranston, Rhode Island, 02920
www.mhrh.ri.gov (401) 462-4680

TREATMENT SERVICES ADDENDUM
to Certification Application for Treatment Services

Instructions: If you are interested in participating in the Access to Recovery (ATR) program then check the treatment or recovery support services your entity is applying to provide at each program site listed on page 2 of the main application. Print as many copies of this addendum that are required to complete one addendum for each program site at which you are applying to provide ATR services. Attach them to the main application. This information is necessary for the provider directory.

The following treatment services are funded through the ATR:

- Adolescent Residential Treatment
- Aftercare/Continuing Care
- Co-occurring Enhanced IOP
- Day/Partial Hospitalization Treatment
- Intensive Outpatient Treatment
- Outpatient Treatment – Group
- Outpatient Treatment – Individual
- Medication Assisted Treatment
- Residential Treatment
- Urinalysis

1. Program Description. Please provide a detailed description on the following areas:
   a. Average Frequency of session contact (face-to-face, collateral with others, telephone, others)
   b. Hours of Services
   c. Current Licensure or affiliation with licensed treatment agency
   d. Treatment documentation requirements to follow the State of Rhode Island Department of Mental Health, Retardation and Hospitals Rules and Regulations for the Licensing of Behavioral Healthcare Organizations sections 25.0 through 28.8.

2. Please provide a detailed narrative on the agency's experience providing this type of service to similar target populations.

3. Program Staff Roster:
Please complete the following and attach copies of licenses or certificates. Use separate sheet if needed. Staff providing clinical supervision shall have, at a minimum, the specific qualifications with education, license, and experience relevant to the service they are supervising. This follows

the State of Rhode Island Department of Mental Health, Retardation and Hospitals Rules and Regulations for the Licensing of Behavioral Healthcare Organizations 9.10 through 9.10.5.

ATTACHMENT A
MASTER CERTIFICATION APPLICATION AND ADDENDUM

Program Staff Roster: ATR Treatment for (Agency/Site:_____)

Last Name, First Name Supervisor & Case Managers	Degrees (if any)	Licensures or Certifications (if any)	Job Title	Languages Spoken (other than English)
Supervisor:				

FOR INTERNAL USE ONLY

Date Received: _____

☐ Approved ☐ Pending ☐ Denied

Assessment:

Reviewed By _____

ATTACHMENT B
CLINICAL TREATMENT SERVICE RATES

Treatment service type	Unit of service	Maximum units	Rate
Initial Assessment – completed only when GAIN is justified as inappropriate	1.5 hours	One	111.55
Individual Counseling Session	50-60 minutes	Twelve	61.95
30 minute Individual Counseling Session	30 minutes	Twenty-four	40.25
Group Counseling Session– maximum of twelve participants	60-90 minutes	Twelve	37.15
Residential – minimum 12 hours clinical service/week to include 2 hrs. individual	Per diem	Twelve weeks	105.80
Adolescent Residential – same clinical requirements as adult residential	Per diem	Twelve weeks	114.00
IOP – minimum of three hours clinical service hours per day with at least one individual session per week, minimum of nine hours per week	Per diem	Twelve weeks	94.50
Day Treatment – minimum of four clinical service hours per day with at least one individual session per week, minimum of twenty hours per week	Per diem	Four weeks	105.25
Continuing Care – minimum one phone screen per month using Department approved model	15-30 minutes	Twelve	20.25
Methadone Maintenance – frequency of clinical services should be individually assessed, justified and documented on treatment plan	Weekly	Twelve	80.50 for first three months 55.00 for 3rd – 6th months with co-pay allowable 30.00 for 7th-9th month with co-pay allowable
Family/Couple counseling	60-90 minutes	Twelve	77.00
Urinalysis Screen, only used when frequency of screening is required or clinically necessary beyond once weekly	As indicated	Twelve	10.00

Co-Occurring Treatment Service Type	Unit of service	Maximum units	Rate
COD Enhanced IOP - Minimum of three clinical service hours per day with at least one individual sessions per week, using Evidence-based practice identified and approved by the Department , minimum of nine hours per week	Per Diem	Twelve	160.00