HealthWest
Muskegon's Behavioral Wellness Connection

July 19, 2017

ADDENDUM #1

Substance Use Disorders Outpatient Services

REQUEST FOR PROPOSALS
RFP 17-2269

Vendor: _____

_____

_____

This is addendum #1 to RFP 17-2269 Substance Use Disorders for Muskegon County HealthWest. Please indicate this addendum on the Addenda Summary of the proposal package; failure to acknowledge all addenda may be cause for rejection of the proposal.

Sealed proposals are due in the Muskegon County Purchasing Office, Central Services Building, 2nd Floor, 141 E. Apple Avenue, East Entrance, Muskegon, Michigan 49442, no later than 2:00 p.m., prevailing time, Friday, July 28, 2017.

The time of receipt shall be determined by the time clock stamp in the Purchasing Office. Bidders are responsible for ensuring that their proposal response is stamped by Purchasing Office personnel by the deadline indicated.

No late proposals will be accepted.

Sincerely,

Beth Dick

Beth Dick, CPA
Director of Finance/Assistant County Administrator

PURCHASING • 141 E. APPLE AVENUE • MUSKEGON, MI 49442-3404
(231) 724-6281 • FAX (231) 724-3337 •
HealthWest.net

QUESTIONS RECEIVED

The following are questions proposed from potential bidders with corresponding answers.

1) Contractor must agree to report the number of days on access assurance indictors, monthly to HealthWest. Can you please direct a bidder to where there may be more information about what this means.
   On page 18 of the RFP, you will find the Access indicators for which providers must send data to HealthWest on a monthly basis. This is part of the Michigan Department of Health and Human Services MMPBIS reporting for the Medicaid population only. (Michigan Mission Performance-Based Indicator System)

2) Item D "Contractor must assure twenty-four (24)-hour on-call emergency services response only for those consumers enrolled in the elected contract services." To be clear does this include an outpatient level of care… is this requiring 24 hour on call or a written plan for clients to address emergencies after business hours to cover 24 hours emergencies.
   Please remove Item D from the RFP. HealthWest covers after-hours emergencies.

3) To be clear this bid does not require psychiatric services to be provided by the bidder, as those are not listed rates.
   This RFP does not require psychiatric services.

4) The description on page 6 indicates that the population to be served is adults and children. Is this correct? If so, can services only be provided to adults?
   Services can be provided to adults and/or children.

5) If an organization has applied for an integrated care license, but not yet received that meet the requirement?
   The agency/organization must be accredited by any one of the national accrediting bodies listed on page 12 of the RFP. The Integrated Care License is for the State SUD license along with Outpatient.

6) How would you recommend documenting competency for proposed staff? Is providing degrees, licenses, and completed training(s) acceptable?
   Attached is a copy of the Credentialing form for SUD staff providers which must be completed. Copies are needed of SUD licenses for both staff and agency, a copy of a staff's transcript of the highest, appropriate degree certified by the school to provide services, NPI Numbers including taxonomy, LARA/Primary Source Verification, of licenses, Supervision, etc. You can refer to the Medicaid Provider Manual for details about who can provide SUD services and the SUD site on the State of Michigan site.

7) Does HealthWest have an electronic billing system that all providers have access to?
   Yes, it is Provider Connect. Providers may receive training on its use.

8) Also attached updated Evaluation Form.

Community Mental Health of Ottawa County HealthWest West Michigan Community Mental Health

CLINICAL APPLICATION

(Entire section beneath staff name must be completed.)

Agency and Site: _____

Staff Name: First: _____ MI: ____ Last: _____

Date of Hire: _____ Position: _____

Date Began Providing Services to CMH clients: _____

Date of Criminal Background Check: _____

Date Medicaid Sanctioned List Checked: _____

Date Communicable Disease Training Completed: _____

Staff has at least 2,000 hours of experience in SUD services: ☐ Yes ☐ No ☐ NA (non-clinical)

Type of Staff: ☐ Treatment Supervisor with CCS-M _____ or CCS-R_____ or DP-CCS_____

☐ SATS – Please complete information under **items #1, 3, & 4** NPI # _____

☐ SATP – Please complete information under **items #2, 3, & 4** NPI # _____

☐ Specifically Focused Staff (specify): _____(See items #3, 6 or 7)

☐ Treatment Adjunct Staff (specify): _____

☐ Intern - Internship Completion Date: _____

1. **Substance Abuse Treatment Specialist:** In order to qualify as a substance abuse treatment specialist an individual must meet the criteria detailed in **any one of** the following three categories **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   Please select the appropriate category below and provide the information requested below the item:

   ☐ Possesses one of the following certifications from the Michigan Certification Board of Addiction Professionals OR a Development Plan for achievement. Please identify which certification and list expiration date:
   ☐ CADC ☐CADC-M ☐CAADC ☐CCJP-R ☐CCDP ☐CCDP-D ☐Dev. Plan
   MCBAP Certification Expiration Date:

   _____

   ☐ Individual has a development plan with MCBAP **and** possesses one of the following licensures: MD/DO, PA, NP, RN, LPN, LP, LLP, TLLP, LPC, LLPC, LMFT, LLMFT, LMSW, LLMSW, LBSW, or LLBSW.
   License: _____ License Expiration Date: _____ MCBAP Dev. Plan Expir. Date: _____

   ☐ Individual possesses one of the following alternative certifications. Please identify which certification:

   ☐ ASAM ☐APA ☐UMICAD Certification expiration Date: _____

2. **Substance Abuse Treatment Practitioner:** In order to qualify as a substance abuse treatment practitioner an individual must have a MCBAP development Plan in place **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   MCBAP Development Plan Expected Completion Date: _____

3. Levels of Care to be Provided: ☐Outpatient ☐IOP ☐Detox ☐Residential ☐Methadone

Service Categories: ☐ Assessment ☐Individual ☐Group ☐Didactic

☐*Case Management* ** ☐*Peer Recovery Support* ***

4. This employee has a **Masters** _____ or **Bachelors** _____ degree in one of the following:
   - ☐Social Work
   - ☐Guidance & Counseling
   - ☐ Other counseling related field, please specify: _____
   - ☐Clinical Psychology

5. ☐This employee has current licensure as a physician or Ph.D. psychologist.

6. ☐ ** This employee has additional education, training, or experience qualifications for performing the duties of this position. *Please describe below (or attach an additional sheet):*

7. ☐ *** Peer Recovery Support. Please attach an additional sheet to include responses to ALL of the following:
   - Three (3) references of support;
   - Current support system for PRS staff;
   - Program's selection criteria for hiring PRS staff;
   - How his/her recovery was verified and how recovery will be monitored;
   - Date of his/her last treatment (if applicable);
   - Specify types of services to be provided by PRS Associate or PRS Coach;
   - Documentation of training received.

Supervisor Name and Certification (please print): _____
**Supervision for SATS and SATP staff must be provided by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.*

Program Director's Signature Below attests to the accuracy and completeness of all verification information in compliance with the most recent

Community Mental Health of Ottawa County
HealthWest (formerly known as CMHS of Muskegon County)
West Michigan Community Mental Health

Treatment and Prevention Staff Qualifications and Credentialing Requirements Policy.

Program Director's Signature: _____ Date: _____

SCORING - REQUEST FOR PROPOSALS
FOR
SUD OUTPATIENT SERVICES

Scoring Instructions- Sections I – VI are scored as met (1) or not met (0). Total the "number met" for each subsection. Total each subsection score for a Section I – VI Total.

I. Contractor Description		**Met - 1**	**Not Met - 0**
A.	Submit the formal name of the organization and a transmittal letter signed by individual capable of binding the organization to the terms of the proposal. The letter must state the contractor's understanding of the work to be done, the commitment to perform the work within the specified time period, and a statement that the proposal is a firm commitment to begin services on or before a date.		
B.	Submit the following information: 1. Name and Title of Executive Director/Chief Executive Officer 2. Contact Person 3. Mailing Address, Phone and Fax Numbers 4. Billing Address, Phone and Fax Numbers 5. E-mail Address 6. Type of Organization and Type of Government Agency (City, County, State) if applicable 7. Organization Medicaid Number 8. Organization Tax ID Number 9. State of Michigan License(s) for the organization providing the SUD services 10. NPI Numbers, licenses, and certifications of all licensed clinical staff providing services under this contract.		
C.	Submit the organization's purpose/mission and relationship of the contractor mission to proposed program/service.		
D.	Identify any potential conflicts of interest for the organization. (RFP Attachment 3 and RFP Attachment 4.		
E.	Submit a copy of the organization's accreditation letter/certificate, most recent accreditation survey report, and any required corrective action plan.		
F.	Submit the organization's malpractice history from the last five (5) years.		
G.	Submit the organization's proof of insurance(s) including Professional, General, and Vehicle Liability Insurance, Employee Dishonesty Insurance, and Worker's Compensation; complete and submit the RFP Attachment 5.		
H.	Submit a list of the last two (2) years of substantiated Recipient Rights claims and corrective action taken by the organization.		

I.	The Bidder shall attach a copy of its audited financial statements for the previous two (2) years of operation including management letters.		
J.	List experience with third party insurers (e.g., Blue Cross Blue Shield, Meridian, Priority Health, etc.)		
K.	Bidder can provide services at the rates as specified in this RFP.		
L.	Bidder can provide services within Muskegon County boundaries.		
M.	Describe your management information system including compliance with HIPAA and HITECH.		
N.	Provide a minimum of three (3) references including organization/individual name, contact person, and telephone number.		
	Total Met ***Possible subsection score of 14 points***		
Comments/Notes			

II. Demonstrated Organization Competence		**Met - 1**	**Not Met - 0**
A.	Describe your current provider services.		
B.	Describe your experience providing similar types of services as those proposed.		
C.	Describe your experience with the identified target populations.		
D.	Describe your experience developing and sustaining coordination of care and collaborative relationships with other relevant entities (i.e., Health Plan Providers, primary care physicians, schools, and other community services), including formal agreements.		
	Total Met ***Possible subsection score of 4 points***		
Comments/Notes			

III. Organization and Management		Met - 1	Not Met - 0
A.	Submit a current organizational chart including administrative and service structures. Include a narrative description of where HealthWest services would be delivered within your structure (may include pictorial representation).		
B.	Submit information regarding the key administrative staff who would be involved in proposed program/service, i.e., Name, title, and responsibilities in reference to HealthWest services.		
C.	Describe how the organization utilizes community involvement and consumer input/participation in policy development, program planning, and routine decision-making.		
	Total Met ***Possible Subsection score of 3 points***		
Comments/Notes			

IV. Credentialing of Clinical Staff		Met - 1	Not Met - 0
A.	Complete and submit staff credentialing, competency, and training information on the RFP Attachment 6: Staff Credentialing, Competency, and Training Information (Form). Note: On the section labeled "Training", indicate which trainings have been completed by your staff expected to serve HealthWest consumers.		

B.	Submit a list of all supervisory and professional staff expected to serve HealthWest consumers including: 1. Name. 2. Job Classification and Title. 3. State of Michigan license/registration with expiration date. 4. Medicaid, NPI, and DEA numbers, if applicable. 5. Licensing restrictions/ sanctions.		
C.	Submit detail on any of the following with a description of the incident, including correspondence with State licensing boards, and/or a detailed description of any litigation, including settlements, Court awards, etc. 1. State license/certification revoked, suspended, or limited. 2. Accreditation revoked, suspended, or limited. 3. Sanctions imposed by Medicare and/or Medicaid. 4. Professional liability insurance denied, canceled, or renewal denied. 5. Been a defendant in a lawsuit regarding the practice of health care, mental health, or substance abuse treatment. 6. Had any malpractice claims regarding the practice of health care, mental health, or substance abuse treatment.		
	Total Met ***Possible Subsection score of 3 points***		
Comments/Notes			
V. Program/Service Operation		**Met - 1**	**Not Met - 0**
A.	Indicate the hours per day, days per week of your organization's service availability.		
B.	Indicate where your services are provided (location)? Is/are the location(s) barrier-free? Do you have provisions for transportation for individuals served?		
C.	Describe your ability to meet the needs of special populations (i.e., hearing and/or vision impaired, limited language proficiency, cultural competence, mobility, wheelchair accessibility).		
D.	Describe your after-hours on-call/emergency services system to serve individuals receiving services.		

E.	Complete and submit RFP Attachment 7: Environment of Care Provider Self-Survey (Form) for each facility at which individuals will be served.		
	Total Met ***Possible Subsection score of 5 points***		
Comments/Notes			
VI. Financial Information		**Met - 1**	**Not Met - 0**
A.	Complete and submit RFI Attachment 8: Fiscal Certification Form, page 1 and RFP Attachment 9: W-9 (Form).		
B.	Assure attachment of a copy of a most recent independent financial audit; copy of 1099 tax form for individual small providers, or a copy of state financial solvency report to the RFI Attachment 8: Accountant Certification Form, page 2.		
C.	Submit information supporting your ability to complete claims on HCFA 1500 forms, or submit electronically via the 837 format, with detailed charges explanation showing all services rendered to a recipient.		
	Total Met ***Possible Subsection score of 3 points***		
Comments/Notes			
TOTAL SCORE – SECTIONS I – VI Possible 32 total points			

Rate the items in each section 0 – 5. Total each sub-section and section score.	**Not Provided 0**	**Provided – Insufficient quality 1**	**Provided – low quality 2**	**Provided – average quality 3**	**Provided – high quality 4**	**Provided- exceeding quality 5**
VII. Quality Standards and Performance Measurement						
1. Quality Improvement						
1.a. Describe your quality assurance monitoring efforts: Describe the internal review process and how often the charts are reviewed within your organization. Describe the follow-up process to address the insufficient findings.						
1.b. Customer satisfaction results: Provide a copy of your customer satisfaction survey. Describe how the results are reviewed and utilized in your organization to improve customer services. Discuss how the information is disseminated to your stakeholders.						
1.c. Recipient complaints and their resolutions: Provide the number and types of recipient rights complaints for this past fiscal year. Describe the actions taken to resolve the complaints.						
Subsection Total Score Possible 15 points						
2. Outcome Measures						
2.a. Describe tracking, monitoring and reporting the outcome data.						

Rate the items in each section 0 – 5. Total each sub-section and section score.	**Not Provided 0**	**Provided – Insufficient quality 1**	**Provided – low quality 2**	**Provided – average quality 3**	**Provided – high quality 4**	**Provided- exceeding quality 5**
2.b. Describe how outcome measure data will be used to evaluate appropriateness of services.						
2.c. Describe any other measurement of client satisfaction taken by bidder-provider examples.						
2.d. Describe the process of utilizing outcome data to determine quality improvement efforts.						
2.e. Identify the frequency of reviews of the outcome measures.						
2.f. Total number of clients treated.						
2.g. Provide the last 3 years of outcome data.						
Subsection Total Score Possible 35 points						
Comments/Notes						
3. Utilization Measures						
3.a. Describe criteria used to establish medical necessity of admission as well as the appropriate scope, duration and intensity of TX.						

Rate the items in each section 0 – 5. Total each sub-section and section score.	**Not Provided 0**	**Provided – Insufficient quality 1**	**Provided – low quality 2**	**Provided – average quality 3**	**Provided – high quality 4**	**Provided- exceeding quality 5**
3.b. Describe service utilization monitoring used to detect and address over/under utilization of service.						
Subsection Total Score Possible 10 points						
Comments/Notes						
4. Recovery Coaches						
Discuss the use of recovery coaches and the use of the community for support.						
5. Access to Public Transportation						
Describe the policy to address access to public transportation including availability of bus passes and proximity to major expressways or roads.						
Subsection 4. – 5. Total Score Possible 10 points						
Comments/Notes						

Rate the items in each section 0 – 5. Total each sub-section and section score.	**Not Provided 0**	**Provided – Insufficient quality 1**	**Provided – low quality 2**	**Provided – average quality 3**	**Provided – high quality 4**	**Provided- exceeding quality 5**
6. Psychiatric Services Indicate the following:						
6.a. Whether the psychiatrist is on-site or are services coordinated with another agency.						
6.b. Bidder policy/procedure for psychiatrist/Bidder to prescribe psychotropic medications despite active substance use.						
Subsection Total Score Possible 10 points						
Comments/Notes						
Total Score for Section VII Possible 80 Points						
TOTAL SCORE – SECTIONS I – VII ***Possible 112 total points***						
Overall Percentage ____ = ____**/ 112=**_____						