DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Statewide Services-Gambling

Request for Proposal

DMHAS-SSG-BCP-2026
ADDENDUM

The State of Connecticut Department of Mental Health and Addiction Services is issuing Addendum #1 to the **Statewide Services Gambling, Bettor Choice Program Request for Proposals.**

Addendum 4 contains:

A. Questions and Answers – The following are DMHAS responses to the questions received during and after the Bidder's Conference.

1. **Is the state issuing this RFP as part of a required renewal process, or are you looking to bring in additional vendors?**

   A: This RFP is being issued as part of a required renewal process.

2. **Are performance indicator reports from the past two years available for review? It would be helpful to understand how outcomes have been tracked and evaluated.**

   A: Please see the link below to review the DMHAS, EQMI Provider Quality Reports: EQMI-Provider Quality Reports Info.

3. **How do you define retention and how will that be tracked?**

   A: Retention will be reviewed with clients in the Bettor Choice program, based on their individual treatment goals. Gambling Assessments are completed during intake and at six (6) month follow up within DDaP (similarly to the completion of other DDaP requirements). These protocols will assist with identifying if the client has achieved their criteria for discharge.

4. **RFP says experience working with prison population is required but I didn't see it mentioned here. Is it a requirement or not?**

   A: At the Department's request, integrate problem gambling awareness into all agency-wide initiatives and services where applicable (include: criminal justice, prevention, substance use, adolescent, and mental health programs).

5. **How do you define crisis for active clients? Is crisis related to gambling episodes, thoughts or urges, or is this more related to suicidality?**

A: The Department requests that there is a protocol in place if active clients call after hours. This could be related to suicidality, significant gambling episodes, or any other reason a client would reach out to the program after hours.

6. **Will we receive a list of attendees?**

   A: No

7. **Could you please confirm whether the Department is open to the inclusion of telehealth or hybrid service delivery models—where remote sessions are supplemented by in-person services as needed—to support accessibility and continuity of care?**

   A: Yes, the Department is open to the inclusion of telehealth services, but the agency must also have active locations, or a location (brick and mortar establishment) within the region.

8. **Does outreach include both internal and external outreach?**

   A: Outreach should be in the community, with other community providers and community members at large. Outreach can also be done in partnership with other agencies, such as the Connecticut Council on Problem Gambling and the Regional Behavioral Health Action Organizations. Intra-agency outreach, or integration, is also an expectation of the Department.

9. **Will you consider splitting the clients served from two different organizations or just one per region?**

   A: One proposal will be accepted per region.

10. **Can the work plan be referenced in the narrative and included as an attachment?**

    A: No. The workplan is part of the Scope of Service Description (main proposal) and counts towards the allowable page limit.

11. **Can you please clarify expectations for IOP services and do you want agencies to have IOP programs already established.**

    A: Having a Bettor Choice IOP would be ideal, but currently none exist within the state. If your agency has IOP groups, it would be expected that Bettor Choice clients could also receive treatment within this level of care. If your agency does not have an IOP, an alternative option such as a combination of individual, family, group, and Peer Recovery Services can be offered during a week (especially within the first 10 weeks), that are slightly below the criteria of an IOP. This protocol will be based on the interest of the individual client.

12. **Could you please clarify whether medication support services may be provided through collaboration or referral partnerships, or if the Department expects these services to be delivered directly by the contracted organization?**

    A: Ideally, the Department expects these services to be delivered directly by the contracted organization. In the event the contracted organization does not offer these services, it would

be allowable for the contracted organization to establish a referral relationship with the appropriate releases in place for continuity of care.

13. **The Budget form only includes expenses. Do we list all expenses if it exceeds the $300,000 and identify third party revenue and in-kind funds separately in the narrative (the amount that exceeds the $300,000)?**

    A: Yes, as the funding from third party reimbursement and other in-kind funding is expected to assist with operating costs of the Bettor Choice program.

14. **Is LMSW allowable for Clinical Manager (not listed)?**

    A: No. Please see page 11 of the RFP for the DPH Licensed Clinical Program Manager staffing expectations.

15. **Please define "value driven" program?**

    A: Value driven means that staff are incorporating client values and strengths within their clinical services and client recovery plans.

16. **Can you describe or define what is considered a "value driven" program?**

    A: Please see question 15.

17. **Can after hours be referred to gambling hotline?**

    A: The Problem Gambling Helpline (hotline) is for individuals who are not active clients seeking assistance. Active clients are expected to be supported by the contracted agency if there is an emergent need after hours.

18. **Audit reports are listed in the attachments to be included, however, in lieu of attaching I believe I heard you say to state in the narrative that they are available via EARS. Is this correct?**

    A: If the three (3) most recent audits are available via the Office of Policy and Management's EARS system, such may be noted in the proposal, and a hardcopy of the audit cover letters *need not be provided*.

19. **Telehealth is being reduced by Medicaid and Medicare -- will the state cover the difference?**

    A: No. In the event that services are not covered by insurance, the grant funding is intended as a payor of last resort in order to eliminate any financial barriers to treatment and recovery services.

20. **For the DPH-licensed Clinical Manager: you do not list LMSW as an allowable degree to be the Clinical Manager but it's allowed under the staffing section. Please clarify whether an LMSW can assume the role of Clinical Manager.**

    A: Please see question 14.

21. **Does the Clinical Manager need to be full-time (100%)?**

A: Yes, the Clinical Manager needs to be a full-time Bettor Choice employee.

22. Are we to create this as a fee for service program?

A: The Bettor Choice programs will be provided with $300,000.00 annually, but funding from third party reimbursement for clinical services, is expected to assist with operating costs. If the contracted agency establishes a fee for service it is to be reviewed and approved by the Department designated Program Manager and must not present a financial barrier to treatment and recovery services.

23. We are a Disordered Gambling Integration grantee. Does that deem us as ineligible to apply ? I know that the current Bettor Choice sites no longer have the DIG-In grant as it is inclusive in the work with Bettor Choice as a treatment program.

A: No, Disordered Gambling Integration programs can apply for this RFP.

24. Are the 50 clients per month unique individuals, or does this number include duplicates (e.g., repeat clients)?

A: A client that is readmitted into treatment can count towards the 50 clients.

25. Is the client count based on their initial entry into the program, or are they only counted once they reach the IOP level for reporting purposes?

A: The individual counts as a Bettor Choice client for the duration of the time they are in treatment with the program.

26. Should we be tracking Young Adult (YA) and Adult (A) populations separately for data reporting purposes?

A: No.

27. Does reporting require a separate DMHAS form, or is it included in our standard DMHAS reporting process? Additionally, is there specific coding within DMHAS that applies to this program?

A: The Gambling Assessment is included within DDaP. Please see the following link to review the form: Gambling Assessment. Bettor Choice will be a separate program within DDaP.

28. Prior to completing the required International Problem Gambling training, would it be acceptable to begin providing treatment and services to clients through our existing addiction program?

A: Yes, but staff should be working towards the International Certified Gambling Counselor (ICGC) and/or International Gambling Recovery Specialist (IGRS) credential(s) within one (1) year of the program's start date if not currently certified.

29. The budget that needs to be completed for the RFP just includes expenses. Since we believe we will be able to bill a portion of the IOP & OP services that will be provided to our clients, if the expenses are higher than the $300,000 grant threshold, how do we properly reflect those expenses that will be offset by the Third Party Revenue and/or In-kind contributions in the Budget Template supplied?

A: Please include this information within the **Budget and Budget Narrative** section of the proposal, **section c., i.**, which states: Complete *a price schedule, budget, or cost proposal in its entirety that will enable the effective delivery of the proposed project or services.*

30. Can Letters of Support or Commitment be submitted with the grant? If so, where among the attachments should they be placed?

A: No, letters of support are not needed for this RFP.

31. The fifth item in the Proposal Content Checklist on p.37 – "Relevant attachments" – appears to say that we can extend our response to any of the 6 sections listed in order to make sure "certain required information is sufficiently captured" and add it as an attachment. Presumably this material is not counted in the 16-page limit. Is this correct?

A: Yes, that is correct.

32. Can experience treating addiction count as experience treating problem gambling?

A: There needs to be some level of experience with problem gambling as identified in the minimum qualifications section of the RFP (e.g. *Demonstrated experience providing gambling treatment services or problem gambling integration as well as outreach, engagement, and specific experience supporting individuals who are at high risk for problem gambling*).

33. Since the RFP states the Bettor Choice grant is the payor of last resort, is there a required minimum threshold of insurance billing (Medicaid/commercial) expected?

A: There is not an expected minimum, but there is an expectation that insurance reimbursement will be a funding component of the program.

34. Will DMHAS provide guidance or oversight on sliding fee scales, or are agencies expected to create their own structures?

A: Agencies are expected to have their own structures, but the Bettor Choice program will work closely with the Department on fiscal monitoring reporting monthly. If the contracted agency establishes a sliding fee scale it is to be reviewed and approved by the Department designated Program Manager and must not present a financial barrier to treatment and recovery services.

35. Will DMHAS provide a standard reporting template for reports? Is this included in the DDAP report card or expected from other sources?

A: Yes, DMHAS will provide standard reporting templates.

36. For the required 20 community outreach events per year, can these be combined with broader agency outreach efforts, or must they be stand-alone gambling events?

A: Yes, they can be combined, but Bettor Choice should be identified within the agency's outreach efforts.

37. Will DMHAS provide materials or branding guidelines for outreach activities?

A: Yes, DMHAS will collaborate with the Bettor Choice programs for materials and outreach activities when applicable.

38. Are online outreach efforts (social media campaigns, webinars) counted toward the 20 events, or must they all be in-person?

A: Yes, online outreach will also be considered, but the 20 events should not be entirely online.

39. Under our existing contract, we had been granted some additional funding that we elected to use for an additional 0.5 FTE Recovery Support Specialist. I'm assuming that this funding line would end at the expiration of the current contract. Would it be allowable to add 0.5 FTE additional time for Recovery Support Specialist if the budget allows it?

A: Yes, the staffing expectation in the RFP is a minimum to operate the program. Your agency can go beyond the minimum staffing identified in the RFP.

40. Is it required to have had 2 years of experience providing problem gambling treatment or integration by the time of the proposal or is it required by time of the start of grant?

A: A timeframe was not identified, but some level of experience is needed as indicated in the minimum qualifications section of the RFP (e.g. *Demonstrated experience providing gambling treatment services or problem gambling integration as well as outreach, engagement, and specific experience supporting individuals who are at high risk for problem gambling).*

41. On Page 14 item g Completing Gambling Assessments in DDaP, can you provide the data points included in the reporting?

A: Please see question 27.

42. Can you confirm that the program capacity expectation is to serve 600 duplicated clients annually, with an average of 50 clients in treatment each month? The RFP states the expectation as unduplicated, but at the bidder's conference we were told it could be a duplicated number.

A: The expectation is that there will be a minimum of 50 clients in treatment during any given month. The Department does not expect that there will be 50 new clients every month, as each client has their unique treatment goals, so timeframes to complete the program may differ. In the event the program is unable to meet the minimum caseload requirements, the agency will provide a documented outreach plan to the Department.

43. On Page 8 of the RFP it states: "The services provided shall be part of a comprehensive recovery-oriented treatment plan that is consistent with evidence-based standards of gambling treatment and recovery services and approved by a Department approved program manager." Can you clarify if the Department approved program manager is a member of the respondent's organization or if it is a member of DMHAS staff.

A: This will be a DMHAS staff member in the Problem Gambling Services Unit.

44. On page 8 in the section C:1:a:ii it notes the following:

> ***ii. Provide organizational chart in attachments including the advisory/oversight committee.***

Can you please explain what you are looking for here? Is this a question about our Board of Directors structure of our organization or something different.

A: This is a chart of your organization that can include Board of Directors.

45. Is it acceptable to integrate IOP and/or group therapy for Problem Gambling with individuals with other substance use disorders?

A: Please see question 11.