COUNTY OF FRESNO

ADDENDUM NUMBER: TWO (2)

RFP NUMBER: 962-5212

CO-OCCURRING DISORDERS MENTAL HEALTH SERVICES

October 11, 2013

PURCHASING USE
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IMPORTANT: SUBMIT PROPOSAL IN SEALED PACKAGE WITH PROPOSAL NUMBER, CLOSING DATE AND BUYER'S NAME MARKED CLEARLY ON THE OUTSIDE TO:

COUNTY OF FRESNO, Purchasing
4525 EAST HAMILTON AVENUE, 2nd Floor
FRESNO, CA 93702-4599

CLOSING DATE OF PROPOSAL WILL BE AT 2:00 P.M., ON NOVEMBER 8, 2013.

PROPOSALS WILL BE CONSIDERED LATE WHEN THE OFFICIAL PURCHASING TIME CLOCK READS 2:00 P.M.

Proposals will be opened and publicly read at that time. All proposal information will be available for review after contract award.

Clarification of specifications is to be directed to: **Brian D. Tamblin, phone (559) 600-7117,** e-mail CountyPurchasing@co.fresno.ca.us, **FAX (559) 600-7126.**

NOTE THE FOLLOWING AND ATTACHED ADDITIONS, DELETIONS AND/OR CHANGES TO THE REQUIREMENTS OF REQUEST FOR PROPOSAL NUMBER: 962-5212 AND INCLUDE THEM IN YOUR RESPONSE. PLEASE SIGN AND RETURN THIS ADDENDUM WITH YOUR PROPOSAL.

- **Questions and answers received prior to and at the vendor conference held October 9, 2013.**

ACKNOWLEDGMENT OF ADDENDUM NUMBER TWO (2) TO RFP 962-5212

COMPANY NAME: _____
(PRINT)

SIGNATURE: _____

NAME & TITLE: _____
(PRINT)

QUESTIONS & ASNWERS

Q1 Given the acuity level and chronic nature of some of the challenges faced by the potential clients of the project, should programs be prepared to manage a static caseload of 98 clients or do you anticipate some throughput/turn in the population? If caseload is not static, what is the county's estimate of maximum number of clients served?

A1 The population that makes up this caseload is not static and there will be some turnover of clients through the program. The County cannot provide an estimate of how many the awarded provider will serve, but does require the awarded provider serve a minimum of 98 unique clients annually. Below are the statistics reflecting those served by the current Co-Occurring service provider from January 2012 through December 2012.

- *Total FSP referrals received: 33*
- *Total Successful Engagement from Referrals: 24 (9 refused services or could not be tracked down)*
- *Total FSP clients served: 79*
- *Total FSP clients receiving services: 64 (# of clients on December 31, 2012)*

Q2 Do you have any additional information about the population of clients the county wants served under this program? It is likely these are your high utilizers of multiple systems, can you tell us any more about their demographics, primary languages spoken, housing status, etc.?

A2 Client Demographics for Calendar Year 2012 (January – December):

Caucasian: 46
Latino: 16
African American: 12
Asian: 3
Native American: 1
Indian: 1

- *The primary language spoken of all CDP clients for CY 2012 was English.*
- *71 consumers were assisted with locating and securing safe and affordable housing during 2012.*
- *42 consumers received housing subsidies from MHSA housing funds.*
- *13 consumers were successfully transitioned to independent permanent housing.*
- *4 consumers have participated in a sober living home/environment*

Q3 Do you want these services centered in the city of Fresno or to be placed throughout the County? Do you want multiple service sites or one service site providing outreach to other areas? Do you anticipate that much of the service will be done through home visits and services at community sites?

A3 Co-Occurring services are currently centered in the city of Fresno at one site. However, this is a Full Service Partnership program so should include a "whatever it takes" approach for providing these services where and as needed. Proposals should identify the best

approach for providing the required services to the targeted co-occurring disorders population. Wherever the service site(s) is, outreach must be incorporated to reach those un/underserved clients that are the target population.

Q4 Do temporary emergency housing, subsidies for independent living, and representative payee service provider fees funds come out of the project allocated budget or are they funded separately? If it is anticipated they will be paid from project funds, is the county able to provide some cost estimates for these items?

A4 All necessary client support expenses (emergency housing, housing subsidies, representative payee, etc.) should be included in the proposed budget. Provided below are the client support year-to-date expenses for the current Co-Occurring service provider from Fiscal Year 2012-13 (July 2012 – June 30, 2013) for reference. Non M/C (Medi-Cal) expenses may include such categories as housing, personal clothing/hygiene items, household items, representative payee, etc.

Client Activities	*$1,485.75*
Non M/C Client Support & Expenditures	*$211,319.03*
Medication Supports	*$20,838.54*

Q5 Section XII. Scope of Work seems to require both a "general discussion . . . of the Scope of Work" and a "detailed description of your proposal as it relates to each item listed under the 'Scope of Work' section of this RFP" (RFP, p. 47). Is it the county's intent for applicants to address the CCISC service delivery framework with its 15 "Required Service Components" (RFP, pp. 26-31) rather than what is labeled in the RFP as "Scope of Work" (RFP 23-25) or both? If only the Scope of Work is to be addressed, should the required service components also be addressed in the proposal and if so, where?

A5 Following the Scope of Work, the proposal should include a clear description of the bidder's understanding of the Scope, and should address at a minimum, their specific experience related to the items #1 through #6, beginning on page 24. Following each of the Required Service Components (beginning on page 26) the proposal should clearly identify the bidder's relative experience and specifically how their program would meet the requirements of each component.

Q6 The "Required Service Components" also includes a very long list of Service/Program Expectations (RFP, pp. 31-34), of which the Culturally Competent Services expectation has 14 sub-components (RFP, pp. 32-34). Should these also be addressed in the proposal and if so, where?

A6 Yes, all program expectations should be addressed. Proposal responses should follow the end of the relative component.

Q7 Can you please clarify the purpose of Exhibit A: Full Service Partnership Service Delivery Model (located at the rear of RFP).

A7 The Co-Occurring Disorders program is a Full Service Partnership (FSP) and must be guided by the FSP Service Delivery Model. The FSP Service Delivery Model outlines the requirement for all FSPs. Proposals need only to incorporate their organizations acknowledgment of an FSP and do not need to respond to Exhibit A.

Q8 As part of the instructions for Section XII, it is stated that "when reports or other documentation are to be a part of the proposal, a sample of each must be submitted. Reports should be referenced in this section and submitted in a separate section entitled 'Reports' " (RFP, p. 47). The meaning of "reports" is unclear. Is this a reference to the Full Partnership Forms: Partnership Assessment Form, Key Event Tracking Form, and Quarterly Assessment Form (RFP, p. 38) and included in the RFP as Exhibits C1, C2, D1, D2, E1, and E2 (in rear of RFP)?

A8 Example: if you have a report that demonstrates your agency's experience in tracking relative statistics and how that report was used to improve specific client services, you might want to include that report in the proposal. If so, then you would need to reference that report in the section as instructed, and then include a copy of that report in a separate section of your proposal entitled "Reports".

Q9 The RFP provides a list of both goals and objectives and also a list of five outcome measurements. "Program Goals and Objectives" are identified (RFP, p. 32) in the "Required Service Components" while there is an entirely different list of five "Outcome Measurements" (RFP, p. 38) in the "Minimum Requirements". Which should be used to guide the program?

A9 Both program goals and objectives and outcome measurements should be used to guide program development and operations. Program Goals and Objectives include issues that the program should be designed to address. The goals and objectives will be measured using at least the five identified Outcome Measurements. The outcome measuring are some of the tools used to evaluate programs for success, to determine where more attention may be needed, and to determine if funding should be pulled, maintained or increased. In addition, organizational programs are allowed to add additional measureable outcomes that will enhance the program and/or identify program success.

Q10 Supportive materials may be submitted with the proposal as appendices but these "must be referenced by the appropriate paragraph(s) and page number(s)" (RFP, pp. 13, 45). Where are the references to be placed?

A10 References to appendices must be made in the proposal paragraph that it pertains to. The reference within the paragraph should include the Appendices title and appendices letter/number.

Q11 It does not appear that specifications have been set down for font, font size, line spacing, or margins, do you have a preference?

A11 Though not required, Ariel Font (12) is easily read. Spacing and margins should be formatted in a standard/common style for ease of review.

Q12 Services shall begin July 1, 2014 with an initial three-year award and a provision for two one-year automatic renewal periods given satisfactory performance outcomes and adequate funding. A maximum of $1,197,668 of MHSA funds is available (RFP, p. 3). It is unclear whether this is per year of life of project, can you please clarify.

A12 The referenced $1,197,668 maximum pertains to MHSA funding only, per fiscal year. The maximum MHSA funds available over 5 years would be $5,988,340. Please keep in mind that your projected budget should be considerably higher than the annual maximum as it

should include estimated Medi-Cal Federal Financial Participation (FFP) revenue, and any anticipated Client Rents/other revenues.

Q13 Are any other non-MHSA funds likely to be available to support client activities?

A13 The funding sources for the Co-Occurring Disorders program include: MHSA funds, Client Rents revenues (paid directly to the provider), and Medi-Cal Federal Financial Participation (FFP). These 3 categories combined will make up the total funding for this program, including client support activities.

Q14 Both "local and corporate administrative costs" must be held to a maximum of 15% of the "total program budget" (RFP, p. 42). Does total program budget means of all revenues, not just MHSA funds?

A14 Administrative costs will be calculated using the total budget, including all funding sources (MHSA, Client Rents/Revenues, FFP). Administrative cost will be no greater than 15% of the overall program budget. In addition, employee benefits will be no greater than 20% of staff salaries working under this agreement.

Q15 Will the county advance funds to the vendor for starting up the program rather than having to bill costs and wait the roughly 100+ days for reimbursement?

A15 The County will consider a request for partial advance of the annual award for start-up of a new program.

Q16 Do we bill Medi-Cal services at the current SMA rate? How does the county want to handle the new Magi Medi-Cal that will be in effect when this program starts? Given that most of the co-occurring consumers will be eligible for Magi Medi-Cal, does the county expect us to plug these revenues into our budget preparation? If so at what rate?

A16 ***Please see page 40, paragraph 5 of the RFP.*** *As of June 30, 2012, interim claims for payment of federal reimbursement for specialty mental health services are not limited the Schedule of Maximum Allowances (SMA). The County must submit claims for reimbursement of services provided by contract providers that are equal to the lowest of 1) the amount the County paid the provider, 2) an estimate of the provider's reasonable and allowable cost to provide the service, or 3) the provider's usual and customary charge for the service. All estimated Medi-Cal revenue should be included in your proposed budget (see p.3 of Exhibit G). Use the usual and customary rate charged by your agency for billable services.*

Q17 Page 24 the page refers to both the mh diagnosis and the Substance abuse diagnosis both being primary—given that Short Doyle Medi-Cal only pays when the MH diagnosis is primary, how do you want us to manage that?

A17 Estimate the Medi-Cal revenue your program can generate, including consideration of the changes in Medi-Cal eligibility. Expenses not covered by revenues, Medi-Cal and otherwise, will be applied to the available MHSA funding. MHSA shall be used as a last resort to cover the costs for those not eligible for any other payer source. Medi-Cal will not cover the cost for services if the Mental Health is not the primary diagnosis, services will be provided and paid out of MHSA funding.

Q18 On the bottom of page 26—do we interpret the reference to 3 residential beds to mean that we budget 3 (30) days stays at a residential facility per year?

A18 ***Residential beds will be readily available at any given time.*** *You should budget for the use of three (3) residential treatment beds at any given time. Budget as though the three beds will always be full.*

Q19 Page 27 "…money will be available for temporary housing", Do we interpret this to mean that the county has funds that we can access outside of our budget for these services.

A19 There will be no funds available outside of the awarded program budget. Include estimated costs for providing temporary housing services. However, the awarded program should be familiar with other housing resources available in the community that may prevent use of MHSA funds in each instance.

Q20 Page 31 " the vendor will establish a program to provide rent subsidies for independent housing" Does the county expect the vendor to subsidize those that need extra rent funds on top of their SSI etc. for an indefinite period of time?

A20 The Co-Occurring Disorders program is an FSP and should be operated utilizing a "whatever it takes" approach to assisting the target population in becoming as independent and stable as possible. Ideally, the program can assist most in becoming independent enough to handle their own rent amount without ongoing subsidies; however, there may be some who require ongoing housing subsidies to attain stability, wellness, and recovery.

Q21 Page 31 refers to a psychiatrist and a FNP but can we presume that a PA is also acceptable medical personnel.

A21 A Psychiatrist, Family Nurse Practitioner and/or Physician's Assistant are all acceptable medical personnel.

Q22 Page 32 the vendor is to develop a "formal written CQI action plan" What time frame for does the county expect this formal written plan to be written by?

A22 Ninety (90) days from contract effective date.

Q23 Regarding outcome measures, does the county want the vendor to develop these outcomes measures themselves or does the county have specific ones they want the vendor to use?

A23 Please see Page 38 of the RFP. Specific Outcomes Measures are:

- *75% reduction in hospitalization;*
- *75% reduction in incarcerations;*
- *75% reduction in homelessness;*
- *75% reduction in crisis episodes; and*
- *A significant increase in LOCUS client functioning.*

However, there are many goals and objectives of the Co-Occurring Disorders program and may be other outcomes measurements requested. It would be useful to include in

your proposal other outcomes your program would measure and how they would be tracked.

Q24 The billable requirement for 35% productivity seems low. What was the reasoning behind that percentage?

A24 The billable requirement of 35% was set based on the current co-occurring program provider's billable time. Given the co-occurring nature of this population, many clients are/were not eligible for Medi-cal. That percentage is subject to reconsideration given the new Medi-Cal requirements and anticipated increase in those who are Medi-Cal eligible. This would also impact the estimated Medi-Cal revenue.

Q25 Due to the need of clarification on the RFP, is it possible to extend the Closing Date?

A25 Purchasing has provided extensions as follows:

- *October 21, 2013 for Written request for interpretation or corrections of RFP*
- *November 8, 2013, for the RFP Closing Date*

Q26 What is the expectation with the mobile crisis unit?

A26 Co-Occurring Disorder mental health services should be provided utilizing a "whatever it takes approach" to reach and serve this challenging population. The mobile crisis unit/team should be available 24/7 to provide client assessments, stabilization, etc for clients determined to be in a mental health crisis when and where it becomes apparent. For example, the mobile crisis unit/team may be called upon to attend to a client's crisis at their home/shelter, the hospital/emergency room, or a lower level care facility.

Q27 The RFP mentions the Wellness Recovery and Action Plan (WRAP), Assertive Community Treatment (ACT), and the Comprehensive, Continuous, Integrated System of Care (CCISC) Model, which one is to be followed for this program?

A27 The proposal should incorporate and reflect the use of each model as it best fits the client needs.

Q28 Is this a new program and MHSA funding stream? If not, has the program funding been increased from previous years?

A28 the Co-Occurring Disorders program is an existing program and currently operated by contracted provider. Most recently, the program funds have been increased to support additional clients (from 60 to 98) as well as three (3) residential treatment beds. The funding increase reflects the support to provide services to the additional clients to be served.

Note: Purchasing's new number for Brian Tamblin is (559) 600-7110