Youth Full Service Partnership Wraparound Services RFP
QUESTIONS & ANSWERS

The following are answers to questions that were posed by prospective applicants:

1. **Is the $3,000 per client for flex funds per fiscal year or per the life of the case? What is the plan to track these allocations as client slots turnover during the year?**
   The flex funds are a total pool of funding (not a capped per client amount) per fiscal year, to draw down as needed for additional client support services, as described in the RFP. The total amount of the flex fund pool is determined based on the client number you propose to serve. For example, if you propose to serve 45 transition-age youth slots, then you will have access to a total amount of $135,000 (45 slots x $3,000) to use as needed throughout the fiscal year, regardless of client slots turnover. There is no cap amount per client, some may end up needing less or more than $3,000.

2. **Providing at least 6 months of step down care.... Will those referrals be included in or in addition to the slots? What is the plan for transition of care planning once those referrals have been received?**

   FSP care teams should coordinate closely with outpatient teams or alternative step down program for a 60-day transition period, where the client's file is open in both programs. Therefore, the client would be included in the total number of slots for the 60 day transition period.

   Please review Appendix E – Step Down Guidelines, Transition Coordination section for additional guidance transition care planning.

3. **CFTs- is the expectation that the FSP team will facilitate CFTs on behalf of CFS? Would the use of another multidisciplinary team meeting model be accepted?**
   The CFT will be conducted by a Child and Family Services (CFS) Social Worker if the client is open to the agency. If the client is not open to CFS or Probation, the FSP team would be responsible for conducting CFTs.

4. **The RFP mentions several youth and caregiver advisory committees/boards to review, guide and/or modify the ongoing operation of the FSP and the TAY Drop-in Centers. How many boards are expected? If more than one, can you distinguish between them?**

   FSP Wraparound program will establish at least one advisory committee of youth and families to advise on operations. More than one advisory group can be proposed. Input should be solicited for each item in the RFP that mentions the advisory committee:

   - **Program Characteristics: item E.1.f. (page 11 of the RFP)**
   - **Drop-in Centers: item E.13.j. (page 10 of the RFP)**
   - **Quality Assurance: item I.2. b. (page 46 of the RFP)**

5. **What is meant by (examples of):**
   - Emergency medical treatment
   Any medical care or treatment to support immediate urgent and potentially life-threatening issues. FSP providers are only expected to facilitate the process of getting a client access to emergency medical treatment. Please refer to section E.12. (page 10 of the RFP) for a full description.

   - Wellness/Drop In Services
   Wellness/Drop-In Services provide a safe location for TAY to meet and receive support services focused on wellness, independence, and skill building. Please refer to section E.13. (page 10 of the RFP) for a full description.

   - Aftercare Services
   Aftercare Services refers to transition services provided to clients after program completion, please refer to section E.16.b (page 24 of the RFP) and Appendix E – Step Down Guidelines for more information.

   - Program completion processes
   Program completion refers to client transfers and disenrollments. Please refer to section E.17. (page 24 of the RFP) for more information.

   - Cost of healthcare services (in addition to what's available through flex funds?
   Healthcare services will primarily be covered by client's insurance and flex funds could be leverage to support unbillable costs.

-Can more than $3,000 be accessed per client, if needed?
Yes, the flex funds are a total pool of funding (not a capped per client amount) per fiscal year, to draw down as needed for additional client support services as described in the RFP. Clients may end up needing less or more than $3,000.

6. Regarding the Wellness Recovery Action Plan requirement: Is the idea that these will be groups or an approach to individual support? If it requires facilitated groups, will the cost of these training facilitators and group expenses be a reimbursable expense in the contract, even if it is over and above the contract amount?

   There is no requirement to implement Wellness Recovery Action Plans intervention to fidelity. FSP providers will ensure that there is interagency and community collaboration to provide access to additional supports that may needed to support Wellness Recovery Action Plans.

7. Referral packet- outlines that the FSP provider would open an Admin RU then request the referral packet... This would not come through the BHRS review committee leader?
   FSP provider opens the Admin RU (reporting unit) following Interagency Placement Review Committee (IPRC) approval. The Treatment RU is open once the completed referral packet is received by the FSP provider.

8. If an enrollee requires a higher level of care than what the FSP Wraparound program can provide, the FSP Wraparound team will contact the BHRS Program Manager for consultation on how to proceed.-It appears that the provider would have an opportunity to assess the client's needs and fit for the program, is that accurate?
   FSP is the highest level of care of BHRS outpatient services offered. BHRS is not a placing agency for Short-term Residential Program (STRTP)/residential placement. FSP Wraparound team can consult with BHRS Program Manager during monthly oversight meetings, Complex Case Conferences and IPRC Case Assistance meetings to explore needs and supports.

9. What is the TBS Assessment? Is that required of all clients- including those who are not on full-scope Medi-Cal therefore ineligible for TBS?
   TBS Assessment is only for clients who have full-scope Medi-Cal. It is managed through a separate contractor.

10. **Clarify the line between "relentless outreach" (page 16) with the expectation of closing clients who are receiving less that 1 contact or/and less than 3 hours per week of service consistently.**
    Initially, outreach efforts will be consistent or "relentless" to ensure engagement. As the client moves into treatment closing client episodes can discussed in the monthly oversight meeting with the BHRS Program Manager.

11. **What is meant by "initiate" a 5150 hold? Would there be time and funding to establish this capacity in a ramp up period for an agency that doesn't already have this capacity?**
    The designation of staff capable of initiating a 5150 hold is determined by BHRS for San Mateo County. Designated staff will be offered training required for this certification. Please include all training costs in your proposed budget. Even if staff were previously certified outside of San Mateo County, a new certification would still be required. Given this, time would be allowed to obtain this certification to establish this capacity.

12. **Crisis response team would be someone "that is a core member of the team and known to the client"- could this include management?**
    Yes. The crisis response team can be a core member of the treatment team known to the client along with management, who may be less familiar with the client and family.

    -Will there be money in the budget to cover overtime for core members to be available outside of the Monday through Friday business hours?
    Funding for crisis response outside of the usual business hours should be included in the proposed budget.

13. **Are training and certification costs for SB803 employees reimbursable expenses?**
    Yes. Training and certification costs for SB803/Peer Support Specialists would be the responsibility of the agency and need to be accounted for within the proposed budget. Scholarships might be available to cover some expenses although this is not guaranteed. FSP providers will ensure that there is interagency and community collaboration to provide access to additional supports that may needed for Peer Support Specialists.

14. **How would the contracting agency get reimbursed for emergency medical transport or emergency medical services if not through this contract?**
    FSP providers are only expected to facilitate the process of supporting a client getting access to this care. Emergency services will primarily be covered by client's insurance and flex funds could be leveraged to support unbillable costs.

15. **Family Support Services- what is the expectation on documenting these services? The provider would not be able to document individual or family therapy for a parent or couple in their youth's medical record.**
    Documentation of services would need to follow the Quality Management Documentation Guidelines for Medi-Cal. Services provided to the client and family would be documented in relation to the client as parent or couple therapy is not currently a reimbursed service by Medi-Cal. However, there might be changes following implementation of CalAIM.

16. **More information about the outside funding for Education support services is needed. What is the agreement already arranged with College of SM and can we get a copy along with the responses to bidder questions?**
    There is a Supported Education program contract offered at the College of San Mateo. FSP enrollees would be able to access these services.

17. **The case manager's role included a minimum education or experience requirement. There wasn't one for the director or program manager. Is this intentional? Are there specific requirements for the leadership roles?**
    The director or program manager would preferably be a licensed or license eligible professional with demonstrated experience working with the identified population.

18. **There was a staffing model available for the integrated youth, comprehensive youth and TAY. What about the staffing for the Drop In Centers?**
    A staffing model for the FSP Wraparound Teams was included to support the required multidisciplinary team-based approach. Please include your proposed staffing model for the Drop-In Centers.

19. **Define "unscheduled work".**
    Item F.2.d.i defines unscheduled work as “extraordinary incidents such as vandalism, natural disasters, and third-party negligence.”

20. **Would the contractor be able to use flex funds for the respite care services?**
    Yes. If a client is connected to Children and Family Services (CFS), they may have access to respite care services. Otherwise, flex funds can be an option.

21. **Remediation plan for staff vacancies longer than 4 weeks.... Is there a specific communication or template for this or is it a topic to be covered in the monthly partnership meetings?**
    There is no template for a remediation plan for staff vacancies and this would be a topic that could be covered in the monthly partnership meetings.

22. **Are the prescribed staffing FTEs suggestions or mandatory?**
    The team-based model and FTEs described in the RFP are required for FSP Wraparound programs.

23. **Who is the Respite Caregiver? Is this a service funded by the FSP contract and provided by the FSP team?**
    If a client is connected to Children and Family Services (CFS), they may have access to respite care services. Otherwise, flex funds can fund respite care services.

24. **Funding for alternate therapies- Would this funding be for individual or/and group therapies? What would be the maximum amount?**
    The provision of alternate therapies would need to be in accordance with Quality Management guidelines.

    There are also alternative care models that consider cultural/ethnic nuances. For example, the use of faith, traditional and religious practices, such as drumming, etc. If an alternative care model were to be provided, the cost should be included in the proposed budget.

25. **The quarterly data- please provide an example of what data may be provide so that bidders can estimate how much QA or administrative time to build into the budget.**
    Quarterly data would be a raw data output of the ongoing day-to-day data collection and entry required and described in section J.3. Data Collection. BHRS has procured an independent evaluation

consultant that will conduct data analysis to support continuous improvement processes.

26. **It would appear as though the clinician isn't expected to diagnose for Medi-Cal billing. Please confirm.**
    The ability to provide a diagnosis for a clinician would still be required as part of a professional training and licensure requirement unless the Board of Behavioral Science Examiners changes this requirement. The implementation of CalAIM will affect some documentation requirements. Also, diagnostic codes may be required for Medi-Cal billing.

27. **Please provide an estimate for the frequency and length of advisory meetings, what the roles (facilitation, outreach, administration, tracking, notes) of BHRS and the providers will be in the formation and management of the advisory group to inform quantifying this in the budget.**
    FSP Wraparound will be responsible for establishing, administering and facilitating at least one advisory committee of youth and families to advise on operations. More than one advisory group can be proposed. The cost of the advisory committee should be included in the proposed budget.

28. **TBS meetings... The FSP Provider is required to submit meeting findings. Is the Provider also expected to convene, facilitate or any other roles?**
    Therapeutic Behavioral Services (TBS) will be provided by a contractor agency. It would be the expectation of the FSP Wraparound provider to convene, facilitate and/or collaborate with the TBS provider as part of care coordination.

29. **Confirm that "Team Meetings" are internal to the contracted agency/assigned wrap team and NOT synonymous with CFTs or Family Conferences.**
    Team meetings would be internal to the agency unless it is specified that it is a CFT meeting which might include other partner agencies such as Child Welfare or Probation.

30. **Diversity & Equity work- Please provide an estimate of number of hours per month for this participation so that it can be factored into the budget and accounted for in the efficiency rate for an assigned staff.**
    Participation in a Health Equity Initiative (HEI) or the Diversity & Equity Council (DEC) to meet the Cultural Competence Plan requirements of contracted agencies, includes monthly one-hour meetings.

31. **Requirement of a Licensed clinician. Could this also be a BBS registered Associate working under a licensed clinical supervisor? Or a clinical trainee working under a licensed clinical supervisor?**
    Clinicians need to be licensed or license eligible which could include an Associate working under a licensed clinical supervisor. Also, a clinical trainee working under a licensed clinical supervisor who met the BBS requirements would be considered.

32. **The monthly units reports will be provided to BHRS. Is this part of the monthly invoice for billing?**
    Yes, any monthly reports should be submitted along with the monthly invoice to support documentation of services provided.

33. **Will the monthly reports on lock outs and prolonged disengagement be a part of the monthly partnership meetings or expected in a different way/format?**
    Monthly reports on "lock outs" and prolonged disengagement would be discussed at the monthly partnership meetings.

34. **Annual focus groups and other feedback activities. Similar to the advisory meetings, please provide an estimate of the roles for the provider (facilitation, outreach, administration, tracking, notes) of BHRS and the providers will be in the implementation of these activities to inform quantifying this in the budget.**
    An independent evaluation consultant will conduct the focus groups and other annual evaluation-related feedback activities including the subsequent data analysis and reporting. FSP providers will support these activities by identifying clients and families to participate and supporting them in the process, which may include attending the feedback activity(ies) with the client if that is preferred. FSP providers are expected to collect ongoing data and enter data as described in the RFP, section J. Reporting and Evaluation Requirements

35. **Statement of Minimum Qualifications (up to 1 page) on page 51 of the RFP, are we to understand this section includes the MQ narrative and the MQ Checklist, and documentation of Medi-Cal certification, but that only the MQ narrative counts as a page?**
Yes, only the MQ narrative counts towards the one (1) page limit. The checklist and certification can be included as attachments.

36. **Please confirm that you want 11 different pdf files (sections a-j under "Submission of Proposals") uploaded and submitted to Public Purchase?**
The items listed are required items to include. This could be one (1) pdf file that includes all items clearly labeled.

37. **Aside from Flex Fund policies (as per top of page 52 of the RFP), what other types of policies would you like included in the "Policies & Procedures as available" section?**
Any relevant policies and procedures that you identify to support the requirements of the RFP could be included but not required. For example, the RFP describes the need for policies in areas such as, but not limited to:
    - **Flexible Funding**
    - **Cultural Competence Plans**
    - **Compliance with HIPAA, Confidentiality Laws, and PHI Security**
    - **Medication Storage**
    - **Equal Employment**

38. **The 11 items a-j outlined for upload on pages 49-50 don't align with the sections of the proposal outlined on pages 51-53. For example, on pages 49-50, there is no request to upload Agency Qualifications (as requested on page 52) or Team Qualifications (also page 52). Instead on page 50, a "Staff Training Plan" is requested. Can you clarify exactly what narrative portions (and how many pages) go in each submitted file?**
Please include the requested “Agency Qualifications” and “Team Qualifications” files. These were unintentionally left out of the outlined list of items to include (pages 49-50 of the RFP). Any item not provided with a page limit can be included as an attachment.

39. **Section 4 Agency Qualifications says it is no more than one page OVERALL, but then item a.ii says to describe three programs taking up to a page EACH. Please clarify how many pages are allowed in this section?**
    Please limit the Agency Qualifications to 1 page. One page descriptions of EACH program is not correct nor required.

40. **Are there any page limits for a Budget Narrative?**
    Please limit the Budget Narrative to 2 pages and include as an attachment with the proposed budget.

41. **Is the Staff Training Plan to be a separate uploaded attachment? Or something that is addressed in the narrative?**
    The Staff Training Plan can be included as an attachment.

42. **Are there any requirements for font size in the narrative? In tables or charts?**
    Arial 12-point Font is preferred, Times New Roman is acceptable. Please make sure information is clearly visible.

43. **Can you provide the Budget template in Excel?**
    Yes, an Excel version of the Budget Template has been uploaded to Public Purchase and will be sent directly to all that have attended the Proposer's Conference.

44. **Edgewood (current contractor) has 40-50 FSP and Drop-In Center staff. Do we need to provide resumes for each one? Or would it be acceptable to include job descriptions? We won't be able to provide qualifications for each within the two narrative pages allowed for staffing (Team Qualifications on page 52).**
    Please include available resumes as attachments (these do not count towards the 2 pages). The two narrative pages should provide a brief description of the general experience and qualifications of the core program team members.

45. **Can the budget request exceed the $6.37M in the RFP in order to account for extra activities such as participation in workgroups, forming advisory committees, etc...?**
    Participation in workgroups and forming at minimum one advisory committee to advise the program operations are considered part of ongoing continuous improvement efforts of programs and should be accounted for in the proposed budget and the administrative activities of the program managers.

46. **Should each of the 11 submitted files be page numbered starting with "page 1", or do you want the pages to be numbered consecutively in some way and tied to a Table of Contents? If the latter, please clarify how pages should be numbered for each upload.**
    Please include a Table of Contents and number each page submitted accordingly, with the exception of attachments. All items listed in section C.1. (pages 49-50 of the RFP) should be clearly labeled.

47. **How does this budget total compare to the current contract amount?**
    The biggest impact on the RFP budget compared to the current contract amount is the allowable indirect expenditures.

    Given this significant change, we would like to request that proposers submit a proposed budget that will meet the needs of the services to be provided as determined by your agency.

    The $6,370,489 available funding described in the RFP, for a total of 125 FSP Wraparound client slots across 3 FSP Wraparound Teams, can serve as a baseline and example of the distribution of funding across the three teams.

    The proposed budget should include 1) Direct Expenditures, which are accounted for under Personnel Expenditures and Operating Expenditures (with examples) in the Attached Budget Worksheet and 2) Indirect Expenditures to be added to the Budget Worksheet at a maximum percentage of 15%.

    Depending on the allocation methodology of each agency, the indirect expenditure may range from 0-15%. Agencies are expected to provide support for the indirect expense calculations including the line item cost objectives that add up to the total indirect cost being proposed and the methodology of allocation to each different cost objective (e.g., square foot for rent/utilities allocation, headcount for HR/finance/payroll/legal costs, etc.). Please refer to Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) No: 21-027 for additional details and definitions of indirect costs.

    Based on DHCS BHIN No: 21-027 referenced above, we are defining direct service and indirect service expenses for FSP Wraparound services as follows:

    Direct service expenses are those which have a clear, direct, and documented relationship to direct services that are provided to FSP Wraparound clients. Typical direct expenses include:

- **Compensation of employees for the time devoted and identified specifically with the delivery of the FSP Wraparound services;**
- **Cost of materials acquired, consumed, or spent specifically with the delivery of FSP Wraparound services;**
- **Cost of maintaining facilities used to deliver FSP Wraparound services;**
- **Depreciation or lease costs of buildings and equipment used to deliver FSP Wraparound services; and**
- **Cost of services provided by subcontractor.**

Indirect expenses are an expense that is incurred for a common or joint purpose (not for the direct service provision), which benefits more than one cost objective and is not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved.

Typical indirect expenses include:

- **Compensation of agency employees for time not devoted and identified specifically with the delivery of a reimbursable activity, or performance of a specific administrative activity;**
- **Allocated, indirect non-personnel expenses such as rent, utilities, insurance, and depreciation of agency facilities; and**
- **Allocated, indirect personnel expenses to cover management services that are necessary to administer FSP Wraparound services. For example, services provided by Director's Office, Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal.**

48. **Are the two Drop-in Centers outlined on pages 20-21 of the RFP also funded by the $6,370,489 total funding amount? How should our discussion of proposed Drop-in Centers be incorporated into the proposal?**
    Yes, the total funding amount includes the cost of all required services, including the Drop-in Centers. Please include the cost of the Drop-in Centers in your proposed budget.

49. **Can you provide instructions ASAP as to what a proposer should submit if they want to apply for all three FSPs? Should all three program components be wrapped into ONE proposal with one budget, or should applications be broken up in some other way? Please clarify.**
    Please submit one proposal and one budget. Your proposal should clearly identify the FSP Wraparound Team(s) you intend to provide:

1) Children/Youth Integrated 2) Children/Youth Comprehensive and/or 3) Transition-Age Youth Comprehensive

50. **Page 52 of the RFP requests:**
A description of not more than three (3) programs similar in size and scope prepared by your agency including client, reference and telephone numbers, staff members who worked on each program, budget, schedule, and program summary. Descriptions should be limited to one (1) page for each program.
Please limit the Agency Qualifications to 1 page. One page descriptions of EACH program is not correct nor required.

Are you saying you want CLIENT references? Or that you want references that are provided in addition to the references you also request in Section 6 of the proposal? Can you also clarify what you mean by "budget" (e.g., just the total contract amount) and "schedule"?
No additional references are required for this section. Please only include short program summaries and total cost of the program(s).

51. **Drop-In Center Hours of Operation: Could the virtual or community based DIC activities (games nights, Peer Partner Chats, and basic need deliveries) be included in the 23 hour per week expectation?**
The Drop-In Center hours of operation will be the hours when the space will be open to the public. Virtual based DIC activities may be offered although this would be independent of the hours of operation.

52. **What is the scope of the Health and Legal Clinics for the drop-in centers?**
A Health and Legal Clinic would not be required to be offered by the contractor. If the contractor develops a partnership with an existing organization, this organization may provide services at the site if there is a shared agreement between the agencies.

53. **Coordination of transportation services for Crisis Situations: Would the provider be required to provide transportation to a hospital?**
No. FSP providers are only expected to facilitate the process of supporting a client crisis needs. Emergency transportation services will be primarily covered by client's insurance and flex funds could be leveraged to support unbillable costs.

54. **Can we get clarification on the role and intention of having parent input in the Drop-In Center programming?**
    The Drop-In Center (DIC) will have a youth and caregiver advisory committee to review, guide and/or modify the ongoing operation of the development of the TAY DIC. This advisory committee may provide guidance for the DIC, Comprehensive FSP Wraparound program and Integrated FSP Wraparound programs. Given that the DIC will be focused on the TAY population, youth input would be more pertinent.

55. **There are specialized services, including Education & Employment support, that 16 & 17 years could access effectively and efficiently through the Drop In Centers. Would the county be open to considering DIC participants starting at age 16?**
    The DIC has been focused on serving TAY clients ages 18-25 for several reasons including clinical issues and legal issues. At this time, the DIC will remain focused on serving the TAY population unless notified otherwise.

56. **Operating at Program Capacity: How will this be monitored? What is the responsibility of the program when the provider is not responsible for referrals?**
    The monitoring of program capacity will occur in a variety of ways including discussion at monthly oversight meetings, census meetings and providing monthly reports on census and billing. Although the contractor is not responsible for generating referrals, the contractor is responsible for related aspects when a referral has been made. For example, the contractor would contact referring providers, discuss engagement strategies with the youth and family and consult with contract managers as needed.

57. **Re page 17 of the RFP about medication practices, it says, "Either a licensed physician (psychiatrist) or a licensed/registered nurse will dispense medication or assist clients in dispensing their own medication." Can you clarify this requirement?**
    There needs to be a licensed medical provider prescribing medications – either a psychiatrist or a licensed nurse practitioner. The only dispensing of medications would be if the provider is offering an injection.

58. **Is it OK to use the Font - Times New Roman 12**
    YES

59. **Please provide any additional information/details on CFT (eg: expectation, available training, etc**
    Additional information/details regarding CFTs would be available form Child and Family Services. This an element of the California Child Welfare Core Practice Model. Contractors will be made aware of available training opportunities.

60. **The budget for these RFP services seems to be lower than previous contracted services. Is this accurate?**
    See Question/Answer #47

61. **How will contractor receive credit/payment for Family Support (eg: Couples Therapy) if not billable through Medical**
    Couples therapy is not currently a reimbursed service by Medi-Cal. Services need to be provided in relation to the client. However, there might be changes following implementation of CalAIM.