COUNTY OF ALAMEDA BEHAVIORAL HEALTH CARE SERVICES (BHCS)
ADDENDUM No. 3
to
RFP No. 18-01 Substance Use Disorder Services

Specification Clarification/ Modification and Recap of the Networking/ Bidder's Conferences held on Thursday February 15, 2018 and Friday February 16, 2018

This County of Alameda, General Services Agency (GSA), RFP/Q Addendum has been electronically issued to potential bidders via e-mail. E-mail addresses used are those in the County's Small Local Emerging Business (SLEB) Vendor Database or from other sources. If you have registered or are certified as a SLEB, please ensure that the complete and accurate e-mail address is noted and kept updated in the SLEB Vendor Database. This RFP/Q Addendum will also be posted on the GSA Contracting Opportunities website located at http://www.acgov.org/gsa_app/gsa/purchasing/bid_content/contractopportunities.jsp

The following Sections have been modified to read as shown below. Changes made to the original RFP document are in **bold** print and highlighted, and deletions made have a ~~strike through~~.

CLARIFICATIONS & CORRECTIONS/CHANGES THAT PERTAIN TO…

I. RFP

- Section I. A. Intent on page 4 – language change
  BHCS will use this Request for Proposals (RFP) to establish contract awards for one year, (with an option to renew through ~~June 30, 2020~~ **December 31, 2020**), with the agencies selected as the most responsible Bidders whose responses conform to the RFP and meet the County's requirements.

  See Section II. ~~E. Instructions on Bid Submittal~~ **F. Submittal of Proposals/ Bids** for more information.

- Section I. B. Background on page 9 – language added
  Added AB 109 in the list of funding streams.

- Section I. C. 5. Priority Service Populations on page 18 – language change
  Priority Service Populations for Perinatal Services
  For the purposes of this RFP, perinatal is defined as ~~a pregnant, post-partum, or parenting woman of a child under the age 5~~. **pregnant women; women with dependent children; women attempting to regain custody of their children; postpartum women and their children; or women with substance exposed infants.**

- Section I. Tables 2, 3, and 4 on pages 7 and 8 – deleted and updated with the tables included in the Addendum Appendix
  Please reference Table 2a and the updated Tables 2, 3, and 4 in the Addendum Appendix.

- I. D. Bidder Minimum Qualifications – Language added
  Proposals that exceed the contract maximum amounts or that are unreasonable and/or unrealistic in terms of budget, as solely determined by BHCS, may be disqualified from moving forward in the evaluation process.

  Bidders are eligible to participate in the RFP process if they meet the Bidder Minimum Qualifications. BHCS will disqualify proposals that do not demonstrate that Bidder meets the specified Bidder Minimum Qualifications, and these disqualified proposals will not be evaluated by the Evaluation Panel and will not be eligible for contract award under this RFP. BHCS has the right to accept all or part of the proposed program model at its discretion.

- Section II. D. Bidders' Conferences on page 41 – language inserted as last sentence under this section
  The Addendum is the final word and response from the County.

- Section II. Table 7 on pages 57-69 – deleted and updated with the Table 7 included in the Addendum Appendix
  Please reference the updated Table 7 for information on scoring weights.

- Section II. Appendices on page 73 – Order change
  ~~II.~~ **III. Appendices**

- Section III. B. f. Level 2.1/ Intensive Outpatient Services (IOT) Assessment/Treatment Plan Review Requirements on pages 84-85 – language change
  For Level 2.1/IOT programs, client assessment and treatment plan reviews include:
  1. Individualized, comprehensive biopsychosocial assessment of a comprehensive substance use and addictive behaviors history reviewed by a ~~physician~~ **LPHA or Medical Director** and if determined needed by a client's medical condition, a physical examination within a reasonable amount of time **which can be provided through a closely coordinated referral**;

- Section III. F. Required Documentation and Submittals Checklist on page 105 – Attachment Title change
  Attachment J – ~~Signed State Required Providers Section~~ **Signed DHCS and BHCS SUD Treatment Provider Required Elements Certification Checklist**
  Please note, use Appendix E of the RFP to include as Attachment J in your bid submission.

II. Fillable Forms

- The Fillable Forms template has been deleted and replaced with the RFP #18-01 SUD Services Fillable Forms REVISED.

III. Budget

- The Residential Worksheet has been deleted and replaced with the Residential Worksheet REVISED.

RESPONSES TO BIDDERS QUESTIONS

General Questions:

Q1) If I am interpreting the recently released data for the RFP 18-01 SUD document, this is not to site *new* OTP facilities, only to expand access to treatment through funding to patients at *current* OTPs. Can you please confirm this?

A1) The current RFP is not applicable to Opioid Treatment Programs. Please refer to Table 1 for a summary of the SUD service modalities that are included in this RFP.

Q2) If a Bidder is proposing services for more than one SUD Service Modality (e.g. Adult Outpatient Treatment and Adolescent Outpatient Treatment), should the bidder submit a separate proposal for each Service Modality being proposed or should one proposal be submitted?

A2) Yes, Bidders should submit a separate proposal for each Service Modality they are applying for or for each geographic priority area for Outpatient Services. Please note, Bidders should check the appropriate box on page 2 of the Fillable Forms to indicate the Service Modality and Population applying for.

Q3) If we are bidding on recovery residence and have multiple residences/ address, does each site address require a separate bid?

A3) For Recovery Residence, a separate bid is not required, however your bid should include the full address of any site you are including.

Q4) For residential perinatal, there is only one modality box on Title page. We serve North and Central County in 2 locations with 2 different budgets. Are these 2 different bids?

A4) For Residential: A separate bid is not required for each site, however a separate budget for each site is required.

Q5) If I have AB109 and Prop 47 beds, do I need to apply for additional beds through this RFP?

A5) This RFP includes residential and recovery residence beds funded by AB109 and Prop 47.

Q6) The RFP details that $14,644,071 are allocated to the outpatient programs. Is the reminder of the overall projected budget going towards the residential/recovery residence programs?

A6) Yes.

Q7) On page 4. the projected total amount available under this RFP is $26,111,347.00. On page 9. of the RFP, the current total budget for SUD services in FY 17/18 is 37.5 million dollars. Please explain the difference in available funds.

A7) The RFP does not include all SUD services. Some existing services are not included in the RFP, e.g. Detox, Sobering Center, Opioid Treatment Programs, Transition to Treatment, Bridge to Treatment, and co-occurring residential treatment programs not funded through DMC system.

Q8) Is Drug Court included in this RFP?

A8) Drug Court funded SUD treatment services are included.

Q9) Page 9 of this RFP lists the funding streams for the SUD DMC-ODS. Is AB109 funding a revenue stream for DMC-ODS too?

A9) Yes.

Q10) In the table Calendar of Events, it lists addendum issued…is this where answers to questions will be provided?

A10) Yes, the Addendum will include all questions received including those emailed and asked during the Bidders Conferences.

Bidder Minimum Qualifications and Eligibility

Q11) In the interest of expanding the number of SUD Treatment services and location of SUD treatment services, presumably there will be new proposed treatment locations. However, page 20 of the RFP stipulates that bidders must be DMC site certified no later than 3 months after contract award. Realistically, DMC site certification can take anywhere from 3-6 months, and is not within control of the applicant. In the interest of expanding access and available treatment locations to patients, will the County consider a more realistic timeframe within which bidders must get DMC site certified, or amend the RFP to designate a timeframe within which bidders must prove they have submitted their DMC application to BHCS? Otherwise, it is highly likely that only currently existing DMC certified providers will be eligible.

A11) The County will maintain its stated timeline for DMC certification per I. D. Bidder Minimum Qualifications on page 20.

Q12) In the interest of expanding access to SUD services to clients, presumably there will be new proposed treatment locations. However, page 20 of the rfp stipulates that bidders must be DMC site certified within 3 months of contract award. Realistically, DMC site certification can take anywhere from 3-6 months and is not something the applicant has control over. In the interest of expanding SUD Tx access by increasing the number of locations available to patients, will the County allow a more realistic timeframe within which bidders must get DMC site certified; OR, will the County amend the rfp to designate a timeframe within which proposers must prove they have submitted their DMC application to DHCS?

A12) Please see response to question 11 above.

Q13) Are bidders eligible if their certification application is with the state – in process/ pending?

A13) Yes bidders are eligible to participate in the RFP process if they meet the Bidder Minimum Requirements. With regards to pending DMC certification with the State, please reference updated Table 7 in the Addendum Appendix for additional information on scoring based on Certification status.

Q14) As a back up to Thunder Road Residential Treatment Program, would you consider contracting with our adolescent residential treatment program which opened in July 2017 and we are already DMC and AOD Certified?

A14) Adolescent residential treatment services are not part of this RFP. Please see Table 1 for a full list of services available in this bid.

Q15) In section D. #3 you mention needing 5 years' experience in specific modality/ASAM Level of Care. Can we assume this can include behavioral health experience?

A15) Behavioral health encompasses mental health and substance use services. Bidders should demonstrate experience providing substance use services in the appropriate modalities bidding upon to meet this qualification.

Q16) Page 9, last paragraph considering there are multiple funding streams it is indicated that for profit organizations may not qualify for funds. Please clarify last paragraph.

A16) For profit organizations are eligible to participate in the RFP process. As stated on page 9 of the RFP and as needed, BHCS reserves the right to allocate categorical funds across contract awardees in a manner that best meets the County's needs as determined solely by BHCS.

Q17) If you have one section on the rating sheet that earns a "fail" does that mean you are eliminated from the whole RFP process?

A17) Bidders are eligible to participate in the RFP process if they meet the Bidder Minimum Qualifications, however, only those proposals that pass the initial Evaluation Criteria which are determined on a pass/fail basis shall be evaluated by the CSC/Evaluation Panel. Please refer to Section H. Evaluation Criteria/Selection Committee for more information.

Q18) Center Point is the Alameda County contracted call center provider. Is Center Point eligible to bid for the services in this RFP?

A18) Yes, as long as Center Point can demonstrate they meet the Bidder Minimum Qualifications.

Q19) For OP and IOP page 20, item #1, please clarify paragraph 1 are we required to be certified at time or submitting proposal? Also does DUI services qualify as Outpatient services?

A19) At time of bid submission, Bidders must already be DMC certified in the State of California for at least one of the ASAM covered services they are bidding on. In addition, Bidders must be DMC certified in Alameda County by October 1, 2018. DUI Services are not by themselves equivalent to ASAM Level 1.0 Outpatient services. Please refer to DMC Certification requirements included on page 20 of the RFP and below for additional information on DMC certification.
http://www.dhcs.ca.gov/services/adp/Pages/Drug_MediCal.aspx

Priority Service Populations and Geographic Services Areas:

Q20) Section 1, Table 2., page 7-8 of the RFP: "We would like to confirm our reading/understanding of what max awards reflect, in light of the fact that several priority populations are identified per Program Identifier/geographic location. For example, page 8: Program Identifier for North Ad-3 lists 3 priority populations with a max award of $374,214—award amounts are not broken down by priority population—is this an accurate reading?"

A20) The total award in the updated Table 2 is based upon projected adult beneficiaries to be served in each region of the county, within each region the awards are distributed by the relative size of defined geographic areas (composed of adult beneficiaries residing in zip codes listed in Table 2). Bidders should be able to serve all populations, however for designated geographic areas with higher concentrations of the priority service populations, Bidders must demonstrate documented experience and staffing expertise in providing substance use services to these populations.

Q21) RFP, page 5 states the following regarding the maximum number of contract award per unique community based organization for Adult Outpatient and IOT in the North, Central, South, and East regions: "No more than 50% of the programs in each County Region, with the exception of East County." The subregions are identified on RFP page 7 (Table 2). Does this mean that BHCS might award one provider more than one sub-region (e.g., A-1 and/or A-2 in the North, but no more than two of the four regions in the north (50%))?

A21) Yes.

Q22) At the top of Table 1 on page 5, under Adult Outpatient and IOP, the right column (Maximum Number of Contract Awards per unique CBO) says "No more than 50% in each County Region, with the exception of East County.) In South County, there are currently two outpatient programs, Second Chance Tri-Cities and Second Chance Phoenix Women's program. So that is 100% of the adult outpatient contracts in that region. Does this RFP mean that if Second Chance submits proposals for both these programs, only one can be funded?

A22) For the two programs identified as A-7 and A-8 under the "South" region in Table 2, two unique CBO contractors will be awarded. However one of those same contractors could also be considered for other adult outpatient programs in different regions or contracts listed in additional tables such as Perinatal Outpatient Treatment (Table 4), adolescent outpatient (Table 3), and the residential and recovery residence beds if they applied for those services separately.

Q23) On page 6, under the SUD Service Modality, Adult Recovery Residences North County and Central County are listed as locations. Is there a reason South County is not included? What is the maximum award for Residential Treatment and/or Recovery Residence by geographical area?

A23) Bidders may propose locations in the South but it should be noted that at least one location in the North and one in the Central region will be awarded. The maximum number of beds is indicated in Table 1. Awards will be based on number of beds.

Q24) If an agency which has a Medi-Cal certified site in Region A-5 wants to submit a bid to have a program (Outpatient/IOP) in Region A-6, do they need to have a Medi-Cal certified site in Region A-6? Up until now the answer would have been, "Of Course!" because Medi-Cal services could only be delivered at a certified site. Now, when they can be delivered anywhere, could a program have a place or places in A-6 where they delivered services and even did some administration, but none of them be Medi-Cal certified site?

A24) Please see Section I. F. 2. Experience in Geographical Priority Area on pages 25-26. DMC certified outpatient/IOP clinic sites are not necessarily required within each defined geographic location; however bidders must address how services will be delivered within the identified geographic locations. The Bidder must also meet all minimum qualifications for their bid to be reviewed by the Evaluation Panel/CSC.

Q25) Can 1 program location serve 2 regions (with separate bids)? Example – A program located in Newark serving Newark/Fremont (region A-8) and Union City (A-7).

A25) Per I. F. 2. Experience in Geographic Priority Area on page 25, BHCS would prefer that all services are located within the identified priority areas, and is a requirement for Outpatient/IOT services. If not located within the priority geographic area, the bidder should clearly indicate in its response the timeline to have a presence in the area/s. Please see response to question 24.

Q26) Like with Options – IOT we have Allison and Center St. which can move back and forth services. Do I need 1 or 2 bids?

A26) If Outpatient and IOT services are within the same geographic area, it can be submitted in one bid.

Q27) Is it possible to submit a proposal for specifically serving the Transitional Age Youth population (18-26 years old)? And not serve all adults?

A27) Per I.C. 6 Priority Geographic Service Area on page 19, Bidders are required to serve the number of clients per program as indicated in the revised Tables 2,3, and 4 and to have the capacity to serve the priority populations. Bidders should have capacity to work with all priority service populations they are applying for.

Q28) Can an agency serve TAY ages 18 to 20 in OP and IOT as a priority population, but no clients over 20 years of age?

A28) Please reference response above to question 27.

Q29) In the tables (p. 16-17), there is focus on “Priority Populations” “Adults” are not mentioned (Non-TAY or Older). Are they not included in this bid? There are only a few that state “All”.

A29) Yes, adults are included in this RFP. Per I. C. Scope – 5. Priority Populations, for the purposes of this RFP, adults are defined as individuals age 18 years and over. TAY are young adults, ages 18-24. Older Adults are people over the age of 60.

Q30) Are we excluding San Pablo Corridor from RFP? I am not in 94607 but I am in West Oakland.

A30) It is expected that programs based in a particular defined geographic area (e.g. A-4, 94607 & Berkeley) serve beneficiaries who live in the wider region (e.g. North County), which will mean also serving clients who reside outside the zip codes that define the geographic area. For purposes of this RFP, the zip code defines the geographical area; neighborhoods are

approximate descriptors of the zip codes and do not themselves constitute the geographic priority areas.

Q31) Please confirm that CA 94608 is also included within the Priority Population for Older Adults on Table 2: Adult Outpatient/IOT/ Recovery North page 7?

A31) 94608 is not one of the defined geographic priority areas. See response to question 30.

Q32) Table 2. How can we count homeless seniors who move between 94608, 94606 and 94501?

A32) See response to question 30. It is expected that programs based in a particular defined geographic area may serve clients, such as homeless clients, who reside outside the zip codes that define the geographic area.

Q33) How do define neighborhoods vs. zip codes?

A33) Please see response above to question 30.

Q34) Section 7 F.2., page 25 of the RFP: "How is the County defining 'physical proximity,' specifically in the context of DMC site certification" (Section 6.D. 1-3)

A34) Per I. F. 2. Experience in Geographical Priority Area, BHCS would prefer that all services are located within the identified priority areas. Outpatient/IOT/ Recovery Support Services are required to have a presence in the geographical priority area (defined by zip codes). For Residential and Recovery Residence, location near these same geographic areas is preferred.

Q35) Section 2 G., Table 5, section 6, page 46 of the RFP: "How is the County defining 'physical location,' specifically in light of proposed mobile service provision to disconnected populations, in lieu of a physical location."

A35) Please see II. Table 5, Section 6.2 on page 47. The instructions pertain to a bidder's physical location where services will be provided in the geographic priority area. Mobile service provision could be consistent with field-based services. Field services are not required to take place at a DMC clinic however it is requested that proposers include at least one fixed address in the geographic priority area where services will consistently and predictably take place in order to promote service accessibility.

Q36) There is considerable discussion about programs which serve the Criminal Justice population. Are you talking about AB109 or programs that receive Drug Court funding or "general populations" which receive referrals of clients who may have criminal justice issues?

A36) Criminal Justice population may include clients funded through AB109, Prop 47, and Drug Court.

Q37) Does the residential recovery residence include AB109 beds?

A37) Yes.

Program Services:

Q38) Where's the table or chart for Residential?

A38) Please refer to Table 1. For residential target rates, refer to question 89 below.

Q39) If you are doing OP and IOP is that considered 2 modalities or we putting in 2 bids?

A39) It is considered one bid with two modalities and Bidders should respond accordingly including estimating clients for each modality.

Q40) Is it required to submit for adult outpatient treatment and IOT together? Not one or the other?

A40) Please refer to response above to question 39.

Q41) For adolescent outpatient contract, will the award be expected to do both 1.0 and 2.1 or can a bid be for just 1.0?

A41) Per I.C. ASAM Descriptions of Levels of Care table on pages 14 and 15, Bidder must provide 1.0 and 2.1 ASAM level of care, along with Recovery Support Services.

Q42) Are OP and IOT clients required to be in separate cohorts for all services? Or can certain interventions (eg. Treatment group) combine OP and IOT patients?

A42) Outpatient and Intensive Outpatient clients can be comingled in treatment groups.

Q43) RFP Page 14 states "The table below lists by ASAM level of care the annual estimate of unduplicated clients to be served…" The table does not provide these estimates. Can the County please provide estimated annual number of unduplicated clients per level? This is different than the info on Table 2 (pages 7-8) because staffing requirements for OP vs. IOT are different, so it would be useful to know how many OP vs. IOT clients will be referred of the total number provided in Table 2.

A43) Bidders should propose a mix of OP vs. IOT clients based on their knowledge and experience of client acuity, applied to ASAM Level 1.0 and Level 2.1 requirements found in Appendix B: Description of Service Modalities.

Q44) While the County does specify required annual number of clients to be served by each region in Table 2, OP and IOT numbers are combined. Can the County please delineate how many annual OP vs IOT clients will be served in each region, so that bidders can create an effective staffing pattern?

A44) Please see response above to question 43.

Q45) RFP, page 12 states that "the goal of the interventions and treatment will determine the methods, intensity and types of services provided." The meaning of the sentence is unclear. Did the county mean to say that the "assessment" or "ASAM criteria" will determine methods, intensity, and types of services provided? Per page 12 bullet three, which states "a treatment referral system where referrals to a specific level of care will be based on a careful and comprehensive assessment of client needs across six ASAM dimensions…"

A45) Client goals based on client assessments will determine the methods, intensity and types of services to be provided.

Q46) 3.1 vs 3.5, how can providers provide amounts of bed days per episode when clients are referred by BHCS portals?

A46) Bidders should propose the mix of 3.1 and 3.5 clients based on their previous experience.

Q47) How will we know the breakdown of 3.5 to 3.1 without knowing how the portals will refer?

A47) Please see response above to question 46.

Q48) Can residential clients be admitted directly to the 3.1 level or will 3.1 always be a step down from 3.5?

A48) They could be placed directly in either 3.1 or 3.5, depending on results of ASAM LOC assessment, medical necessity, and county authorization for these services.

Q49) Do Residential Treatment Centers have to be both 3.1 and 3.5?

A49) Yes.

Q50) If the provider's clinical assessment determines that the level of care authorized is not sufficient, can the client be referred to the necessary level of care?

A50) Yes.

Q51) What happens if a person after 4 months of treatment still assess at 3.5 level of care?

A51) The answer to this question lies in the particular details of an individual's case. Utilization Management will be available to answer questions in such a situation, and provide direction on issuing Notices of Action if relevant. The individual may not be appropriate for 3.5 or may need referral for other services. In addition there may be other avenues for additional lengths of stay under special circumstances.

Q52) Does eligibility for Recovery Residence participation require a determination of "Medical Necessity" for the client?

A52) Recovery Residence does not need a determination of "Medical Necessity" however, clients in Recovery Residence must be actively engaged in Outpatient, IOT, or Recovery Support Services as part of the eligibility rules for Recovery Residences. In order to qualify for Outpatient, IOT, or Recovery Support, a client must meet medical necessity for these services.

Q53) If putting in a bid for Recovery Residence can it be one bid – if awarded Breakdown that awarded bid into more than 1 house?

A53) Yes, please provide number of beds by location. Please also see response to question 3 above.

Q54) Can activities, other than the planned program clinical activities (i.e., 5 hours for 3.1 and 12 hours for 3.5) be conducted in groups larger than 12 clients?

A54) Please consult MHSUDS Information Notice No. 18-001 for clarification on the required components of residential treatment for reimbursement, and group size requirements. http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_Info_Notice_18-001-Residential_Reimbursement.pdf

Q55) On page 13 of the RFP, providers in the DMC-ODS will address "lapse and relapse as learning opportunities and clients will not be dismissed from programs". If a client in residential services has a lapse or relapses and requires detox, is the client dismissed or discharged from residential treatment or recovery residency? If the participant is sent to detox is the bed to be filled by a new client in order to maintain utilization?

A55) Please consult CalOMS Tx Data Collection Guide section 8.5, Program Participants Administratively Discharged, Deceased, or Incarcerated. In accordance with the Guide, beneficiaries in residential treatment are allowed seven consecutive days before an administrative discharge is required as cited: "Residential or day program: report an administrative discharge if s/he has been absent from the program without leave (from the program or treatment counselor) for seven consecutive days. If leave has been granted and the individual does not return by the date s/he is expected, begin counting from the day s/he was due back to the program."

http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

Q56) Are Case Management services available to clients in treatment, to clients who have ended treatment and are receiving recovery services, or both?

A56) Outpatient, IOT and Residential clients should receive case management, which is billed at a separate case management rate. Recovery services include case management.

Q57) Can BHCS please list Recovery Support Services that are "substance use services only"?

A57) Please refer to http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/DMC-ODS_Recovery_Services_FAQ.pdf for additional information on recovery services.

Q58) Table 5, page 48, Recovery Residents item c is a clinical process (individual treatment plan) which currently is prohibited by DHCS. Also on page 49 items I through M are also extremely questionable regarding the prohibited portions of DHCS regarding clinical treatment practices.

A58) Clients in Recovery Residence need to be actively engaged in Outpatient/ Intensive Outpatient or Recovery Services. Under the DMC ODS Waiver, individual treatment plans along with items I through M are not prohibited in Outpatient, IOT or Recovery Support Services.

Q59) There are several new services that are required for outpatient: Patient Education, Psycho-Education, Case Management and Recovery Services. What kind of documentation will be required for these?

A59) If billing for services, all methods of service must be documented by whomever provided the service under their scope of practice. Upon admission, all referrals must be documented in the beneficiary record-including timeframes if needed.

- **The beneficiary's name,**
- **purpose of the service & service code,**
- **description of how the service relates to the beneficiary's treatment plan,**
- **date, start & end time of each service,**
- **printed or types & signed name of LPHA or counselor/adjacent to each other.**
- **Must also identify if the service was in person, by telephone or telehealth and include the location of services and how confidentiality was ensured if in the community.**

Documentation must be dated within 7 calendar days of the day of the service.

Q60) On page 15 residential perinatal treatment for 3.1 and 3.5 is described as treatment for pregnant women and up to 2 months postpartum. On page 18 perinatal is defined as women that are pregnant, post partum or parenting a child under the age of 5. These statements seem to be contradictory.

A60) Perinatal Residential serves pregnant women and women up to two months postpartum. Reference updated language defining perinatal services in Section I above. Perinatal services are for pregnant and parenting women as defined in the Perinatal Services Network Guidelines published by the California Department of Health Services. Drug Medi-Cal limits perinatal services to women who are pregnant through two months postpartum; BHCS is requiring all perinatal programs to have both perinatal and non-perinatal DMC certification. Bidders bidding on Perinatal Residential are required to be DMC certified for both.

Q61) The RFP says that Perinatal programs need to be DMC certified in Perinatal and Non-Perinatal. What if our DMC certification is only for Perinatal at this time?

A61) Per I. E. 1. Drug Medi-Cal Certification in Alameda County, Bidders applying for services to the Perinatal population, will need to be DMC certified to provide Perinatal and Non-Perinatal services.

Q62) On page 21, E. 1. states that perinatal programs need to have DMC for both Perinatal and Non-Perinatal modalities. Does this apply only to Perinatal Outpatient programs and not to Residential Perinatal programs?

A62) Perinatal services including Outpatient, IOT and Residential require DMC certification; these services will be required to be certified to serve both perinatal and non-perinatal clients.

Q63) Do you require that a Perinatal Residential program have both 3.1 and 3.5 designations?

A63) Yes.

Q64) DHCS SUD Certification requires Perinatal and Parenting women to provide 20 hours of payable services per week. How do we explain the difference between 3.1 ASAM (24 hour structure with available personnel, at least 5 hours of clinical service per week requirements) vs 3.5 (24 hour care with trained counselors are all billable) only clinical services are billable? Will BHCS deduct the DHCS required 15 hours?

A64) Bidders should propose 3.1 Perinatal Residential Services in line with their knowledge and experience of client acuity, applied to ASAM level 3.1 requirements found in Appendix B: Description of Service Modalities. The five hours clinical service per week requirement for 3.1 is a minimum.

Q65) Can perinatal residential programs admit post-partum and parenting women with a child under 5? If so, what is the length of stay?

A65) Pregnant and post-partum women have special length of stay eligibility rules under the DMC-ODS. Length of stay can extend throughout the duration of pregnancy and two month post-partum. A perinatal program, certified to also serve non-perinatal clients who are not pregnant or post-partum, could also admit women with a child over the age of 2 months with different length of stay requirements, i.e. 3 months maximum with the possibility of a one month extension annually.

Q66) The state defines perinatal as women parenting a dependent child (generally up to age 17). What residential services are available for women with children 5 and over, especially if social service is involved and there is a reunification in progress? Currently Perinatal programs generally take women with children up to age 5 and one existing program takes children up to age 7?

A66) To be determined through the RFP process. Please see response to question 65 above.

Q67) If perinatal residential programs can admit women post-partum and parenting with child under 5, do we have to discharge the women when the child turns 5?

A67) No, not unless rules dictated by an individual program have limited the age of children who can be served in the program.

Q68) On page 15 level 3.1 for perinatal residential length of stay includes duration of pregnancy and 2 months postpartum. The bidders conference mention that 3.1 length of stay was generally two weeks. How do we reconcile these two length of stay for budgeting purposes?

A68) Bidders should estimate the length of stay based on experience of client activity applied to ASAM criteria and service descriptions.

Q69) Some contractors have purchased their own EHRs. Are contractors forced to relinquish their EHRs for Clinician's Gateway (and lose large financial and time investments)?

A69) Bidders do not have to relinquish their EHRs. Contractors will have to enter data into Clinicians Gateway and InSyst.

Q70) For criminal justice clients (RFP page 83), "SUD providers will be invited to conduct field-based services at co-located probation sites." In order to determine how much time will be spent providing field-based services, can BHCS please provide an estimated number of CJ clients, per region?

A70) Per I. C. Figure 1, please see http://www.acbhcs.org/Providers/SUD/docs/medi-cal/Med-Cal_Beneficiaries_Data.pdf for a spreadsheet of FY 2016-17 Medi-Cal beneficiary data disaggregated by zip code, age and ethnicity.

Staffing:

Q71) Since BHCS is awarding one contract for both OP and IOT, are providers required to have two separate staffing plans or can staff overlap? Required staffing qualifications differ by level.

A71) Staffing plans can overlap as long as they meet staffing requirements in III. B. Description of Service Modalities.

Q72) Is there a specific FTE % required for direct service staff?

A72) Staff FTE should meet staffing requirements in Section III. B. Description of Service Modalities of the RFP.

Q73) Page 85, Staffing Requirements states "Physicians treating clients in Level 2.1/IOT should have specialty training and experience in addiction medicine or addiction psychiatry." What constitutes "specialty training and experience"? Is this "specialty training and experience" not required for Level I/OP? What services are physicians to provide? MAT and primary care, according to the RFP, are to be provided through linkage, not directly.

A73) Physicians are not a required element of IOT or Outpatient service provision, but they can provide services as one of the LPHA professionals listed on page 85. Please refer to DMC-ODS staff categories link for more information on physician requirements, pg 79. Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

Q74) In the staffing requirements (RFP page 81), physicians are included in number 1: "Appropriately credentialed and/or licensed treatment professionals including addiction-credentialed physicians, counselors, psychologists, social workers, and others to assess and treat substance-related, mental, and addictive disorders." Is a LPHA considered a credentialed physician or its equivalent? What is the difference between a LPHA physician and a LPHA non-physician (ODS-staffing grid linked on RFP page 79)?

A74) Please refer to third page of ODS Staff Grid on link found and page 79 of the RFP and below for definitions of LPHA Physician and LPHA Non-Physician.

http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/ODS_Staffing_Grid_032017.pdf

Q75) RFP page 84-85, Assessment/Treatment Plan Review Requirements, states that client history should be "reviewed by a physician and if determined needed by a client's medical condition, a physical examination within a reasonable amount of time." Is the word "referral" missing here? The same requirements for OP on page 80 state "a referral for a physical examination…"

A75) See language change in Section I. above allowing for LPHA and Medical Director to review and closely coordinate referral for physical examination.

Q76) Does family therapy differ by OP (listed on RFP page 80) and IOT (page 84) modality? For IOT, page 84 states that "family therapy which involves family members" is required. However, no details about family therapy are provided in the OP section. If they differ, can BHCS please indicate how the service differs by level of care?

A76) Family Therapy is not intended to be different between Outpatient and IOT. See Table 4: ASAM Description of Level of Care. The required available service components for IOT and Outpatient are the same, i.e. " See Level 1.0 Outpatient Services for Level 2.1 program service components per page 15." Family Therapy , however, is required therapy and prominent feature of Level 2.1.

Q77) RFP page 84 states "ongoing psychiatric services that are appropriate to the clients' mental health condition are available by telephone or on-site or closely coordinated off-site". Does this mean that psychiatry can be provided by linkage/ coordination and proposers are not required to include a psychiatrist on staff?

A77) Yes.

Q78) Page 81, staffing requirements, #2 states "Recovery Support Specialists provided by a LPHA, SUD Counselor, or PEERS (for substance abuse assistance services only). Peer Support Specialists with lived experience in substance use treatment can provide peer to peer services…" A "Recovery Support Specialist" is a position, not a service. Is this supposed to read that Recovery Support "Services" will be provided by a LPHA, SUD Counselor, or Peers? Peer Support Specialists were not mentioned before this point. Is this an optional position?

A78) Peer Support Specialist is an optional position. Peer-to-peer services are eligible for reimbursement under the DMC-ODS Program when provided as substance abuse assistance services - a component of recovery services. See DHCS document "Recovery Services: Frequently Asked Questions" for more information.
http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/DMC-ODS_Recovery_Services_FAQ.pdf.

Collaborations and Partnerships:

Q79) Will County allow agencies to subcontract in order to meet geographic requirements?

A79) No, subcontractors are not permitted as part of this RFP. Bidders can contract staff positions and include these contracted staff in their budget and justification as Professional & Specialized Services.

Q80) Regarding RFP Section E-1. Specific Requirements - Drug Medi-Cal Certification in Alameda County (p 21). Can a subcontractor/partner meet the Medi-Cal certification requirement or must this requirement be met by the lead agency?

A80) Please reference response above to question 79.

Q81) Is Center Point eligible to be a sub-contractor to a prime contractor bidding to be the provider/contractor?

A81) Please reference response above to question 79.

Q82) Regarding Section F - 2 Bidder Experience, Ability and Plan - Experience in Geographical Priority Area (p 25). Can a subcontractor/partner meet the requirement for engaging clients in the geographic service area(s) being proposed or must this requirement be met by the lead agency?

A82) Please reference response above to question 79.

Rates:

Q83) Is the room and board amount included in the residential daily rate or is it billed for separately?

A83) The room and board amount is included in the residential daily rate.

Q84) Is the Case Management amount included in the residential daily rate or is it billed for separately?

A84) The Case Management amount is billed separately.

Q85) What about third party revenue for Residential? Does it still apply?

A85) Residential providers may include client funds used to offset program costs as revenue in the fiscal year received and spent. These client sources of revenue may be used in the first year of DMC-ODS for residential treatment only (not to include recovery residence). County will revisit this practice in the second year of DMC-ODS implementation.

Q86) Will provider's authorized cost (as included in approved budget) be covered or will providers be paid only for services rendered at agreed upon rate?

A86) For the first year, cost settlement for programs will be up to allocation, with the following requirements:

- **Reimbursement for denied services will be capped (3% is under discussion)**
- **A minimum amount of Drug Medi-Cal revenue is required to receive entire allocation.**

While providers and BHCS analyze the cost to deliver new services and meet higher quality standards, BHCS will waive cost per unit caps.

Q87) Can we bill for non-Medi-Cal recipients? How is this done? Assuming that all Medi-Cal recipients are billed via InSyst?

A87) Yes, a DMC-ODS provider can bill for eligible and non-Medi-Cal recipients who are indigent, and have no other third party health insurance. InSyst, BHCS' current claiming system, will not bill DMC to the State for clients who do not have active Medi-Cal.

Q88) Regarding Case Management, what are the minimum and maximum durations allowable in order to bill?

A88) No minimum or maximum durations for case management have been established. BHCS will closely monitor case management utilizationwith the intent to provide guidance to any program that is at risk of not being able to deliver contracted services because too much of their allocation is spent on case management.

Q89) Currently outpatient programs bill for units of Individual Counseling and Group Counseling. Are Case Management and the various recovery services going to be additional unit categories or will they be part of the all-inclusive rate?

A89) Similar to mental health, billing for non-residential services is based on direct staff time rather than visits. There are separate target rates for each service as shown in the table below:

RFP #18-01 SUD Services Target Rates	
Service	**Rate**
Residential 3.1 – Adult	$129.95/ bed day
Residential 3.1 – Perinatal	$139.72/ bed day
Residential 3.5 – Adult	$170.69/ bed day
Residential 3.5 – Perinatal	$217.17/ bed day
Recovery Residence – Adult	$45.15/ bed day
Recovery Residence – Perinatal	$50.00/ bed day
Outpatient – Adult and Adolescent	$2.72/ minute
Outpatient – Perinatal	$3.18/ minute
Intensive Outpatient – Adult and Adolescent	$2.72/ minute
Intensive Outpatient – Perinatal	$3.24/ minute
Recovery Support Services	$2.38/ minute
Case Management	$2.10/ minute

Q90) Is there a maximum per bed per year for Perinatal Residential?

A90) Please see response to question 89 above.

Budget:

Q91) Which line item would the Medical Director go under?

A91) Staff should be included in the Personnel tab of the budget. Staff should be allocated based on the role they will play in program services. Bidders should justify their rationale for personnel status (Direct Client Services, Administrative or Supervisorial) in their proposal.

Q92) Is a QA staff a direct or Admin person?

A92) Please reference response above to question 91.

Q93) Does the Quality Assurance Manage for Chart/Utilization review go under Personnel Expense Direct Administration or under "indirect administration"?

A93) Please reference response above to question 91.

Q94) Can Family Partners be used (paraprofessionals) who do case management/brokerage/linkage and family support or do case managers who are social workers have to be used?

A94) Qualified paraprofessionals can provide substance use assistance services, a component of recovery services, subject to meeting OIG requirements for working in the Medi-Cal program, and having been trained in accordance with the County approved SUD Peer Support Training Plan (forthcoming).

Q95) If MD is a contractor, do we link his/her cost under specialized services?

A95) Yes, staff that are not employed by the Bidder should be included under Professional and Specialized Services in the budget.

Q96) What if your federally approved indirect rate is higher than 15%?

A96) Bidders with a federally approved indirect rate higher than 15% should submit documentation demonstrating their federally approved indirect rate and BHCS may issue a waiver.

Q97) Explain the Administrative Costs cap of 15%.

A97) Administrative/ Indirect Rate cap is 15%. The cap is in line with the County's maximum allowable administration rate for DMC, and is consistent with administrative/ indirect rate cap for the County's Special Mental Health Plan.

Q98) Will the Budget form indicate/ alert us if we go over the maximum?

A98) Yes, however Bidders should also make sure to reference Tables 2, 3, and 4 for the Maximum Award amounts and should not exceed these maximum award amounts for the service modality/ies applying for.

Bid Submission and References:

Q99) If an applicant cannot use Alameda County BHCS staff as references, is it acceptable to obtain references from staff from AC HCSA, or another county agency?

A99) Yes, Bidders can include references from County departments outside of BHCS such as HCSA, as well as funders and contractors.

Q100) Section I. Statement of Work - A. Intent (page 4) includes the following: "See Section II. E. Instructions on Bid Submittal for More Information." Section II. E. does not appear to be in the RFP (pages 41-42 of the RFP Include Sections II. D. and II. F. but not II. E). Is there an additional section of the RFP that will be provided?

A100) Per Section I of the Addendum above, please reference II.F. Submittal of Proposals/ Bids on pages 42-44 for instructions on bid submission.

Q101) ASAM Questionnaire, if DHCS issued licensure lists obtained levels of care, is the ASAM questionnaire still to be attached to RFP?

A101) Yes, if bidding on Residential services, Bidders should include the ASAM Residential LoC Designation Questionnaire. Per I. F. 3. Planned Service Delivery Approach on page 27, reference http://www.dhcs.ca.gov/provgovpart/Documents/ASAM_Designation_Questionnaire_8-19-15.pdf **for the Bidder's ASAM Residential LoC Designation Questionnaire.**

Q102) What if we have more than 10 bids?

A102) Bidders applying for multiple service modalities will need to submit a separate bid for each service modality. Bidders may use two Budget Templates to complete their bid.

Q103) If a potential interviewee has an important commitment during any of the potential dates on page 40, is there any flexibility?

A103) No. Bidders should assign a delegate/s to participate in the interview.

Q104) Should attachments go after each section or should they all go at the end of the proposal?

A104) Please include attachments in the order they appear in Table 5 of the RFP.

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Alameda County BHCS 1900 Embarcadero Cove, Suite 400 Oakland, CA 94606	Jill Louie	Phone: (510) 383-1684
		E-Mail: Jill.Louie@acgov.org
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		Subcontractor: N/A
		Certified SLEB: N/A
Alameda County BHCS 1900 Embarcadero Cove, Suite 400 Oakland, CA 94606	Nathan Hobbs	Phone: (510) 567-8127
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Alameda County BHCS 2000 Embarcadero Cove, Suite 205 Oakland, CA 94606	Laura Fultz Stout	Phone: (510) 383-2765
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		Certified SLEB: N/A
Alameda County BHCS 2000 Embarcadero Cove, Suite 400 Oakland, CA 94606	Sharon Loveseth	Phone: (510) 567-8244
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		Prime Contractor: N/A
		Subcontractor: N/A

Company Name / Address	Representative	Contact Information
		Certified SLEB: N/A
Alameda County BHCS 2000 Embarcadero Cove, Suite 205 Oakland, CA 94606	Wendi Vargas	Phone: (510) 567-8179
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		Subcontractor: N/A
		Certified SLEB: N/A
Alameda County BHCS 2000 Embarcadero Cove, Suite 205 Oakland, CA 94606	Marthea Alley	Phone: (510) 383-2763
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		Subcontractor: N/A
		Certified SLEB: N/A
Tom Pinizzotto & Associates 1821 Nighthawk Circle Roseville, CA 95661	Tom Pinizzotto	Phone: (916) 960-7497
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		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A
La Familia	Charles Flores	Phone:
		E-Mail: CFlores@lafamiliacounseling.org
		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A
Magnolia Women's Recovery	Linda Stewart	Phone: (510) 535-1344
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		Prime Contractor:
		Subcontractor:
		Certified SLEB:
Horizon Services, Inc.	Rochelle Collins	Phone: (510) 247-8200
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Company Name / Address	Representative	Contact Information
		Prime Contractor:
		Subcontractor:
		Certified SLEB:
Horizon Services, Inc. Cronin House 2595 Depot Rd Hayward, CA	Steve Diamond	Phone: (510) 329-7694
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		Subcontractor:
		Certified SLEB:
Magnolia Women's Recovery	Chris Derrius	Phone: (510) 468-6159
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		Prime Contractor:
		Subcontractor:
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Terra Firma Diversion 30086 Mission Blvd. Hayward, CA 94544	Bertha Cuellas	Phone: 510-675-9362
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		Prime Contractor:
		Subcontractor:
		Certified SLEB:
Senior Support Program of the Tri-Valley 5353 Sunol Blvd. Pleasanton, CA 94566	Nicole Albrecht	Phone: 925-931-5378
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		Prime Contractor:
		Subcontractor:
		Certified SLEB:
Tri City Health Center 40910 Fremont Blvd Fremont, CA 94538	Amy Hsiel	Phone: 510-252-6806
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	Khea Gumbs	Phone: 510-910-6411

Company Name / Address	Representative	Contact Information
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		Subcontractor:
		Certified SLEB:
Cula Inc. 4510 Peralta Blvs #1 Fremont	Joe Coopra	Phone: 510-713-3202
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		Subcontractor:
		Certified SLEB:
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		Subcontractor: N/A
		Certified SLEB: N/A
City of Fremont	Annie Bailey	Phone: 510-574-2111
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		Certified SLEB: N/A

Company Name / Address	Representative	Contact Information
Refuge Inc. P.O. Box 19275 Oakland, CA	Jason Henderson	Phone: 510-301-8809
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		Subcontractor: N/A
		Certified SLEB: N/A
AHS	Leonard Daniels	Phone: 510-618-5725

Company Name / Address	Representative	Contact Information
7677 Oakport Rd Oakland, CA 94621		E-Mail: ledaniels@alamedahealthsystem.org
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		Subcontractor: N/A
		Certified SLEB: N/A
CURA 4510 Peralta Fremont, CA	Rita Locarie	Phone:
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		Subcontractor: N/A
		Certified SLEB: N/A
Magnolia Women's Recovery Program	Chris Perrins	Phone: 510-460-6159
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		Subcontractor: N/A
		Certified SLEB: N/A
Terra Firma Diversion	Maryann Salimpour	Phone: 510-675-9362
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		Subcontractor: N/A
		Certified SLEB: N/A
Terra Firma Diversion	Anibal Blanco	Phone: 510-514-1596
		E-Mail: ablanco@terrafirmadiversion
		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A
City of Fremont Youth and Family Services	Annie Sousa	Phone: 510-574-2137
		E-Mail: asousa@fremont.gov
		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A

Company Name / Address	Representative	Contact Information
Options Recovery Services	Porter Sexton	Phone:
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		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A
Axis Community Health	Jennifer Permey	Phone: 925-249-3151
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		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A
Horizon Services	Karen Andrews	Phone: 510-582-2100
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		Certified SLEB: N/A
La Familia	James Cann	Phone: 510-300-3116
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		Prime Contractor: N/A
		Subcontractor: N/A
		Certified SLEB: N/A
Mental Health Systems, Inc.	Leonardo Martinez	Phone: 925-483-2223
		E-Mail: lemartinez@mhsinc.org
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		Subcontractor: N/A
		Certified SLEB: N/A
Sanion Support Program	Robert Taylor	Phone: 510-410-1741
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		Subcontractor: N/A

Company Name / Address	Representative	Contact Information
		Certified SLEB: N/A
		Subcontractor: N/A
		Certified SLEB: N/A

APPENDIX

Table 2A: Overview of Adult Population

OVERVIEW OF ADULT POPULATION				
Region	**Total Beneficiaries**	**Total Adults by Region**	**Percentage of Adults (n=297,851)**	**Projected Clients Served (2772)**
North	205,378	139,573	46.86%	1299
Central*	149,704	90,269	30.31%	840
South	73,394	49,624	16.66%	462
East	28,685	18,385	6.17%	171
Totals	**457,161**	**297,851**	**100.0%**	**2772**

**Contains zip code 94603*

Table 2: Adult Outpatient Treatment/ IOT/ Recovery Support Priority Population, Geographical Coverage and Amounts

OUTPATIENT/ IOT/RECOVERY SUPPORT SERVICES - ADULT/OLDER ADULT/TAY							
Program Identifier	**Zip Code**	**Approximate Neighborhoods**	**Priority Population**	**Adults in Geographic Area**	**% of Adults in Zip Code(s)**	**Number of Clients to Serve**	**Maximum Award $10,891,769**
NORTH = 46.9% of Adults in Alameda County							
A-1	94606 and 94501	San Antonio/Clinton/Highland and Alameda	Criminal Justice, TAY, Older Adults and Asians	25,510	27.2%	**353**	**$1,387,232**
A-2	94601	Fruitvale/Jingletown	Criminal Justice, TAY, Latinos	16,866	18.0%	**233**	**$917,172**
A-3	94621 and 94605	Lockwood/Coliseum and Eastmont/Millsmont/Bancroft	Criminal Justice, TAY, Latino and Black/African American	25,989	27.7%	**360**	**$1,413,280**
A-4	94607 and Berkeley	West Oakland/Chinatown/Old Oakland and City of Berkeley	Criminal Justice, TAY, Black/African American and Asian	25,491	27.2%	**353**	**$1,386,199**
		TOTAL NORTH		**93,856**		**1299**	**$5,103,883**
CENTRAL = 30.3% of Adults County							
A-5	94541 and 94544	Hayward	Criminal Justice, TAY, Latino, Older Adults	32,173	50.5%	**425**	**$1,668,409**
A-6	94603, 94578 and 94577	Southeast Oakland and San Leandro	Criminal Justice, TAY, Latino and Black/African American	31,488	49.5%	**416**	**$1,632,886**
		TOTAL CENTRAL		**63,661**		**840**	**$3,301,295**
SOUTH= 16.7% of Adults in Alameda County							
A-7	94587	Union City	TAY, Latinos and Asian	13,062	32.9%	**152**	**$597,627**
A-8	94538/ 94536/ 94560	Fremont/Irvington/ Cabrillo/Newark	TAY, Latinos, Asian and Older Adults	26,598	67.1%	**310**	**$1,216,941**

TOTAL SOUTH				**39,660**		**462**	**$1,814,569**
EAST = 6.2% of Adults in Alameda County							
A-9	94551 and 94550	Livermore	TAY, Latinos	8,218	100.0%	**171**	**$672,022**
TOTAL EAST				8,218		**171**	**$672,022**
TOTAL ADULT PROGRAMS				**205,395**		**2772**	**$10,891,769**

Table 3: Adolescent Outpatient Treatment/ IOT Programs Priority Population, Geographical Coverage and Amounts

OUTPATIENT/IOT/RECOVERY SUPPORT SERVICES - ADOLESCENT							
Program Identifier	**# Field-Based Sites (e.g. schools)**	**Community Clinic Site**	**Priority Population**	**Total Adolescent Medi-Cal Beneficiaries**	**Percentage of Total Clients in Priority Areas**	**Required Number of Clients Served per Year**	**Maximum Award**
NORTH							
Ad-1	12	Oakland	Juvenile Justice, Black/African American, Latino, Asian	22,030	49.4%	261	**$1,236,045**
	TOTAL NORTH			22,030		261	**$1,236,045**
CENTRAL/EAST							
Ad-2	8	Hayward	Juvenile Justice, Latino and Asian	14,777	33.1%	175	**$829,098**
		TOTAL CENTRAL		14,777		175	**$829,098**
SOUTH							
Ad-3	2	Fremont	Juvenile Justice, Latino and Asian	7,822	17.5%	93	**$438,872**
	TOTAL SOUTH			7,822		93	**$438,872**
ADOLESCENT PROGRAMS				**44,629**	**1.00**	**528**	**$2,504,015**

Table 4: Perinatal Outpatient Treatment/ IOT/ Recovery Support Priority Population, Geographical Coverage and Amounts

OUTPATIENT/IOT/RECOVERY SUPPORT SERVICES - PERINATAL

Program Identifier	Zip Code	Clinic Sites	Priority Population	Total Perinatal Medi-Cal Beneficiaries	Percentage of Total Clients in Priority Areas	Required Number of Clients Served per Year	Maximum Award
NORTH							
P-1	N/A	Oakland	All	1,800	51.0%	121	**$636,626**
		TOTAL NORTH		1,800		121	**$636,626**
CENTRAL/EAST							
P-2	N/A	Hayward	All	1,281	49.0%	117	**$611,660**
		TOTAL CENTRAL		1,281		117	**$611,660**
TOTAL PERINATAL PROGRAMS				**3,081**	**1.00**	**238**	**$1,248,286**

Table 7

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
1. TITLE PAGE	Reviewed for completeness	Complete/Incomplete Meets/Does Not Meet Minimum Qualification • Responses to this RFP must be complete. Responses that do not include the proposal content requirements identified within this RFP and subsequent Addenda and do not address each of the items listed below will be considered incomplete. Additionally, bid responses that do not conform to the page limitations in Table 1, will be rated a Fail in the Evaluation Criteria and will receive no further consideration.	**Pass/Fail**
2. EXHIBIT A: BIDDER INFORMATION AND ACCEPTANCE			
3. LETTER OF TRANSMITTAL / EXECUTIVE SUMMARY			
4. BIDDER MINIMUM QUALIFICATIONS	***a.*** **Current Drug Medi-Cal Certification in California for the ASAM covered services they are bidding on**		
	b. **ASAM Designation for Residential services** – For those bidding on Residential services or Perinatal Residential services must show Residential ASAM designation from Department of Health Care Services boy July 1, 2018	• Did the Bidder submit evidence of ASAM designation for Residential services? • Did the Bidder submit evidence of progress towards receiving ASAM designation for Residential services by implementation date of July 1, 2018?	**Pass/Fail**
	c. **At least five years' experience in providing services for the modality/ASAM Level of Care bidding on**	• Does the Bidder have at least five prior years of continual experience in providing services for the modality/ASAM level bidding on?	**Pass/Fail**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
	d. **Agreement to Use Clinician's Gateway and InSyst**	Bidder has signed agreement to use Clinician's Gateway and InSyst.	**Pass/Fail**
	a. ***Debarment and Suspension***	To be considered for contract award, Bidders, its principal and named subcontractors must not be identified on the list of Federally debarred, suspended or other excluded parties located at the following databases. • https://www.sam.gov/portal/SAM/#1 • https://exclusions.oig.hhs.gov/ • https://files.medical.ca.gov/pubsdoco/SandIlanding.asp	**Pass/Fail**
5. REFERENCES	***a.*** BHCS will check ***references*** for Bidders placed on the shortlist and ask the references standard questions, which will be evaluated by the Evaluation Panel.	How do the Bidder's references rate the following: • Bidder's capacity to perform the services as stated; • Areas in which the Bidder did well; • Areas in which the Bidder could have improved; • Communication and Responsiveness; Accuracy and completeness of Reporting; Accuracy and completeness of Invoicing; Client Satisfaction; Compliance with program, legal, and/or funding requirements; Staff retention; Awareness and responsiveness to community needs; Overall Satisfaction with Bidder on a scale of one to five; • Is/Was Bidder within their budget and meeting deadlines; • Experience with the priority population in the RFP • Experience with the geographic location as stated in the RFP	**2**
6. BIDDERS EXPERIENCE, ABILITY AND PLAN	***a.*** The Evaluation Panel will read and assign a score based on how detailed and specific the Bidder's response to following questions which will become the total score under the Bidder's Experience, Ability and Plan		**Sub-section Total (44)**
	1) Experience in Serving the Priority Service Population	• How comprehensive is the Bidder's understanding and years of experience working with each priority service population (and any subpopulations)? • How well does the Bidder's define risk factors, challenges and barriers that impact access to service and treatment for each priority population? • How well does the Bidder's past, current and proposed outreach actives expand services to priority populations specifically associated with geographic areas that are bid	**5**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		upon? • Did the Bidder include the demographic/ethnic breakdown of clients served in FY 2016-17 (as a percentage of overall clients served in FY 2016-17)? • How extensive is the Bidder's staffing expertise for population? **For Adolescents** • Does the Bidder show knowledge and experience of developmentally appropriate treatment for adolescents that addresses their multiple biopsychosocial needs, and involves families? **For Perinatal** • Does the Bidder's show knowledge and expertise with pregnant women and/or parenting women with dependent children? **For Older Adults** • How extensive is the Bidder's experience providing treatment with following age-specific considerations for older adults, including: mobility issues, medication and medical problems, social isolation, hearing, vision, and loss of other abilities, age-related stigma associated with addiction, age specific treatment approaches? **For Criminal Justice** • How extensive is the Bidder's knowledge and experience addressing criminogenic needs within context of drug and alcohol treatment? • How extensive is the Bidders experience with providing drug and alcohol treatment as part of an interdisciplinary team that includes strong collaborative relationships with corrections and/or probation?	
	2) Experience in Geographical Priority Area	• Does the Bidder have physical services located in the geographical area(s)? Does their response include locations and how reasonable and feasible are these locations (including the ability to have them up and running by start date)? • Does the Bidder show that it has locations that are easily accessible (public transportation, walk, etc.) to priority populations in the geographical area(s)?	**5**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		• Does the Bidder provide evidence to meet site compliance with ADA standards including the 2010 Standards for Accessible Design? • How extensive is the Bidder's experience, including any partnerships and organizational relationships with community-based institutions, that will be of use in reaching and engaging clients in the specified geographical area(s)?	
	3) The Evaluation Panel will read and assign a score based on how detailed and specific the Bidder's response to following questions which will become the total score under **Planned Service Delivery Approach:**		**Sub-section Total (31)**
	a) Program Services and Priority Populations	○ How well does the Bidder's plan for program services match ASAM Criteria treatment standards for the level(s) of care that is being proposed? ○ How adequate and appropriate is the mix of program services for the priority populations, especially any priority populations for which the bidder is claiming a specialized expertise, that also that takes into consideration the following: **For Adolescents (in addition to above)** ○ Does the Bidder describe proposed services that are tailored to the priority population and meets the DHCS Youth Treatment Guidelines (2002)? **For Perinatal (in addition to above)** ○ Does the Bidder describe proposed services that are tailored to the priority population and meets the DHCS FY 2016-17 Perinatal Service Network Guidelines and meet the child development needs of dependent children? **For Criminal and Juvenile Justice (in addition to above)** ○ Does the Bidder demonstrate plan to actively coordinate with Deputy Probation Officers (DPO) for case planning purposes? ○ Does the Bidder agree to participate in Interdisciplinary Treatment Teams (IDTT) convened by Probation Department to better coordinate client care? The IDTT consists of a Behavioral Health clinician(s), DPO, and one to two collateral contacts (e.g. Unit Supervisor, Community Provider, Family Member, etc.).	**9**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		Does the Bidder show willingness to conduct field-based treatment services at co-located probation sites including possible office sites in Oakland, Hayward, San Leandro and Pleasanton. Site selection to be finalized prior to July 1, 2018. **For Residential Services (in addition to above)** ○ Did the Bidder submit a completed DHCS ASAM Residential Level of Care Designation Questionnaire? ○ Does the Bidder have an addiction physician on staff to review admission decisions to confirm clinical necessity of services? **For Recovery Residence (in addition to above)** ○ How well does the proposed service meet the standards for National Association of Recovery Residences? • To what extent does the Bidder's plan reflect a commitment to individualized treatment based on identified client strengths and needs, and an approach to continuous re-assessment of the six life dimensions (ASAM Criteria) throughout the course of treatment? • How likely is it that the Bidder will adequately serve and reach the required number of clients with their proposed staffing mix and levels?	
	b) Outreach and Service Location	• How well does the Bidder describe outreach activities to each population? • How well does the Bidder describe outreach activities in the geographic area to improve access to treatment and services? • Does the Bidder show that the proposed locations are easily accessible (public transportation, walk, etc.) to priority populations in the geographical area(s) that meet site compliance with ADA standards including the 2010 Standards for Accessible Design?	**10**
	c) Treatment and Client Transition	• How well does the Bidder's plan address coordination of treatment with MAT providers, and other treatment providers? • How does the Bidder's plan ensure timely access to treatment? What strategies are proposed to quickly engage new referrals, and follow up with those who are difficult to	**6**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		engage? • To what extent does bidder have the ability to transition clients to other ASAM levels of care within own organization, or to another provider within the Organized Delivery System?	
	d) Case Management, Client Engagement, and use of EBPs	• How well does the Bidder integrate effective and proactive case management services into their treatment programs at all ASAM Levels of Care? • How well does the Bidder indicate the capacity to provide Recovery Support Services not only for clients who may have completed treatment in their programs, but also to clients referred to them from a different program? (Outpatient/IOT only) • How well does Bidder strategies to engage clients and how appropriate are the tools and resources that Bidder plans to use in relation to the clients' needs? • How well-matched are the EBPs to the priority population and how well does the Bidder describe implementation, monitoring and adherence to the EBPs?	**6**
	4) Forming Partnerships and Collaboration	• How well does the Bidder describe established partnership/s or ability to cultivate strong relationships with other health providers (i.e. mental health, physical health, Alameda County Care Connect)? • To what extent does the Bidder have established partnerships or ability to cultivate strong relationship with other County, City or State government agencies (i.e. Alameda County Probation Department, Department of Children and Family Services, School Districts, etc.)? • Does the Bidder include letters of support from these partnerships? Are the letters provided on agency letterhead and include authorized signature/s. •	**3**
	5) The Evaluation Panel will read and assign a score based on how detailed and specific the Bidder's response to following questions which will become the total score under **Organizational Infrastructure:**		**Sub-section Total (26)**
	a) Overall	• How well does the proposed program integrate into Bidder's	**1**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
	Organizational Structure and References	existing organizational structure, business operation, and services? • Did the Bidder include an organizational chart that includes structure of the overall organization and how this program fits into their organization? • How well does Bidder demonstrate experience with or capacity to deliver, track and bill for Medi-Cal services and manage operations to maximize revenue generation while maintaining quality of care? • How well does the Bidder integrate the SUD treatment foundational principles and practices within their proposals?	
	b) Capacity to billing Medi-Cal	• How adequate is the Bidder's system and activities to maximize revenue generation while maintaining quality of care?	**2**
	c) Quality Management	• How realistic and feasible is the Bidder's experience, plan and capability to adhere to Medi-Cal documentations standards and requirements? • Does the bidder describe the organization's QI activities that include but are not limited to QI staffing, supervision, training and leadership • Did the Bidder adequately describe their systems of quality assurance as it related to clinical chart documentation and compliance? • How well does the Bidder allocate sufficient resources and staffing to ensure meeting the requirements for quality management under the DMC-ODS system? • How well does the Bidder's quality management workforce perform the necessary QI activities, data entry, data and outcomes tracking, and program evaluation functions?	**5**
	d) Electronic Health Records and Data Systems	• Does the Bidder demonstrate how they have systems and information technology infrastructure to collect and regularly report data? • How familiar is Bidder with the following systems? - InSyst– billing and claiming data - State Drug and Alcohol Treatment Access Report data system (DATAR); - SUD treatment capacity, access and wait lists - State CalOMS Treatment data system	**4**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		• Does the bidder demonstrate appropriate staff capacity to provide electronic registration and eligibility verification functions, as well as scheduling, billing, reporting, quality management, monitoring, and program evaluation requirements? • Does the Bidders show they have the organizational capacity, including adequate staff and hardware, for data system training at the time of bid submission?	
	e) Staffing and Workforce Development and Support	• Is the Bidder's SUD treatment staffing plan adequate to meet the needs of the proposed program, and the priority service populations (shows proposed SUD treatment full-time equivalents (FTEs) by profession and where those FTEs report within the provider's organization, clinical supervisor to staff ratios, staff to client ratio, professional credentialing, staff specialization in priority population needs)? • How well does the Bidder's QM Staffing Plan adequately address the number and diversity of the QM activities (staffing plan should include QM administrative staff, including Quality Improvement activities, data entry, data and outcomes tracking, and program evaluation functions)? • How adequate is the Bidder's supervision model to meet the needs of the program? • How adequate is the Bidder's SUD treatment staff training and technical assistance plan to meet the needs of the program? ○ How well does Bidder demonstrate capacity to provide access to continuous training and support for staff within the organization?	**5**

	f) Staffing to meet threshold languages	• What percentage of staff are knowledgeable and formally trained in CLAS?
		  ○ How does the Bidder plan for training staff on cultural responsiveness to meet the needs of the priority population?
		• To what extent does the Bidder's staffing language abilities reflect the size and needs of the priority service populations?
		  ○ Does the Bidder describe adequate and appropriate services to provide interpreters and translation services if staff do not speak the languages of priority populations?
			3

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		○ Does the Bidder provide a list of staff fluency of the languages spoken by priority population within geographical area(s) including title of staff, languages and verbal and written fluency in each language?	
	g) Organizational Policies and Procedures	• How well does bidder's current organizational practices take into account the CLAS standards; client confidentiality requirements; proper credentialing/re-credentialing and monitoring of licenses; and workforce training needed to be in full compliance with the Federal and State regulations?	**1**
	h) Communications	• How well does the Bidder demonstrate the ability to inform and communicate with the public and beneficiaries regarding services?	**1**
	i) Financial Management Capacity & Fiscal Integrity	• How well does the Bidder's audited financial statements demonstrate its fiscal management and controls in order to maintain good fiscal standing? • How adequately does the Bidder explain any issues related to their audited financial statements?	**2**
	j) Tracking Data and Outcomes	• How developed is the Bidder's current systems to collect, monitor and analyze data? • How well does Bidder describe prior experience in data collection to make mid-course correction in order to achieve positive outcomes and for continuous quality improvement? • How thoughtful and realistic is Bidder's plan to collect data to monitor the proposed measures and desired outcomes?	**2**
COST	*The Evaluation Panel will review the Exhibit B-1 Budget Workbook and the Budget Narrative and assign a score based on how the Bidder's proposed program budget aligns with the requirements of the RFP which will become the total score under the Cost. The Cost-Coefficient is scored by applying the standard County formula.*		**Sub-section Total (8)**
	***a.* Cost Co-Efficient**	• Low bid divided by low bid x 5 x weight = points *For example:* *$100,000 / $100,000 = 1 x 5 x 5 = 25 points* • Low bid divided by second lowest bid x 5 x weight = points • Low bid divided by third lowest bid x 5 x weight = points Low bid divided by fourth lowest bid x 5 x weight = points	**2**
	***b.* Budget and** ***c.* Budget Narrative Review**	• How well-matched is Bidder's budget to the proposed program? • How well does the budget capture all activities and staff	**6**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
		proposed in the Budget? • How well does the Bidder allocate staff and resources? • How appropriate are the staffing and other costs? • How much value does the proposal add considering the cost of the program, expected outcomes and the number of clients served? • How well does the narrative detail how Bidder arrived at particular calculations? • How well does Bidder "show the work"? •	
IMPLEMENTATION SCHEDULE AND PLAN	The Evaluation Panel will read and assign a score based on how detailed and specific the Bidder's response to following questions which will become the total score *under Implementation Plan and Schedule*		**Sub-section Total (10)**
	a. **Implementation Plan Review**	• How complete and realistic is the implementation plan (should contains major activities, milestones and deadlines) submitted by the Bidder? • How likely is the Bidder to be fully functioning at the launch of the waiver on July 1, 2018? • How many facilities will the Bidder need to acquire or set-up in order to be fully operational by the start of the pilot? What percentage of total sites proposed by Bidder are already owned or leased/rented? • What percentage of the staff required to operate the program are already hired and how many still need to be hired? • What are the bidder's plans for staff hiring and training in preparation for the July 1, 2018 start date? Is the plan realistic with regard to the amount of time required to hire and train staff for program readiness? • What percentage of the staff have training in ASAM and other appropriate trainings in order to be fully operational in their position at the start date? • How experienced is the Bidder with the use of using electronic health records software?	*If bidding on Outpatient, IOT, Residential* **5** *If bidding on Recovery Residence only* **8**
	DMC Certification in	• To what extent is the Bidder appropriately DMC Certified in	**3**

RFP SECTION	EVALUATION METHOD	EVALUATION CRITERIA	WEIGHT
	Alameda County *(If bidding on Outpatient Treatment, IOT and Residential only)*	location for which programmatic services are being proposed in submission? • Did the Bidder attachment of copies of certification or evidence of status if in process of submission? • How well is the Bidder following-up regularly with DHCS if in process of receiving certification and timeline to receive certification? NOTE: ~~Only a proposal with ALL sites that are DMC certified in Alameda County will get a rating of 5 under this section. The rating will be adjusted according to the proportion of proposed sites that are DMC certified in Alameda County versus those that are non-certified.~~ **Bidders that are DMC certified in Alameda County at the time of bid submission will get a rating of 5 under this section. Bidders that have submitted for certification by December 31, 2017 will receive a score of 4. Bidders that submitted for certification by January 31, 2018 will receive a score of 3. Bidders that submit for certification by February 28, 2018 will receive a score of 2. Bidders that submit for certification on or after March 1, 2018 will receive a score of 1.**	
	c. Identification and Strategies for Mitigation of Risks and Barriers	• How thorough, thoughtful and realistic is Bidder's identification of challenges and barrier mitigation strategies? • How creative and solution-oriented are Bidder's strategies?	**2**
EXHIBITS	**Exceptions, Clarifications and Amendments**	Complete/Incomplete Meets Minimum Requirements/ Fails to Meet Minimum Requirements	**N/A**
ORAL INTERVIEW, IF APPLICABLE	Criteria are created with the CSC/Evaluation Panel.		**10**
PREFERENCE POINTS, IF APPLICABLE	SLEB		**(5%)**
	Local (not SLEB certified)		**(5%)**