Amendment Two
QUESTIONS FOR REQUEST FOR PROPOSALS (RFP)
Congregate Care and Child Placing Agency Services
RFP No. 2024ICCCP001
RFx Number: 3140004080
Issue Date: December 27, 2024

No.	Question/ Request for Clarification
1.	Is this one RFP that includes all these different services or is each one separate? *This is one RFP with different services. Offerors are allowed to submit a proposal that includes one or multiple services.*
2.	Are all the notices sent out the same or were there changes? *The information is the same. However, the RFX number for this solicitation has been changed from 3180002430 to 3140004080. Please refer to Amendment One.*
3.	In reference to the RFP portion listed below, is there a specific EBP program the state wants the agency to follow/implement? We have received an unsolicited request for partnership and were not certain if this were prompted by the state. *"As a part of the Continuum of Care, each partnering agency commits to its designated service role (according to the contract) within the CoC and is required to engage in evidence-based practices that promote physical and psychological safety, shared parenting, a culture of trauma awareness, and actively collaborate with MDCPS regarding youth admissions and discharge transitions."* *RFP #2024ICCCP001 - Congregate Care and Child Placing Agency Services was prompted by MS Child Protection Services. The agency recommends EPB approved by the Families First Prevention Services Clearinghouse.*
4.	Regarding RFP #2024ICCCP001 - Congregate Care and Child Placing Agency Services: Is this RFP issued to replace the following contracts? • Therapeutic Group Home Services - contracts 8200051588, 8200051585, 8200051587, 8200051565, and 8200051586 • Regular Group Home Services - contracts 8200051583 and 8200051584

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- Emergency Shelter Services - contracts 8200051605, 8200051604, 8200051600, 8200051602, 8200051601, and 8200051603
- Therapeutic Foster Care Services - contracts 8200051580, 8200051566, 8200051567, 8200051569, 8200051581, 8200051568, and 8200051582
- Centralized Intake 24-Hour Hotline Staffing Services - contract 8200052990

Yes, RFP #2024ICCCP001 - Congregate Care and Child Placing Agency Services will replace the current contracts for Therapeutic Foster Care Services, Intake & Assessment Centers formerly known as Emergency Shelter Services, Traditional Group Home Services, and Therapeutic Group Home Services. The Centralized Intake 24-Hour Hotline Staffing Services is not a part of this RFP. In addition, t*he contract numbers provided are no longer valid due to the DHS and CPS agency split. The new contract numbers for Congregate Care and Child Placing Agency Services under CPS are listed below.*

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<tr><td>8200071098</td><td>8200071099</td><td>8200071110</td></tr>
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<tr><td>5.</td><td>Will the current well child/sibling daily per diem rate for Therapeutic providers fall under the age-specific per diem rates for Traditional Foster Homes Scope of Services? *Yes*</td></tr>
<tr><td>6.</td><td>Will a LMSW or CMHT Mental Health Professional be able to provide clinical justifications for admissions and discharges? *Yes, an LMSW/CMHT will be able to provide the clinical justifications under the supervision of a fully licensed professional (to include the fully licensed clinician's signature).*</td></tr>
<tr><td>7.</td><td>On Attachment L, there are categories entitled, "Special Needs I" and "Special Needs II", for partner providers. How will a child be classified into these categories for Therapeutic Foster Homes and what are the differences? *MDCPS will provide designations for any child being classified into such categories. A Partner Provider may also request a review of such as well.*</td></tr>
<tr><td>8.</td><td>Partner providers for Therapeutic Foster Homes must provide 24 hours a day, seven days per week to include holidays and weekends, on call process for emergency admissions. How will these after hours, holidays and weekends emergency admissions be approved through Therapeutic Placement when a provider has a home available? *MDCPS Therapeutic Placement Unit will be*</td></tr>
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	making the approvals via referrals to Partner Providers. Ongoing communication shall occur.
9.	Will MDCPS be providing any funding for partner providers to go through TBRI, CPI, and SAFE Trainings? *Yes, final awardees of the RFP will be notified of the process.*
10.	What is an Initial Safety/Risk Assessment and where can this be obtained for use by partner providers? *Partner Providers will need to locate/create a Comprehensive Initial Safety and Risk Assessment to complete on each youth.*
11.	**Questions and Requests for Clarification: QRTP** Is it acceptable to convert one level of care to another for the purposes of expanding the state's Continuum of care? For example, would changing a Therapeutic Group Home to a QRTP be acceptable? *Yes. The Partner Provider will need to describe such in the submitted RFP.*
12.	Is it acceptable to only offer select portions of the Continuum of Care? For example, offering only QRTPs and not offering emergency care. *Each provider may select to offer one or more of the services provided in the RFP*.
13.	In seeking to provide QRTP services, is this designation applied to an individual home, or can this designation apply to multiple on-site buildings? *QRTP's applications must describe how many beds will be offered for services.*
14.	If QRTP designation is applied to specific buildings, then for each building in which such programs are to be offered, is a separate RFP is necessary? *No, provider must describe how many beds will be offered for QRTP services.*
15.	Will this RFP alter any on-going contract to provide services to CPS? If we are already operating under a multi-year contract that remains in force, this means that additional services, such as QRTP or SGH can be proposed as additions to current services under contract, correct? *All services described within the RFP, must be applied for. Any contracts that are currently being offered that are not being outlined in the RFP will remain separate at this point.*
16.	On QRTP Scope of Service, page 2, item E: It is indicated that two (2) staff members must be on site at all times. Does this mean physically in the same building, or it is possible for one staff member to be in the home with one or more youth, while the other staff member escorts a youth or youths to individual counseling. Is "on site" a single building or the entire campus? *Please describe your plans to provide supervision "on site" in your proposal response to the RFP*. *Please keep in mind the increased demands of youth present within the QRTP setting.*
17.	Will this RFP alter any on-going contract to provide services to CPS? If we are already operating under a multi-year contract that remains in force, this means that additional services, such as QRTP or SGH can be proposed as additions to current services under contract, correct? *No, RFP #2024ICCCP001 - Congregate*

	Care and Child Placing Agency Services will replace the current contracts for Centralized Intake 24-hour Hotline Staffing Services, Therapeutic Foster Care Services, Emergency Shelter Services, Regular Group Home Services, and Therapeutic Group Home Services. New contracts will be executed.
18.	On the written monthly summary of progress, is there a template or form developed for this? *No, MDCPS template or form has been developed for the monthly summary of progress.*
19.	When the RFP refers to written communication, does that also include email and other digital forms of communication by text? *Yes, emails are considered "written communication". Texting will not be considered "written communication".*
20.	Under QRTP Scope of Service description, page 3, item J, what does this item mean? *All youth referred for QRTP services shall receive an comprehensive assessment by an independent assessor contracted with MDCPS to determine if a QRTP is the appropriate setting.*
21.	Same page, under L: *A qualified and independent individual must conduct a comprehensive assessment of a child placed in a QRTP within thirty (30) days of the placement start date.* Who selects this "qualified and independent individual?" If we were to contract for such assessments with a local practitioner, that person would no longer be independent. Is there a list of such individuals? Is this an MDCPS person? Not sure how this is going to work. *All youth referred for QRTP services shall receive a comprehensive assessment by an independent assessor contracted with MDCPS to determine if a QRTP is the appropriate setting.*
22.	Who initiates and coordinates the legal/judicial review of placements? Is this CPS staff? Does such review originate in the youth's county of origin? *MDCPS will coordinate such reviews.*
23.	Who initiates and coordinates the USDHHS Secretary review? *MDCPS*
24.	Who is the Title IV-E agency? *MDCPS*
25.	On page 4, item Q, it mentions that independent contractors within a QRTP must have certain training. This refers to contractors who engage with youth, correct? Not the HVAC contractor, or plumber, who would not interact with any youth and who would never be unescorted in a building where youth were present. *Correct. All employees, volunteers, interns, and independent contractors within a QRTP must be trained in that trauma-informed approach. MDCPS has identified Trust-Based Relational Intervention (TBRI) as its trauma-informed approach of choice. Any other model must be deemed evidence-based according to the Family First Prevention Services Act Clearinghouse and approved by MDCPS. In addition, organizations shall have a trauma-informed treatment model that addresses services of youth's and family's clinical needs.*
26.	Also under item Q, the last line mentions services of family's clinical needs. We need more information on provision of a treatment model that meets families' clinical needs. Are we expected to provide these? What about when the family is

	in a county far from our campus? *Yes, Partner Provider is expected to provide such services. QRTP's will need to describe their plans to address youth and family clinical needs to include the use of virtual technology, partnerships with other providers within the Continuum of Care, etc.*
27.	Same page, item S. Family participation is discussed. It's also a part of the score card. What about cases where the youth is either not in contact with family or there is a prohibition about such contact? What about cases where parental rights have been terminated? Will the presence of youth in such situations result in the partner organization being penalized for not meeting the 100% objectives for family/sibling visits, etc.? *Partner Providers will be expected to adhere to court orders regarding family engagement and collaborative work with MDCPS identified Specialist.*
28.	Same page, item V, what happens when it is a case of elopement or the youth moves out of state? Or in case of total youth non-compliance. *Partner Provider is expected to document their efforts outlined in their written plan to provide outreach and aftercare support services*.
29.	Page 5, item X. It references "excluding (see attached.)" Please clarify what is excluded. Error - please disregard "excluding".
30.	Page 7, item C. Denials. How is medicine non-compliance handled? What if a diabetic has refused to comply with blood monitoring and insulin administration? *Such situations would be considered on a case-by-case basis and include collaborative efforts between MDCPS and the Partner Provider.*
31.	Is physical violence toward one's self included in violence? *Yes, active suicidal threats and/or gestures would be considered violence towards self.*
32.	In the various places in the documentation where it mentions 24/265 emergency admissions, would stepped admission be acceptable? For example, a youth arriving on an emergency basis at 2:00 am would be placed in an apartment until the following day to minimize disruption to facility operations. Is this acceptable as long as youth is covered by appropriate staff presence? This method would actually increase our staffing, but allow for the youth to be brought to the proper home after proper processing, etc. and less disruption to already placed youth who would be sleeping. *Please describe your admission process in your proposal response to the RFP.*
33.	On page 8, item G, it references a "denial of discharge." Does this mean that the partner provider may deny a discharge to move a youth to a facility offering the same services? It would be nice to not move youth around to various facilities offering the same services against the youth's desire and therapists' recommendations. (Judges have done this and it is very stressful on the youth.) *MDCPS and the Courts reserve the right to move a youth based on their identified best interests.*

34.	Are there forms or templates for discharge plans? *No, MDCPS template or form has been developed for the monthly summary of progress. Discharge requirements may be found in MDCPS Regulations at www.mdcps.ms.gov*
35.	Page 10, item L: Where does medical non-compliance fall in terms of "challenging behaviors?" When a youth refuses meds behavior can escalate or existing health problems become exacerbated. This is a serious concern. The list in item L is NOT an all inclusive list of challenging behaviors. *Such situations would be considered on a case-by-case basis and include collaborative efforts between MDCPS and the Partner Provider. Please describe possible challenging behaviors your process in your proposal to RFP.*
36.	When CPS move to Pathways invoicing, is weekly billing a possibility? This might help in preventing excessive accounts payable balances due from CPS to the Partner Provider. *Weekly invoicing will not be a possibility at this time.*
37.	**General question:** Are we correct in believing that being at full capacity is an acceptable reason to deny admission? *Yes*
38.	**Questions and Requests for Clarification: Scorecard:** Item #2, placement utilization rate: Does this imply Provider Partners will be penalized if they maintain less than 100% of their contracted capacity? *The Sections identified as Safety, Permanency and Well-Being will serve as the primary indicators. The sections identified as Overall Assessment Period Data and Performance Indicator by Incidence shall serve to identify ongoing patterns to be addressed and could have an overall effect on contracts.*
39.	Item #9: Are youth who have had parental rights terminated or who simply do not have family counted toward the attainment of 100% on this score? Or is this element to be calculated for those youth who are eligible for such visitations? *This item shall be determined based on the unique situations for each youth involved.*
40.	Item #11: What if the MDCPS specialist does not show up for the Family Team meeting? Is the Provider Partner penalized for this? *If the Partner Provider has documented evidence that the MDCPS Specialist was invited to the FTM with advanced notice, the Provider will NOT be held responsible.*
41.	Under the items listed for "Well Being," there are things like medical exams, dental, vision, etc., listed. If a youth had already had a scheduled evaluation while at another facility will this count as fulfilling this expectation, or must every new admission be run through complete exams as if they have had no other exams prior? Does "current" include previous, documented evaluations? *Required exams must be within the identified timeframes (i.e., dental - every 6 months; vision - annual, etc.) Items such as comprehensive initial mental health assessment and independent living skills opportunities must be conducted by the Partner Provider*.

42.	**Questions and Requests for Clarification: Supervised Independent Living** What if facility policies are more stringent than those outlined in the scope of service? For example, the directive that youth in SIL should have visitors of their own choosing at any time could be problematic. We have a closed campus. We also have regulations about on-campus dating. Will the SIL scope of service invalidate our established policies? *Please describe your process in your proposal to RFP.*
43.	Emergency SIL admissions will be problematic in that the youth will need significant evaluation and instruction/coaching on the Handbook, policies, to sign the agreement, etc., prior to being placed independently. Is it possible to not accept SIL youth on an emergency basis? Or to accept them into another program until they have been evaluated, coached and placed? *Please describe your process in your proposal to RFP.*
44.	**Questions and Requests for Clarification: Teen Maternity Home:** Will there be any financial consideration for providing newborns with all the required items, including clothes, diapers, etc.? Part of preparing these teen moms to be independent will include (presumably) outfitting them with provisions to become effective parents. *The corresponding per diem rates may be found on page 45 in the "Request for Proposals - Congregate Care and Child Placing Agency Services" RFP.*
45.	On page 3, item A, it reads that transitional living plans must be developed for each youth admitted to the program. Basic life skills to include but not limited to: #3, Childcare facilities. Does this mean we educate the teen moms about childcare facilities or are we expected to provide childcare facilities? Does this mean we must develop and staff a childcare facility or place the infant in an off-site licensed childcare facility? Please elaborate. *Error: Childcare facilities is referring to daycare (licensed child care facility).*
46.	The time during which the young lady is in the hospital giving birth/recovering will count as a "higher level of care," to ensure that board payments are not disrupted, correct? *Yes*
47.	**Questions and Requests for Clarification: Therapeutic Group Home:** Page 3, item L: The scope of service indicates that we must have at least one full-time social worker or comparable professional for every twelve children. What are examples of "comparable professionals?" We have multiple licensed therapists, credentialled Peer and Community Support staff, a Psychiatric Nurse Practitioner. We also have an activity director, independent living coordinator, and on and on. Will any of these be considered comparable professionals? If these individuals are not comparable professionals, what are these social workers expected to be doing? *Item L refers to the professional providing overall case management services to the youth.*
48.	**Questions and Requests for Clarification: Traditional Foster Homes:** If a Foster Family is licensed as a therapeutic foster home, may they take in a non-therapeutic placement?

	This may be found in the Licensure and Operations Standards for Congregate Care Providers (Section: 2.12.6 / Procedure 4.12 - G(9): *Occupancy. Traditional and Therapeutic Foster Homes may have no more than a total of six (6) children, including biological, foster, or adopted children. No more than two (2) children in the foster home may be under the age of two (2). No more than one (1) child may have therapeutic/special needs. However, a sibling group may be placed together more than these limits, but only upon written consent from MDCPS and a waiver from MDMH.*
49.	May we keep ALL foster family training at the level of therapeutic foster family training and not differentiate between the levels of training to simplify things? (i.e., over-train traditional foster parents**)** *Please describe your training plan in your response to the RFP***.**
50.	We know the DUNS number will be in by the application date, but we are unsure if we will have it by the Recommended Letter of Intent submission date. We noticed that the DUNS number is one of the required information. Could you submit the Recommended Letter of Intent with the DUNS number pending? *Yes, the Recommended Letter of Intent can be submitted without the DUNS Number.*
51.	**Evidence-Based Practices (EBPs)** Are providers allowed to continue using and/or identify and implement evidence-based practices (such as Managing Aggressive Behavior (MAB) instead of CPI), or will MDCPS mandate the use of specific EBPs (CPI, TBRI, etc.)? (Scope of Services, pg. 8, RFP for Congregate Care and Child Placing Agency Services) *Yes, Partner Providers will need to adhere to the requirements described in the RFP.*
52.	**Training Implementation Responsibility** Will training need to be completed before the expected service start date of April 1, 2025? (Training Requirements, pg. 4-5, RFP for Congregate Care and Child Placing Agency Services) *No, Partner Providers will collaborate with MDCPS regarding training requirements and timelines involving CPI, TBRI and/or SAFE following the award.*
53.	**Clinical Justifications for Admissions, Denials & Initial Assessments** Can MDCPS consider expanding qualifications for clinical justifications to include LMSWs and/or DMH-certified therapists? (Admission Requirements, pg. 7, Traditional Foster Home & Therapeutic Home Scopes & Admission Requirements, pg. 5, and Discharge Requirements, pg. 6, Intake & Assessment Center Scope *Yes, an LMSW/CMHT will be able to provide the clinical justifications under the supervision of a fully licensed professional (to include the fully licensed professional's signature).*
54.	**Alternative Crisis Intervention Training** o Can providers currently use alternative evidence-based crisis prevention training models, such as Managing Aggressive Behavior (MAB), and continue to utilize these instead of Crisis Prevention and Intervention (CPI)? (Training Requirements, pg. 4-5, Therapeutic Foster Home Scope)

	The Partner Provider must adhere to the described training requirements outlined in the RFP. The purpose is to establish overall consistency across the Continuum of Care.
55.	**Transition of Existing Resource Homes** If a current MDCPS-licensed traditional resource home transfers to a provider, will MDCPS share existing documentation (e.g., home study, background checks) to streamline licensing with the provider, or must the licensure process begin anew? This would ensure faster placement opportunities. (Licensure Requirements, pg. 2, Therapeutic Foster Home Scope) *Yes, Partner Providers within the Continuum of Care may share documentation. If the documentation has expired, Partner Providers must work to update it accordingly.*
56.	**Changing Foster Home Designation** Can currently licensed therapeutic foster homes transition to traditional foster care, and vice versa, provided they meet the licensing requirements for the new designation? (General Requirements, pg. 2, Traditional Foster Home Scope) Yes
57.	**Minimum Home Requirements** o Is the timeline for achieving the minimum number of 50 traditional foster homes and 35 therapeutic foster homes flexible to allow for gradual growth, or is there a specific deadline? (General Requirements, pg. 2, Traditional Foster Home Scope) o For Organizations submitting RFPs for Traditional and TFC, would a licensed Therapeutic Foster home willing to also serve traditional foster youth count towards the minimum 35 TFC homes and the minimum 50 traditional homes? As opposed to expecting the provider organization to work towards 85+ foster homes in total. **(General Requirements, pg. 2, Traditional & Therapeutic Foster Home Scopes** *Please describe your plan in writing in the RFP. Note: Preference will be given to those Partner Providers that specifically target each Scope requirement.*
58.	Is a separate proposal and letter of intent required for each line of service under this RFP? For example, if we intend to operate therapeutic group homes, QRTPS, IACs, SGCs, and SILs do we need a full proposal packet for each line of service? *No, offers may submit one proposal which includes each facility type that they would like to apply for.*
59.	How are the cost factors considered as part of the proposal when the rates are pre-determined by MDCPS with only the possibility of a 5% annual increase as described in section 1.19.4? *All respondents will receive 35 points for cost factors, as the contract rates are established by the Mississippi Department of Child Protection Services (MDCPS). MDCPS retains the sole discretion to determine if a price adjustment will be permitted. Recommendations for any price increases for Congregate Care and Child Placing Agency Services will be provided by the state economist.*

60.	We currently operate Therapeutic Group Homes but plan to convert to QRTPS- Do we need to submit proposals for both? *Each provider may elect to offer one or more of the services provided in the RFP.*
61.	What will be process be to determine licensure as a QRTP- Can it occur with the current licensure cycle which is in April? *The process is described in the RFP and Standards found at www.mdcps.ms.gov.*
62.	Is there a limit to the number of homes or programs that can be requested under each program? *No, but it must be clearly described within your proposal to the RFP.*
63.	Can the different programs be phased in over the 5 year period of the RFP, or must they all be operational within 120 days? *Please describe your operational plan within your RFP submission. Note: Preference will be given to those providers that can become operational within the stated timeframe.*
64.	How long will the providers have to become compliant with the new training requirements, for the Pathways system and TBRI? *MDCPS and Partner Provider shall work collaboratively for implementation timelines.*
65.	We need a meeting to discuss the Bi-Annual Scorecard in detail. *Awardees will be invited to a meeting to review the Scorecard for clarity and expectations.*
66.	In most cases, children either leave custody, move and are no longer in close proximity to a home placement after discharge. Please detail the providers responsibility in this requirement for QRTP: Plans to provide outreach and six (6) months of aftercare support for the child and the family must be documented and maintained in the youth's case file; (services may be provided directly or via partnerships with providers in close proximity to the youth's home); i. The provider will continue to document at least monthly for six (6) months verifying aftercare support services to be kept in the youth's file. *QRTPs will need to describe their plans to address such aftercare support services including the use of virtual technology, partnerships with other providers within the Continuum of Care, etc.*