



Round 2: Agency Response to Bidders' Questions, Request for Clarifications and Suggested Changes

Question No.	RFP Section	Page	Section #	Topic	Specific Question/Inquiry	HHS Response
1	Bidder's Ability to Coordinate FCS Services in a Service Area.	25	3.2.4.1	# of Proposals	<p>To help ensure Families First Counseling Services is interpreting the proposed submission structure of the RFP properly, we would respectfully request to add the following question to the Q&A.</p> <p>Section 2: Basic Information about the RFP Process, pg. 28, section 3.2.4.1. In the past, previous RFP's have requested 3 separate entire bid proposals be submitted, one separate bid proposal for each service area a provider is bidding on. In the current RFP we want to clarify, is the Agency asking for one single proposal to be submitted with separate service area specific subsections as part of their larger, overarching organizational proposal?</p> <p>The RFP section is outlined below for point of reference to our question.</p>	<p>Per section 3.2.4.1 the Agency is looking for one proposal (Singular) to be submitted with separate Service Area specific subsections for each Service Area upon which the Bidder plans to bid.</p> <p>RFP Section 3.2.4 describes how the bidder shall complete each of the sections below for each Service Area being bid :</p> <p>3.2.4.1.1, Service Area Proposal Title 3.2.4.1.2, Family Centered Services (FCS) Location(s) 3.2.4.1.3 Service Area Narrative, and 3.2..1.4 Letters of Support</p> <p>If for example a bidder is submitting a proposal for the Northern and Eastern Service Areas they will need to complete the four required sections for each Service Area in addition to the main bid proposal. Their proposal response for section 3.2.4 will be formatted as described below:</p> <p>Northern Service Area: 3.2.4.1.1, Service Area Proposal Title 3.2.4.1.2, Family Centered Services (FCS) Location(s) 3.2.4.1.3 Service Area Narrative, and 3.2..1.4 Letters of Support</p> <p>Eastern Service Area 3.2.4.1.1, Service Area Proposal Title 3.2.4.1.2, Family Centered Services (FCS) Location(s) 3.2.4.1.3 Service Area Narrative, and 3.2..1.4 Letters of Support</p>
2				Hand Delivery	<p>I wanted to reach out regarding the upcoming Family Centered Services (FCS) RFP submission timeline. With agency responses to questions scheduled for November 24 and proposals due on December 12, the turnaround period falls immediately after the Thanksgiving holiday, which can make mail delivery unpredictable.</p> <p>In previous procurements, HHS has permitted hand-delivery of proposals in addition to mailing them. Given the shortened timeframe and ongoing postal delays, would HHS consider allowing bidders the option to hand-deliver proposals to ensure timely receipt?</p> <p>Thank you for your consideration of this request and for your continued communication throughout the RFP process.</p>	<p>The Bureau of Services Contract Support is located on the fourth floor of the Lucas Building which is a secured area requiring key card access, where the general public does not have access or ability to hand deliver proposals. Due to security restrictions in place the building is not currently set up to receive and check in proposals which are hand delivered.</p> <p>HHS Contracting is in the process of implementing an online bidding and contracting solution which will receive bids electronically, but that solution will not be implemented by the due date for this RFP.</p> <p>In response to this request, per Amendment #3 HHS has extend the due date from Friday 12/12 at 3 PM to Tuesday 12/16 at 3 PM to allow for extra time in shipping.</p>

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3	Clarification for Information Presented by the Coalition at the Bidders Conference			<p>11/3/2025 HHS Clarification Question Sent to Coalition: (Conversation below is based on data presented by the Coalition at the bidders conference) Did contractors count all cases where there is more than one household, regardless of the level of participation from additional households or was it a simple yes there are multiple households or no there are not multiple households?</p> <p>11/6/2025 Coalition Response: Contractors only included open Family Interaction (FI) cases when identifying instances with more than one household. Staff were asked to indicate whether each FI case involved multiple households ("yes" or "no")—not to evaluate the level of participation or frequency of involvement by additional caregivers, in addition case files were reviewed.</p> <p>The 44% figure therefore represents cases where more than one active caregiver household was identified in open FI cases, rather than across all service cases.</p> <p>Currently, the 10/20 Family Interaction hour structure is routinely used as a standard rather than a maximum in many areas. While some of these hours are already shared among multiple households, this has been the only option available to meet needs within existing limits. Moving forward, it is our understanding that HHS will have the ability to authorize additional hours for other households under the new contract, in addition to requiring shared time within the same 10/20 framework.</p>	<p>HHS does not see a need to make changes to the caseload numbers in Appendix B. Monthly payments are based on the total of all case types each month. Contractors are not required to allocate percentages of funding based on anticipated max caseloads, they may shift funding between services based on actual caseloads. We recognize that the load of any particular service may fluctuate month-to-month, so our primary focus is on whether the total of all case types fluctuates more than 5%. Based on our calculations, we are well within the maximum possible caseload for all case types and there is sufficient additional funding to accommodate the added family interactions cases.</p>	
4	Attachment L Technical Response Document	82	Question 8 Contractor Scope of Work Obligations for Family Interactions, section E, subsection a	General Obligations for Family Interactions	<p>Agencies have identified 44% of open cases have an additional parent engaged in FI. While this number is not reflective of additional caregivers actively engaged in FI services, even if 50% (22% of 44%) of open cases have additional parent household FI referrals that engage in services we will see a substantial need for additional staffing patterns to meet referral demands. If we assume 22% of anticipated max caseload proposed on Appendix B, that is 270 additional FIOOH parental referrals, which would equate to an additional 22 FTE for Families First for the NSA, ESA and CRSA, assuming each FI contact takes the agency accepted 4.25 hours. With this updated information, is the Agency open to continued collaborative negotiations and discussions to ensure the FCS contract is sustainably funded for high quality service delivery?</p>	<p>The anticipated maximum total caseload for all case types is the absolute highest HHS anticipates seeing in any given month. Based on HHS calculations, actual caseloads will be within the anticipated maximum caseloads. This includes the expected additional referrals for Family Interactions. HHS also included an additional \$5 million annually to the FCS budget for the upcoming contract cycle as a result of concerns/questions presented in the prior round of Q&A. This was on top of an increase to the FCS budget initially presented in the original RFP. HHS does not have additional funding available to allocate to FCS.</p>
5	Attachment L Technical Response Document	72	Question 4, Contractor Scope of Work Obligations for Family Focused Meeting Facilitation, Subsection B	General Obligations for Provision of Family Focused Meeting Facilitation	<p>With the agency no longer submitting FFM referrals, Providers are assuming additional administrative burden for the ongoing tracking of FFM junctures and facilitating FFM meetings at each identified juncture, which is a shift in practice from current FCS contracts. The additional responsibility of meeting FFM junctures during the life of the case on open agency cases (assuming a minimum of 3 FFM's per case and an average monthly caseload of 20 FFM meetings per Facilitator) increases Facilitator staffing patterns across the NSA, ESA and CRSA for Families First by 6 FTE, 2 FTE per Service Area to fulfill new service demands. With this updated information, is the Agency open to continued collaborative negotiations and discussions to ensure the FCS contract is sustainably funded for high quality service delivery?</p>	<p>Under the new contract, administrative burden is shifting based on the needs of the Agency. Specifically for FFM's, rather than providers chasing down HHS to obtain new referrals for FFM's at contract-required junctures, providers will be able to move forward with making arrangements for FFM's at the contractually required junctures. This insures that providers have stronger control over meeting contract requirements. Additionally, as stated in the above answer, HHS significantly increased funds allocated to FCS contracts for the upcoming contract cycle. These additional funds are expected to support adequate staffing for FCS. HHS does not have additional funding available to allocate to FCS.</p>
6	Attachment L Technical Response Document	80	Question 7, contractor scope of work for post removal conferences, subsection B	General scope of work for Post removal conferences	<p>With the addition of post removal conferences as a new service element for qualifying open agency cases, at Families First we project an additional 915 PRC meetings according to the FI data outlined on Appendix B Contract Payment Matrix for Anticipated Max Caseload. We believe we will need additional Facilitators who are properly trained to provide this service. With this updated information, is the Agency open to continued collaborative negotiations and discussions to ensure the FCS contract is sustainably funded for high quality service delivery?</p>	<p>As stated above, HHS significantly increased funds allocated to FCS contracts for the upcoming contract cycle. These additional funds are expected to support adequate staffing for FCS. HHS does not have additional funding available to allocate to FCS.</p>
7	Section 1: Special Terms	94	1.8 Additional Terms	Appendix B Contract Payment Matrix	<p>HHS response to bidders questions indicated the 2nd and third round of FPS services were factored into the monthly FPS projections for each Service Area averages on Appendix B, the contract payment matrix. For Families First, in the Eastern Service Area where one contractor holds both contracts, that contractor averaged 41 FPS cases per month in FY '25 when including 2nd and 3rd rounds of FPS services, not including Mid-Iowa Family Therapy in the HAWC-BDF counties. The Agency shows a projected 22 FPS cases in Appendix B, representing a significant difference in past experience versus future projections. Can the Agency outline or define how they came up with 22 FPS cases per month when including 2nd and 3rd round of FPS services into anticipated max caseloads? With this updated information, is the Agency open to continued collaborative negotiations and discussions to ensure the FCS contract is sustainably funded for high quality service delivery?</p>	<p>Calculations were based on historical data over the two prior fiscal years. HHS recognizes that the projected numbers may not be exact due to variances in how Service Areas utilize services. HHS has not and will not mandate that funding is allocated based on projected caseloads identified in the RFP. HHS' main focus is on the total caseload for all services. Payments are based on the total caseload for all services. Fluctuation between caseloads for individual services is expected.</p> <p>As stated above, HHS significantly increased funds allocated to FCS contracts for the upcoming contract cycle. These additional funds are expected to support adequate staffing for the total caseload for all services. HHS does not have additional funding available to allocate to FCS.</p>
8	Section 1: Special Terms	93	Appendix A:	Casework Contract Matrix	<p>When risk levels raise and a family is moved from the service phase back to the initiation phase for more frequent contact, what criteria is then used to move them back into the service phase again if the functional assessment, case plan/service plan and FFM have already been completed/hold?</p>	<p>It is expected that HHS clearly identify the reasons for shifting backwards and what specific steps need to occur to move forward (ex. meeting with the provider weekly, addressing specific safety hazards, development of service plan goals related to an additional safety concern, etc.)</p>

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9	Section 3.1	26	Bid proposal formatting	Number of Hard Copies	Can HHS please clarify how many hard copies of the bid proposal an agency must provide if an agency is submitting bids for more than one service area?	See response to Question and Answer #1
10	Attachment L Technical Response Document	80	Question 7, contractor scope of work for post removal conferences, subsection B	General scope of work for Post removal conferences	Is it HHS intention to have designated Facilitators for PRC's or can providers have FSS/IS facilitate their own PRC's on their cases as long as that FSS/IS have attended the PRC facilitation training?	HHS intends for PRCs to be available at consistent times each week so that HHS staff and FCS staff know when to have time available on their calendars and can plan accordingly. The contractor has discretion of whether to utilize dedicated PRC facilitators or train FSS/IS to facilitate PRCs.
11	Attachment L Technical Response Document	72	Question 4, Contractor Scope of Work Obligations for Family Focused Meeting Facilitation, Subsection B	General Obligations for Provision of Family Focused Meeting Facilitation	Is it the Agency's intent for families to still have a voice in goal planning at the FFM or is the family voice of goal planning captured in the development of the refrigerator list and case plan?	HHS has no plans to change the current format of FFMs, which includes opportunity for the family to share their perspective. Families having a voice in case planning is a critical piece of families owning their plans and being part of the team.
12	Attachment L Technical Response Document	72	Question 4, Contractor Scope of Work Obligations for Family Focused Meeting Facilitation, Subsection B	General Obligations for Provision of Family Focused Meeting Facilitation	Is it the Agency's intent for the FFM to incorporate family voice in the Action Step development process instead of goal setting?	Family voice should be incorporated both in the Action Step development process and goal setting process. Goals should be reviewed during each FFM and family voice incorporated in identifying successes toward achieving goals, modification of goals that are not working, and deciding what steps are needed to achieve goals. Family involvement in all phases of case planning and service planning increases the family's ownership of their plan.
13	Section 1 Background and Scope of Work	16-17	1.3.2.2	Performance Measures: SafeCare	The RFP measure states: families receiving SafeCare will not experience removal of their children." However, published program documentation for SafeCare indicates its evidence base focuses on improving caregiver skills, reducing service referrals, and reducing out-of-home placements—not guaranteeing that no removals will occur. For example, a North Carolina study found that families receiving SafeCare were 26% less likely to experience CPS reports than families who received standard home visiting services alone (https://practicenotes.org/v18n1/SafeCare.htm). Question: Will HHS revise or clarify this performance measure to align with the established evidence base and ensure realistic expectations for providers? Documentation: SafeCare's official program materials emphasize reducing maltreatment recurrence and out-of-home placements, not complete prevention of removal: <ul style="list-style-type: none"> • SafeCare Curriculum Overview – outlines key outcomes focused on caregiver skills, home safety, and child health. https://safecare.publichealth.gsu.edu/safecare-curriculum/ • HomVEE Profile – lists targeted outcomes addressing neglect and abuse prevention. https://homvee.acf.gov/models/safecarer?utm_source=chatgpt.com • Menu of Evidence (DFFH) – identifies "reduce out-of-home placement" as an aim. https://menu.dffh.vic.gov.au/menu-item/safecare-pm These sources collectively indicate SafeCare's research supports reduction of maltreatment recurrence and placements, not an absolute absence of removals'.	HHS plans to evaluate the effectiveness of all performance measures after the first year of the contract. Adjustments to performance measures will be considered upon completion of that evaluation. No performance measure requires 100% success to meet the measure.
14	Section 1 Background and Scope of Work	17	1.3.2.4 (A)	Performance Measures: Open Child Welfare Service Cases	The RFP establishes Performance Measure 1: Children served by the Contractor during an Open Agency Case will have interactions with their Parents for the duration as set in the Family Interaction Plan. The target is to achieve 90 percent on all Cases served. Questions: <ul style="list-style-type: none"> • Will HHS clarify whether this 90 percent performance expectation refers specifically to the most recent, HHS-approved Family Interaction Plan in the case file? • Given the variability in current practice—where some service areas regularly update Family Interaction Plans and others do not, and where delays in plan revisions are outside provider control—how will HHS ensure that contractors are not penalized for factors outside their authority? • Will HHS consider including a provision allowing for documentation of provider efforts (e.g., requests for updated plans, scheduling attempts) when the 90 percent target cannot be met? 	a) Correct, the expectation will be based on the most recent FIP in the case file. b) A reset of expectations for HHS staff will be provided prior to contract implementation. This will include information on when specific items are needed, including FIPs. If HHS staff are not sending FIPs when needed, providers will need to elevate this concern to their supervisor, who can in turn elevate to Service Area leadership. c) See answer to question 18 above regarding evaluation and consideration of adjustments to performance measures after the first year of the contract.
15	Section 1 Background and Scope of Work	16	1.3.2.1 (B)	Performance Measures: Family Casework	The RFP lists Performance Measure 2: Families served by the Contractor will receive in-person contacts at the frequency determined by their case progression each month. The target is to achieve 90 percent on all cases served. Questions: <ul style="list-style-type: none"> • Has HHS evaluated this 90 percent target against the historical contact data reported such as the March 2022 FCS Survey, which showed statewide median performance at approximately 74 percent of families receiving 3–4 casework contacts per month? • If the 90 percent threshold is retained, will HHS define how "frequency determined by case progression" will be measured and verified to ensure consistent statewide implementation and interpretation? 	a) See answer to question 18 above regarding evaluation and consideration of adjustments to performance measures after the first year of the contract. Contact expectations are changing under the new contract and will be a more informative data set for evaluation. b) HHS plans to use information entered into the forthcoming shared data environment to determine expected frequency of contacts with families for this performance measure.

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16	Section 1 Background and Scope of Work	16	1.3.2	Performance Measures	Several proposed performance measures (e.g., contact frequency reductions in Appendix A and L and Family Interaction Plan compliance) depend on corresponding HHS practice and procedural changes. Question: Will HHS develop and implement an internal staff training and practice change plan to ensure these expectations are applied consistently and statewide across service areas, referrals, and case types? Rationale: Providers identified that multiple measures rely on HHS practice alignment and internal consistency. Clarification ensures expectations are realistic and applied equitably statewide.	The Agency plans to hold joint trainings for HHS and provider staff across the state in the spring of 2026. These will be developed similarly to the trainings that shared the rollout of the initial Practice Standards.
17	Section 1 Background and Scope of Work	16	1.3.2.1 (B)	Family Casework: Performance Measure 2	In the March 2022 statewide FCS survey, the median percentage of families classified as "MIA" (Missing in Action) was 12.42%, with agency ranges between 7% and 18.21%. "MIA" was defined as no family contact at all for the month, representing family-driven non-engagement rather than workforce or agency error (e.g., unresponsive or non-cooperative parents). Families participating in Family Interactions were not considered MIA. Will HHS provide a definition of "MIA" that differentiates between family-driven non-engagement and provider non-compliance when calculating performance measures? Rationale: Consistent statewide definitions of "MIA" are critical to accurately assess provider performance and avoid penalizing agencies for family circumstances beyond their control. The 2022 survey data demonstrate that a portion of MIA cases are family-driven and should not be classified as contractor non-compliance for performance calculation purposes.	The Agency continues to evaluate family engagement and provider efforts to engage families in advance of contract implementation in July 2026. Discussions regarding a clear definition of diligent efforts to engage families and how this will impact performance monitoring are also ongoing.
18	Section 1 Background and Scope of Work	16	1.3.2.1 (B)	Family Casework: Performance Measure 2	Will HHS clarify how the 90 percent in-person contact performance target will be calculated when families are designated as "MIA" (i.e., family-driven non-engagement)? Specifically, will these cases be excluded from the denominator or adjusted to reflect only families available for engagement during the measurement period? Rationale: Providers noted that family-driven non-engagement (MIA) directly impacts the ability to achieve the 90 percent contact performance measure, despite contractor compliance with outreach and documentation expectations. Adjusting the denominator or providing exclusion guidance would ensure that performance data accurately reflect provider practice rather than family circumstances beyond contractor control.	The Agency continues to evaluate family engagement and provider efforts to engage families in advance of contract implementation in July 2026. Discussions regarding a clear definition of diligent efforts to engage families and how this will impact performance monitoring are also ongoing.
19	Section 1 Background and Scope of Work	17	1.3.4	Contract Payment Methodology	HHS received official federal approval for Amendment 1 of the IV-E Prevention Plan, effective retroactively to January 1, 2025. Where are the additional IV-E Prevention funds reflected in the FCS RFP, given that Motivational Interviewing (MI) and related practices were added as federally approved evidence-based services? In addition, how are these new IV-E Prevention funds being utilized to support FCS program implementation, training, or fidelity monitoring?	The additional funding from IV-E Prevention funding is going to support the increase in FCS payments. The Agency has added more than \$6 million to the FCS budget, which includes all additional funding the Agency will receive from IV-E Prevention funds as a result of Motivational Interviewing use.
20	Section 1 Background and Scope of Work	18	1.3.4.3	Payment Rate	Will HHS provide advance notice and supporting documentation before adjusting rates for agencies that exceed or fall below the 5 percent administrative cost threshold? In addition, what process will HHS use to verify or validate administrative cost calculations, and will providers have an opportunity to reconcile or appeal the findings before rate adjustments are implemented? Rationale: Providers request clarification on how administrative cost compliance will be reviewed and communicated. Establishing a transparent verification and reconciliation process—complete with advance notice and documentation—will ensure fiscal accountability, allow providers to correct potential data discrepancies, and prevent unintended financial penalties.	The Agency will discuss any rate changes with the contractor prior to making a rate change. Any rate changes will be based upon actual total caseload and resulting costs. When the actual total caseload is more than 5% above or below the established maximum total caseload listed in Appendix B of the RFP, the Agency will evaluate actual costs and discuss any adjustments with the contractor. The Agency only plans to make contractual changes to the established rate if the actual total caseload and actual costs are consistently (i.e. for more than two consecutive quarters) more than 5% deviant from the established maximum caseload and rate listed in Appendix B. Quarterly, the Agency will review actual total caseload and resulting costs. If there has been a deviation of more than 5% below the established maximum caseload, the monthly payments in the following quarter will be adjusted to make the contractor whole in the following quarter. Example: The established payment is \$500,000/month. A contractor's caseload is lower than expected and resulting costs are \$400,000/month for quarter 1. Payments in quarter 2 would be \$400,000/month to make the contractor whole back to \$500,000/month. The intent of this methodology is to avoid the Agency having to claw back unused funds. If there has been a deviation of more than 5% above the established maximum total caseload, the Agency will evaluate the report of actual costs and provide approval for the contractor to bill the Agency for actual costs above the monthly payment. For the purpose of evaluating additional costs above the monthly payment, the Agency will consider the actual total caseload, comparative costs in other Service Areas, and comparative costs to the same contractor in other reporting periods. This will include evaluating the number of FTE needed to serve the actual total caseload.
21	Attachment L Technical Response Document	80	Question 7	Contractor Scope of Work for Post Removal Conferences	The RFP states that the Contractor shall provide a Post-Removal Conference (PRC) within five calendar days of the Child's removal from the home, and defines a PRC as a meeting between the parents, Agency, Contractor, and placement caregiver to discuss the Child's needs, Parents' next steps, and the Family Interaction Plan following the court-ordered Removal of a Child from their home, led by a trained facilitator from the Contractor's organization. Questions: <ul style="list-style-type: none"> • Does "court-ordered removal" refer to the ex parte removal order, the formal removal hearing, or another triggering event? • How will this five-day timeline be operationalized in counties where court hearings occur only once per week? We want to clarify implementation expectations for PRCs, including the definition of "court-ordered removal and timing flexibility. Providers note that these factors significantly affect scheduling feasibility, coordination with courts, and staff. 	a) "Court-ordered removal" means the date of the initial court order removing the child from parental custody. In most instances, this will be an ex parte order, though there may be other instances when the court removes the child from parental custody. b) A court hearing does not need to occur for a child to be under a court-ordered removal. The triggering date for a PRC is the date on the initial order removing the child.

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22	Attachment N Cost Report for FCS Payments	Attachment N	Direct Costs	Concrete Supports	At the Bidder's Conference, HHS stated that "Concrete supports" are limited to 3 percent of the budget for family goods (e.g., beds, food, furniture, gas/grocery cards) and that this would be a "use it or lose it" allocation. Please clarify whether this 3 percent limit is applied monthly or annually, and whether it includes interpretation or transportation tied to individual family needs. We recommend that interpretation and transportation directly related to family services be included within the allowable Concrete Funds category. If funds are not fully utilized within the defined period, can they be reallocated for other family-specific needs within the same fiscal year rather than forfeited?	a) The 3 percent limit is applied on a monthly basis and may include provision of funds for individual family transportation, including but not limited to direct purchases of gas, gas cards, bus tokens/passes, and minor vehicle repairs to a family's vehicle. If successful bidders are unsure whether something can be covered under concrete supports, they are welcome to contact their contract specialist or the FCS Program Manager. b) If funds are not fully utilized within the defined period, contractors will be allowed to purchase gift cards, gas cards, and/or bus tokens/passes to be saved for later use.
23	Section 1.3.2 Performance Measures	16	1.3.2.1	Family Casework: Performance Measure 1	Performance Measure 1 states: "Children served by the Contractor are safe from abuse during the service period and for 12 consecutive months following the conclusion of their Case." Under the proposed FCS model, when children enter out-of-home care, FCS providers will no longer have ongoing contact with children or their caregivers as part of the service delivery continuum. Question: How will FCS contractors be held accountable for child safety measures when providers no longer have contact with the children and therefore have limited or no influence over their safety outcomes? Please clarify how safety-related performance measures will be calculated when providers have no direct service contact with children in out-of-home care under the proposed model.	This performance measure has not changed from the current FCS contract. FCS staff will continue to have contact with the children during supervised Family Interactions.
24	Attachment N Cost Report for FCS Payments	Attachment N	Attachment N	Entire Cost Report Structure	Question: The Coalition's Q RTP Financial Workgroup has developed a Simplified One-Page Cost Report Model, including standardized definitions of Program Costs, Occupancy Costs, and Administrative Costs. This model will be formally presented to HHS during the November 10, 2025 meeting. Through this work, all Q RTP providers statewide have demonstrated that this simplified model: • Produces consistent and comparable cost data across agencies; • Reflects true program costs and avoids inflating administrative percentages; • Aligns with standard accounting principles and existing provider financial structures; • Uses cost definitions that HHS leadership indicated should be aligned across CPS contracts (per the joint HHS-Coalition meeting on October 8, 2025); and • Can be completed efficiently and accurately, reducing administrative burden for both providers and HHS. Conversely, the current Attachment N format uses definitions that place large volumes of program, occupancy, and compliance-required expenses into "administrative cost," resulting in administrative percentages of 30-35% or more, making the 15% administrative-cost cap unattainable for all providers. Given the strong alignment between HHS and providers regarding the need for a common, simplified, transparent cost report methodology, and given that the improved model will be presented to HHS on November 10th, we respectfully request: Will HHS allow Bidders to submit the Q RTP Simplified One-Page Cost Report Model, with the associated standardized "legend" of cost definitions, in place of Attachment N for purposes of this procurement? If not, will HHS authorize the simplified model to satisfy the cost-report requirement for determining the administrative-cost cap (15%) and the cost-adjustment review required under Section 1.3.4?	As noted in the RFP, Attachment N- FCS cost report, is a draft document and further discussion will occur to successful bidders. The RFP procurement team did not have access to the Q RTP cost report model at the time this RFP was released and has not had a chance to review the proposed document. The team did review the current RRTS and Parent Partner cost reports as part of the development of the FCS cost report. The Agency will not be making changes to Attachment N at this time.
25	Section 2: Basic Information About the RFP Process	25	Section 2.32 - Use of Subcontractors	Subcontracting & MOUs	Under the current FCS contract, providers use MOUs with other awarded FCS contractors to ensure statewide coverage without requiring subcontractor approval, since all parties already hold FCS contracts with HHS. Question 91 states that MOUs will not be accepted and that subcontractor forms must be completed for any agency a bidder intends to subcontract with. This response does not address how current FCS contractors may continue partnering with one another. Question: Can HHS clarify whether the subcontractor form is only required for non-FCS-contracted agencies, and whether current FCS contractors may continue using MOUs with one another for cross-service-area coverage, as allowed today?	See Round 1 Bidder's Question and Agency Answer # 91. Subcontract forms should be used for FCS and Non FCS contracted agencies. By definition, an MOU is a non-legally enforceable agreement. A subcontract is a legally enforceable agreement... If the entities you speak of are being compensated for work required under the resulting contract, it is likely they are considered subcontractors.
26	Section 3: Bid Proposal Formatting	25	3	USB Flash Drive	Is the requirement for searchable (non-scanned) text limited to the narrative portions of the proposal? Please confirm that signature pages, Letters of Support, organizational charts, and similar supporting documents may be scanned and included as images on the USB flash drive.	The expectation is to be searchable to the maximum extent possible whether that is using Word or pdf (with OCR Text recognition), etc. If for example letters of support are hand written then images may be scanned and included. However the intent is as much as practical for the proposal to be searchable.
27	Section 1 Background and Scope of Work	4	General Question	Original Signatures	Will the state allow Providers to submit their proposal with electronic signatures on the letters of support and other required documents or are original, physical signatures required?	E- signatures tools such as Adobe Sign, or DocuSign, are acceptable, or you can use physical "pen and ink."
28	Section: Section 3	26	3.1 Bid Proposal	Proposal Page Limit	Would DHHS consider not including attachments into the overall page limit of 200 pages for Attachment 1?	However, using a standard font from a word processing software that has the appearance of a signature is not acceptable. HHS will not be changing section 3.1 Page Limits

Round 2: Agency Response to Bidders' Questions, Request for Clarifications and Suggested Changes

29	Section: Section 3	26	3.1 Bid Proposal Formatting	<p>How will DHHS verify receipt of proposals so bidding organizations understand proposals submitted via mail were successfully received? If providers send the proposal certified, which requires a signature, will DHHS sign to show receipt? What is the timeframe and format between receipt of proposal and provider confirmation from DHHS so providers know they have been received?</p>	<p>Receipt of proposals will be verified by the Lucas Mailroom at the Due Date and Time. Bidders are encouraged to get tracking on their shipping package and share that with the Issuing Officer as well. Bidders can send an email to the Issuing Officer to request confirmation of receipt of their proposal.</p> <p>Certified Mail can be accepted, but bidders should note that all mail goes first to the Department of Administrative Services (DAS) Mail Center in the morning and then early afternoon the same day goes to the Lucas Building Mailroom. Proposals not at the Lucas Mailroom by the due date and time will be counted as late.</p> <p>Important Note: Per Amendment 3 additional time was added to this RFP and the due date was extended to ensure proposals would have adequate time. As stated in the RFP document, late proposals will not be accepted so add additional time into your timeline to ensure mail has time to process, and do not wait until the last minute to submit your proposals. Also see question and answer #2 above.</p> <p>Please review RFP Section 2.8 2.8 Submission of Bid Proposal.</p> <p>Each Bidder is responsible for ensuring that the Issuing Officer receives the Bid Proposal by the time and date specified in the Procurement Timetable at the address provided in the RFP for the Issuing Officer. The Agency will not waive this mandatory requirement. Any Bid Proposal received after this deadline will be rejected and will not be evaluated.</p> <p>Bid Proposals are to be submitted in accordance with the Bid Proposal Formatting section of this RFP. Bid Proposals may not be hand-delivered to the Issuing Officer. Rather, Bid Proposals are to be mailed through the postal service or shipping service.</p>
30	Section: Section 4	27	3.1 Bid Proposal Formatting USB Flash Drive	<p>Due to client reference letter inclusion in the bid proposal, may providers use a password protected USB drive for HIPAA compliance due to mailing the proposal? If yes, can DHHS confirm providers are able to send the password in a separate email prior to the submission deadline and if so, would the issuing officer be able to accept those passwords?</p>	<p>If bidder intends to use a reference that they determine should be kept confidential they should review RFP section 2.20 Public Records and Request for Confidential Treatment discussing how proposals received by the Agency will be treated as public information unless the bidder properly requests bids be treated as confidential, and also review RFP section 3.1 Bid Proposal Formatting, sub section Request for Confidential Treatment regarding the process required to request confidential treatment and Attachment B Primary Bidder Detail and Certification to understand steps required for confidential treatment of a bidder's proposal.</p> <p>Regarding the password question specifically, if requesting confidential treatment (per the previous paragraph) a password would be allowed for the Original Technical Proposal USB, but not for the Public Copy USB since confidential information would be redacted.</p>