Commonwealth of Virginia
RFP 720-04448-15C

Issue Date: June 22, 2015

RFP Title: IDD Group Home(s) with Skilled Nursing

AGENCY: Department of Behavioral Health and Developmental Services (DBHDS)

Purpose: RFP Questions and Answers

The following questions were submitted to the Department. Answers are provided after each question

Q1. **As you mentioned yesterday, the grant will require us to partner with a small business, a minority-owned business, or woman-owned business. For this purpose, I see that the goal of the Commonwealth is to offer 42% of its purchases from small businesses. Does that require us to ensure that a certain percentage of our project be completed in conjunction with a small or minority-owned business? Are we held to the 42% goal**?

A1. No. Contractors should submit a small business plan as part of the proposal providing the small business subcontractors business name and the proposed dollar value of the subcontracted work.

Offerors are not held to the 42% goal. Evaluation points for small business subcontracting and utilization are based on a standard formula. The formula is SWaM subcontracted Dollars/Total proposed price * .75 of evaluation points.

Q2. **May we use grant monies for acquisition of wheel chair vans**?

A2. No

Q3. **If we write the grant contingent upon the approval of the proposed HCBS waiver and rate, may we offer that in the alternative, we may need to license our homes as ICFs? As discussed yesterday, your current waiver would not be sufficient to cover the cost of care needed to be provided for people living with such high medical acuity whom you seek to place**.

A3. Yes

Q4. **Does Virginia offer any other low cost financing for homes for people with disabilities**?

A4. No

However you can talk to Virginia Housing Development Authority (VHDA), or Department Housing Community Development (DHCD) for special funds.

Q5. **On homes, are you expecting actual addresses or is it sufficient to say we will be acquiring homes in the greater Lynchburg area? or do we have to have an option to buy in place**?

A5. Your plan for housing should be included in the proposal and the critical information to provide is the timeline that shows milestones to include when individuals can move in.

Q6. **Since RIVA operates group homes currently (in other areas of VA) -- but will NOT be transitioning these to ICF's - is our understanding correct that we DO NOT need to apply for a certificate of need?**

A6. Correct

Q7. **Under section 2 -- Proposal instructions -- do you want the proprietary and confidential information removed from just the cost section or from all sections?**

A7. All sections.

Q8. **In section 6 c -- I assume we just need a proposed plan in the geographical area they are requesting the homes. Did you want to know who our realtor, GC or architect is or just merely that we have the means to do this quickly? I ask this as in a different part of the RFP there appears to be more interest in the execution part of the homes**

A8. Your plan for housing should be included in the proposal and the critical information to provide is the timeline that shows milestones to include when individuals can move in. Yes, we do want a clear picture of a plan and environmental activities that will take place before and after individuals move in.

Q9. **I see that Medically Fragile in your proposed waiver is at Tier 6 but I don't see what that rate is. Is the rate strictly based on the SIS or is there an upper limit?**

A9. As proposed the tiers, levels and rates are based on the support needs of the individual. In the leveling system “Level 6, Significant medical support needs” will provide for all support needs, and this may fall outside of the published rates and are exceptions. However, there are those individuals whose support needs will fall in level 5 who reside in CVTC as well.

Q10. **I also see that the waiver model builds in 21 annual absences. We know that these people will unlikely go home. So is the provider just left to cover that hole or is there another revenue source for those days?**

A10. We had to determine the number by which we would divide that annual cost in order to create a daily rate. We chose to divide by 344 days, which produces an ‘inflated’ rate compared to the result if we would have divided by 365. This ‘inflated’ rate may be less than the current rate (and, in many cases, will be less), but is still ‘inflated’ compared to the rate that would result by dividing by 365. But the issue of the number of billing days is a separate matter altogether and the 344-day billing policy is completely in providers’ best interests.

The intent of allowing this type billing is to promote innovative ways to support people going out on trips, visiting family and any other opportunity that is chosen by the person. It is in the best

interest of the individual that we encourage them to go outside the home. We expect the provider to work through these requests and plan with the person and/or their families to have successful visits/outings.

Q11. **If we submit a capital budget and a model that is selected but we do not have an approved budget, would we be legally held to move forward if we determine that the budget will not meet the need of the people we are to serve?**

A11. No. A selected provider can say no and return all funds **(is there a timeframe for this)**

Q12. **How soon do you think we can get a list of medical diagnosis and medical equipment needs? This is a really important piece of the puzzle.**

A12. These are based on the needs of individuals who select the provider. Medical equipment, not built into the properties may be provided through the individual's Bridge budget or Medicaid (MFP). General information is being compiled and will be posted.

Q13. **Can the same provider bill for skilled nursing as well as residential support**?

A13. YES

Q14. **Just looking at the provider rate study, it appears to me that at Tier 4, Levels 5- 7 the top annual cost is $88,103.04? Is that correct? Is that just for Residential Services and then Day Support and Nursing Services would be on top of that?**

A14. Depending on which table you were reviewing for the rates, this may be correct. Day supports and nursing services rates would be on top of the residential rate. This also includes any therapies, and assistive technology.

Q15. **During the Pre-Proposal Conference a provider agency asked about scoring of proposals based on whether a 5 bed or 4 bed model is used and the preference for the 4 bed model. If a five bed model is scored less favorably, will that also be the case if one of the beds in a 5 bed home is used only as a respite bed?**

A15. We are not requesting respite beds. Homes are licensed by number of beds. We determine size by license.

Q16. **At the conference we discussed the use of Bridge Funding. After the award of the contract(s) and development of the service sites, will it also be possible later for bridge funding to be used for individuals that may choose to live in one of the provider service sites?**

A16. Yes - If the residences are ready for occupancy and the provider has been chosen and this all occurs prior to the new waiver are implemented.

Q17. **Is there the possibility for the provider(s) awarded a contract to have an early buy out on the 20 year time frame?**

A17. Yes

Q18. **What will happen if Virginia stops providing funding for Medicaid waiver in the next 20 years?**

A18. We cannot predict what will occur in the next 20 years. In final negotiations it will be made clear that if the needs for the housing changes a provider can petition to allow other populations to be supported in the homes and possibly discharge the remaining years.

Q19. **Will there be another opportunity to submit questions prior to July 9? The answers to questions may create additional questions.**

A19. No

Q20. **Do all companies submitting bids have to sign up under eVA prior to submitting the bid?**

A20. Yes