FREQUENTLY ASKED RFA QUESTIONS

What is the timeline for the RFA process?

- The RFA application will be available for request on October 1st.
- The proposal, with all required attachments, will be due to the MHRS Board at the close of business on December 31st.
- The proposals will be evaluated and scored by MHRS board and staff between January 1st and March 31st. MHRS staff will work with providers to schedule their presentations to the MHRS full Board during that time frame also.
- Mid-April the agency allocation awards will be announced. Notifications will be in writing.
- April draft service contracts will be sent to the providers for review and feedback.

Do I combine the programs into one document?
No – if you choose to apply for Treatment and Prevention funding, you will submit two applications. One for Prevention and one for Treatment, Crisis and Recovery Supports. Each application is limited to 15 pages, not including the revenue and expense budgets.

Do I leave the questions in the application as I answer them?
Yes. This enables the reviewers to determine if the question has been answered completely and succinctly.

Where do I put in the application what the total amount is that I am asking the Board to fund?
Under Part One: Priority Effort, question 1, part a.

What are the NOMs referenced in the application? *Several resources listed for different outcomes*
SAMHA has identified 10 domains for National Outcome Measures (NOM). The domains embody meaningful, real-life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. These NOMs are an effort to develop a reporting system that creates an accurate and current national picture of substance misuse and mental health services. The NOMs serve as performance targets for states and federally funded programs for substance misuse prevention and mental health promotion, early intervention, and treatment services.
Substance Abuse and Mental Health Services Administration (SAMHSA) has identified 10 domains for National Outcome Measures (NOM). The domains embody meaningful, real-life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. The NOMs matrix represents the beginning of a state-level reporting system that, in turn, will create an accurate and current national picture of substance-abuse and mental-health services.
Since President Obama signed into law the Government Performance and Results Modernization Act of 2010, this is one valid and reliable method of obtaining performance data..
NOMS
https://hhs.iowa.gov/sites/default/files/SAMHSA-National-Outcome-Measures_09-01-2011.pdf?030720191352
2023 Ohio CPC Thresholds
HEDIS® is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. Through HEDIS, NCQA holds Buckeye Health Plan accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc) delivered to its diverse membership.
https://www.ncqa.org/wp-content/uploads/2022/07/HEDIS-MY-2023-Measure-Description.pdf
https://medicaid.ohio.gov/static/Providers/PaymentInnovation/CPC/2022-CPC-Thresholds.pdf

KPI metrics
You can measure the health of your therapy and rehab practice by using key performance indicators. KPIs are objective, quantifiable, data-driven measures of activities that show the success of your practice – from administrative operations to financial tracking.
https://www.nssbehavioralhealth.com/nss-blog-important-kpis-you-need-to-measure-for-behavioral-health/#:~:text=Sample%20KPIs&text=It%20might%20be%20the%20number,revenue%20each%20unit%20brings%20in.

What are the MHRS Board priorities to be addressed in the application?
The outline that describes the various tiers of services/programs will be included as part of the application packet.

PREVENTION: Description is not a true definition of prevention . . . it is a definition for intervention.
It is not meant to be a definition for prevention. It is defined to prioritize the programs/services that are delivered to high-risk population.

How will the applications be evaluated?
Applications will be reviewed by MHRS Board's Program Staff and the fiscal/program committees on the MHRS Board as well.
A copy of the evaluation template will be included in the application packet.

Should I include actual outcome results in my application?
Outcome proposals are an important tool to show the effectiveness of programming. The most recent outcomes should definitely be described within the application.

How are applicants who are awarded funding paid for the services?
All applicants must have the capacity to bill through the Board's billing system. The Board currently uses the GOSH (Great Office Solution Helper) system.

Is the MHRS board setting dollar amounts/limits per service and/or per county?
The MHRS Board establishes a unit cost for each service. These costs are aligned with Medicaid reimbursement rates. We anticipate there will be a need to set reimbursement caps on some services. This will be discussed as the needs are identified.

Would a 10% administration fee be possible?
Administration costs are included in the reimbursement rate through the Uniform Cost Report proposed budget.

If something changes mid-year, would you follow along with that?
There are provisions in the contract/ contract standards manual for how to handle material changes to the contract. The Board is always open for discussion, but any changes to the contract would require the issuance of a 120-day notice on you or the board's part with negotiation, edits and/or amendments to the contract to follow.

If a service or program is not a priority in the new funding process, how do we resource that?
All services included on the continuum of care are available for funding. The safety net of services includes not only those services mandated by Ohio Revised Code and other funding bodies, but services that without such, would negatively impact the lives of those in Coshocton,

Guernsey, Morgan, Muskingum, Noble and Perry Counties. We can look at adding a section for new projects not identified on the priority list for consideration.

1. Highest priority will be given to programs that serve priority populations and identified carve-out services.
2. Higher priority will be given to non-redundant programs which address underserved or emerging programs.
3. Higher priority will be given to programs that leverage outside resources in a way that reduces Board expenditures.
4. Higher priority will be given to programs that demonstrate the ability to coordinate services across organizations.
5. Higher priority will be given to programs that demonstrate that individuals served are likely to experience a reduction in system dependence.
6. Higher priority will be given to programs that are innovative and that are evidenced based.
7. Lower priority will be given to programs/services that MHRSB is not mandated to provide.

Will the MHRS Board and Board of Directors visit the sites they are funding through the RFA?
MHRS Board members will not be traveling to each applicant's site due to the size of our service area. There is a possibility that virtual tours could be created so that the MHRS Board members will be able to see the program sites.

Will there be additional funding available for unforeseen expenses or scope changes?
Since any additional funding is unknown at the time of the application, this will not be included as a part of the application process. Providers and affiliates do have the opportunity to apply for additional funding through the previously established grant application processes. Questions about these grant applications may be directed to mistyc@mhrs.org. Any requested changes to the contract must be submitted in writing and approved by the Board.

What are the expected reporting deliverables and outcomes for the RFA? Are there regular reporting requirements or progress updates we will be required?
Providers who receive funding will be expected to provide quarterly and/or yearly outcomes for the services provided. The outcome's reporting form is currently in development but Board staff are working to reduce any administrative burden for the agency.

Are we just supplying our costs for the service and being told how much you plan to support the effort(s), if at all? Or do you want us to clearly ask for a certain amount from the board to ensure our services are supplied?
We want the UCR completed to illustrate true unit costs of your organization but we are only going to pay the negotiated or Medicaid rate. This procedure will continue to develop as we work together to refine the RFA process.

Will there be a rebuttal/review/grievance process in the event our funding request is denied?
The Board always welcomes an open exchange of information with providers. However, the following reasons would lead the board to consider denying a request for funding.

1. Failure to provide sufficient information to award request
2. Reduction in state, federal, local funding to the board
3. Failure to submit complete and timely reports as stated in the contract.

4. Inappropriate, unethical or negative feedback from community providers and stakeholders, clients, or family members.

Where are you getting benchmarking data from?
Benchmarking and/or outcome data comes from the Board's Community Assessment & Plan (CAP), our Strategic Plan and specified indicators as identified by the Department of Mental Health and Addiction Services. Most are national and state in nature. The CAP and Strategic Plan are available on our website at www.mhrs.org or by emailing admin@mhrs.org.

Provision for crisis care can change rapidly. Can you move easily between tiers to reflect those changes?
The contract is for a full fiscal year. Should an extreme circumstance arise, this issue will be reviewed and discussed as indicated.

Where do I find the figures for Part Two, questions 2 – 6?
Those answers are available in your annual audit report.

Do we have the ability to ask for more dollars?
Requests for increased funding will be based upon the priority area that the program is serving. If programs are not meeting the expectations of the MHRS Board and/or have not fulfilled the deliverables as agreed upon in the program proposal, increased funding should not be expected. The ability to receive additional dollars after the contract has been awarded will depend on new funding that MHRS Board should receive during a fiscal year. These funds will be allocated based on the new evaluation process for areas where it is appropriate.
Current processes for re-allocation occur at the mid-year point and are detailed out in the contract. If an agency is unable to spend their allocation, the MHRS Board has the right to initiate the re-allocating process. Historically, the trend has been to spend levy dollars last, which means that most do not draw against these dollars until the later part of the fiscal year.

It is anticipated that— in the coming months — men, women and children will be significantly impacted by being kicked off Medicaid rolls. Organizations will be seeing a huge influx of clients who will have no health insurance coverage. It was noted that the MHRS Board has been the providers' safety net, and service providers have been the safety net for persons needing treatment without the ability to pay for care. Where does that leave us? The MHRS Board system is a safety net to serve the indigent population. Organizations will need to identify and prioritize services in their budget planning for those individuals. At the time of this proposal, no major changes have occurred within the board network that would necessitate a system-wide plan for addressing this issue. As incidents occur, the Board is willing to review on a case-by-case basis.

Recovery housing units are struggling to fund operations. This service provides support to people that are fighting addiction (particularly, those in early recovery that do not have a safe place to stay). One factor in making recovery housing admission decisions is where would the individual be if they did not have recovery housing (jail or homeless). It was mentioned that AOD providers may need to take a look at asking residents to pay market rent amounts. It was noted that recovery house utility costs are also going up.
These issues need to be addressed in the Heart Coalition meetings, with a plan developed for the Board to support provider efforts. If this is an area of priority for providers, would you be willing to sacrifice levy allocations to support it. This is your story to share with the communities that vote for your levy.

Don't tell – show
This concept is the basis for this application. The Board is familiar with the various programs conducted by each Contract Provider. In this application make sure that you have shown the reviewer the impact on the population served, outcomes, and difference made. Why should the program or service be funded. What sets it apart.

Scoring
Scoring will begin by reviewing and comparing each evaluator's responses to determine if the majority reached a consensus about the program application. The scoring tool is one aspect of the evaluation of the RFP and will be used as a common point of reference for funding discussions.
Proposals with the highest score in the mandated Tiers will be considered for funding first, followed by all other proposals in the order of ranking for that Tier. This process will continue through that Ter until all applications have been considered. This concept will be repeated through each Tier until the funds have been exhausted. Should the budget remain after all programs within each Tier have been adequately funded, the remaining funds will be utilized to address unmet needs in the community plan.

If a model requires service teams or multiple providers then it cannot be accomplished to fidelity, particularly in crisis service situations. How will the Board measure fidelity in future applications?

If an application states that the programming used is evidence based, there should be an explanation as to why it is not being done to fidelity. This could impact which funding sources are utilized, depending on the funding guidelines.

What deadlines? How is efficacy measured?
Throughout the fiscal/calendar year Boards are requested to submit demographics, financial information, contracts, and attachments, RFA's and various outcome measures by a deadline. Efficacy is measured by the Agency's ratio of meeting deadlines versus being late.

What does the Board consider "success"?

Each provider should have a methodology for tracking and reporting outcomes to gauge their measure of success.

Documents to be submitted
Application cover letter
Application
Revenue budget
Expense budget completed in the UCR format