



Massachusetts Behavioral Health Partnership

Procurement for Community Behavioral Health Center Programs

Inclusive of:

- Community Behavioral Health Centers (CBHCs)
- Adult Community-Based Mobile Crisis Intervention (AMCI, a.k.a. Emergency Services Programs (ESP))
- Youth Community-Based Mobile Crisis Intervention (YMCI, a.k.a. Mobile Crisis Intervention (MCI))
- Adult Community Crisis Stabilization (Adult CCS)
- Youth Community Crisis Stabilization (YCCS)

Request for Proposals

February 1, 2022

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I. Introduction

The Executive Office of Health and Human Services (EOHHS) is expanding and strengthening the delivery of community behavioral health services across the Commonwealth. A key component of this initiative is EOHHS' development of a comprehensive network of Community Behavioral Health Centers (CBHCs). CBHCs will serve as hubs of coordinated and integrated mental health and substance use disorder treatment for MassHealth members of all ages and will provide routine and urgent outpatient services, crisis services for adults and youth, and community crisis stabilization services for adults and youth. The current Adult Community-Based Mobile Crisis Intervention (AMCI) program, also known as the Emergency Services Program (ESP), and Youth Community-Based Mobile Crisis Intervention (YMCI), also known as Mobile Crisis Intervention (MCI), will be integrated into the CBHC network. EOHHS has developed program specifications and quality measures to ensure the success of this model.

As the statewide behavioral health vendor for EOHHS, the Massachusetts Behavioral Health Partnership (MBHP) is procuring the network of CBHCs to serve MassHealth members enrolled in MBHP. CBHCs procured through this process will deliver services in accordance with the EOHHS approved performance specifications and other programmatic requirements. Other MassHealth-contracted Managed Care Entities (MCEs) will also be expected to contract with the selected CBHCs. Bidders can also apply for Delivery System Reform Incentive Payment (DSRIP) funds to support CBHC infrastructure development. As described in Section XIV, MBHP will manage, disburse, and monitor these funds that are awarded to the CBHCs.

This document outlines all expected performance measures via the programs' detailed EOHHS approved specifications, as well as quality measures that will be used to measure the effectiveness of the programs.

A. Vision Statement

EOHHS seeks to create a network of behavioral health services and programs that ensures everyone has access to the right treatment when and where they need it.

In February 2021, EOHHS released a summary of its Roadmap for Behavioral Health Reform: Ensuring the Right Treatment *When* and *Where* People Need It. Based upon feedback from statewide stakeholder listening sessions, the Roadmap identifies historical and structural challenges in access to mental health and substance use disorder treatment and provides a multi-year blueprint to meet these challenges. The Roadmap proposes the following critical behavioral health system reforms:

- A new, centralized “front door” service through a statewide 24/7 Behavioral Health Help Line, for people to get connected to the right treatment in real time
- Readily available outpatient evaluation and treatment:
 - More mental health and substance use disorder services available through primary care
 - Same-day evaluation and referral to treatment, evening and weekend hours, and high-quality treatment in person and via telehealth at designated Behavioral Health Urgent Care providers and CBHCs throughout the Commonwealth
- More community-based alternatives to the emergency department for urgent and crisis intervention services:

- Urgent appointments for behavioral health at CBHCs and other community provider locations
- A stronger system of 24/7 community and mobile crisis intervention

The Roadmap also seeks to advance health equity, reduce administrative and payment barriers to encourage more providers to accept insurance, broaden insurance coverage for behavioral health, and implement targeted interventions to strengthen workforce diversity and competency.

The reforms identified in the Roadmap do not replace or disrupt existing services or provider relationships – rather they aim to help individuals and families more quickly and easily get connected to the treatment they need.

B. System Principles

The following key principles guide the new system:

- Ensure parity between physical and behavioral healthcare.
- Expand provider networks through MassHealth and private insurance.
- Expand timely outpatient and urgent care access to promote early intervention and to reduce crises.
- Integrate the delivery of mental health and substance use disorder treatment and integrate behavioral and physical healthcare.
- Ensure treatment is based on goal-oriented, trauma-informed, evidence-based practices for individuals across the age spectrum, with specialized services for complex and high-risk populations.
- Support health equity by ensuring capacity to meet the diverse needs of all individuals in the Commonwealth, including those who are systematically disadvantaged.
- Require “no-reject” of individuals who need treatment, including returning patients.

C. Goals

- Individuals will easily connect with appropriate treatment.
- Primary care practices will have the capacity and competence to provide integrated treatment for mental health, substance use, and co-occurring disorders.
- Specialty behavioral healthcare will provide integrated treatment for mental health, substance use, and co-occurring disorders with urgent and walk-in appointment availability.
- The 24/7 behavioral health crisis response system will support stabilization and successful transitions to an appropriate level of treatment.

D. Definitions

Adult Community-Based Mobile Crisis Intervention (AMCI), also known as Emergency Services Program (ESP): AMCI provides adult community-based behavioral health crisis assessment, intervention, stabilization, and follow-up for up to three days. AMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences) and provided via telehealth to individuals age 21 and older when requested by the member or directed by the 24/7 Behavioral Health Help Line and clinically appropriate. AMCIs operate Adult CCS programs with a preference for co-location of services. AMCI programs must have capacity to accept adults voluntarily

entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

Adult Community Crisis Stabilization (Adult CCS): Adult CCS services are available to individuals 18 years of age and older. Adult CCS provides 24-hour, short-term, staff-secure, safe, and structured crisis stabilization and treatment services for adults with mental health and co-occurring mental health and substance use disorders. Adult CCS services are preferred, but not required, to be co-located with the AMCI at the CBHC location. Stabilization and treatment include the capacity to provide induction and bridging with medications for the treatment of opioid use disorder (MOUD) when access to these services is needed outside of the CBHC operating hours. Adult CCS provides continual assessment for additional, acute psychiatric stabilization and the need for a higher level of SUD care.

24/7 Behavioral Health Help Line: A statewide, multichannel entry point (telephone, text, chat, website, etc.) that provides behavioral health information, resources, and referrals in a supportive, coordinated, and user-friendly approach, including 24/7 referral and dispatch to AMCI/YMCI for behavioral health crises.

Community Behavioral Health Center (CBHC): A comprehensive community behavioral health center offering crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youth, including infants and young children, and their families. CBHC services for adults are collectively referred to as the “adult component,” and CBHC services for youth are referred to as the “youth component.” CBHCs include an Adult Community-Based Mobile Crisis Intervention (AMCI), Youth Community-Based Mobile Crisis Intervention (YMCI), and Community Crisis Stabilization (CCS) units for both adults and youth.

Youth Community-Based Mobile Crisis Intervention (YMCI), also known as Mobile Crisis Intervention (MCI): YMCI provides a short-term service that is a mobile, on-site, face-to-face therapeutic response to youth under the age of 21 experiencing a behavioral health crisis and includes follow-up for up to seven days. YMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences, congregate care programs, and residential settings for youth in the care and custody of the Commonwealth), and via telehealth when requested by the family and clinically appropriate. YMCIs will have access to Youth Community Crisis Stabilization (YCCS) services. YMCI programs must have capacity to accept youth voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

Youth Community Crisis Stabilization (YCCS): YCCS services are available to individuals up to and including 18 years of age. YCCS offers short-term, 24/7, staff-secure, safe, and structured crisis treatment services in a community-based program that serves as a medically necessary, less-restrictive, and voluntary alternative to inpatient psychiatric hospitalization. The Commonwealth intends to ensure YCCS services are provided in all regions of the state. If the CBHC does not itself provide YCCS, it must have formal agreements with a CBHC in its region who is providing YCCS services. YCCS shall be primarily used as a diversion from an inpatient level of care. YCCS must provide assessments for substance use disorders and

facilitate warm hand offs for initiation of MOUD services as clinically appropriate. It is preferred but not required that the YCCS is co-located with the CBHC.

II. CBHC Model Components

CBHCs are comprehensive community behavioral health providers that deliver crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer services, and screening and coordination with primary care. CBHCs serve youth and adults, ensuring an approach to healthcare that emphasizes recovery, wellness, and physical-behavioral health integration.

For youth-serving components, the CBHC must have the ability to provide clinical expertise in working with youth under the age of 21 and their families, including infants and young children.

CBHCs will be an entry point for timely assessment and connection to behavioral health treatment. CBHCs will:

- Offer same-day crisis, urgent, and routine care with assessment and referral to higher levels of care when clinically appropriate and timely follow-up appointments.
- Offer high-quality, evidence-based, integrated treatment, with attention to cultural humility.

The CBHC must deliver the services defined in the EOHHS approved CBHC performance specifications. See Appendix 2 for additional details.

A. Guiding Principles and Required Competencies

The following competencies and principles will guide the delivery of services by CBHCs:

1. **Capacity and competency to treat a variety of populations, including but not limited to:**
 - a. Persons with mental health conditions
 - b. Persons with co-occurring mental health and substance use disorders
 - c. Persons with co-occurring behavioral health and medical conditions (utilizing assessment capabilities and referrals for medical conditions)
 - d. Persons with substance use disorder conditions
 - e. Persons with opioid use disorder (OUD) requesting induction and bridging services for medication for opioid use disorder (MOUD) and referrals to ongoing care
 - f. Persons who are pregnant, postpartum, and lactating
 - g. Older adults (age 65+)
 - h. Persons with cognitive or decisional impairment (e.g., Alzheimer's or dementia)
 - i. Military service members, veterans, and families
 - j. Culturally and linguistically diverse populations in their geographic area
 - k. Persons with Autism Spectrum Disorder (ASD) and/or intellectual and developmental disabilities (IDD)
 - l. Persons who are deaf or hard of hearing
 - m. Persons who are blind, deaf-blind, and visually impaired
 - n. Persons with physical disabilities that limit mobility
 - o. Persons who lack stable housing
 - p. Persons who are LGBTQIA+
 - q. Persons involved with the justice system

- r. Youth in the care and/or custody of the Commonwealth
- 2. **Recovery-oriented:** CBHCs will support resiliency, rehabilitation, and recovery of all individuals to whom they provide behavioral health services. They will integrate mental health, substance use disorder, and co-occurring disorder recovery and rehabilitation principles and practices throughout the service delivery model and implement specific recovery-oriented services, including peer and family support services. Recovery-promoting treatment approaches instill hope; capitalize upon the strengths of the person and their family/support system; are aimed at enhancing problem-solving, coping, and other skills that support recovery; and are highly individualized and collaborative. Recovery-oriented processes recognize and respect that change occurs in non-linear stages, and effective providers assess individuals' stage of change while pairing effective interventions and techniques accordingly.
- 3. **Cultural and linguistic humility:** CBHCs commit to implementation of Culturally and Linguistically Appropriate Standards (CLAS) ([Culturally and Linguistically Appropriate Services \(CLAS\) Initiative | Mass.gov](#)) and ensure that the content and process of all services are informed by knowledge, respect for, and sensitivity to culture and are provided in the individual's preferred language and mode of communication. Cultural and linguistic humility includes:
 - a. Ability to provide services in a culturally and linguistically competent manner, including access to informal and formal supports reflecting the family's cultural and linguistic preferences, bilingual and American Sign Language professionals, materials, and interpreters;
 - b. Ability to hire, develop, and retain culturally and linguistically competent staff, including staff reflective of the racial, ethnic, linguistic, gender, and sexual orientation diversity of the population in their geographic area;
 - c. Organizational commitment to continuous learning in the area of cultural competence, reflected in training curricula, supervision, and performance evaluation at all levels of the organization; and
 - d. Commitment to continuous evaluation of the service environment, written materials, communications, facilities, and approach of staff from a cross-cultural perspective to promote an open, welcoming, and accepting environment.
- 4. **Commitment to client choice and client-centered care:** CBHCs will deliver services in an individualized, respectful, flexible, and coordinated manner.
- 5. **Broad knowledge of the community behavioral health system and commitment to community-based care:** Knowledge of behavioral health and social services provided in the community, how they are funded, and how clients access them; experience in developing professional relationships with colleagues in these organizations.

B. CBHC Program Overview

- 1. Each CBHC must offer the full suite of outpatient and crisis services for adults and youth, including AMCI, YMCI, and Adult CCS, and provide access to YCCS. The AMCI and YMCI must be co-located at the CBHC. It is preferred, but not required, that the Adult CCS be co-located at the CBHC.
- 2. Due to the specialized nature of the YCCS program, not every CBHC will be required to operate a YCCS; however, those CBHCs not operating their own YCCS will be required to ensure access to and develop formalized agreements with regionally located CBHCs who are providing YCCS services.

3. It is preferred that the suite of services is offered by a single agency. If there is more than one agency providing services as part of the CBHC, a single agency must serve as the lead agency, ensuring all contractual obligations, performance standards, and quality metrics are met. The lead agency will be the sole contractor for all services provided by the CBHC. The lead agency may subcontract with other provider entities to offer the required suite of services. All reimbursement for CBHC services will be through the lead agency.
4. The Commonwealth seeks to ensure CBHC coverage across all cities and towns. There are 20 suggested CBHC catchment areas, defined in Appendix 1. Entities may submit bids on an entire suggested CBHC catchment area; or entities may bid to operate CBHC services within all or part of a suggested CBHC catchment area; and entities may submit a response to this RFP to serve more than one CBHC catchment area. Providers wishing to bid on part of a catchment area are required to list the cities and towns that they propose covering. Any proposal that does not cover the entirety of a currently defined catchment area must describe its rationale for covering only part of the catchment area and demonstrate why this will provide value to the residents of those communities.
5. The only components of this suite of services that may be offered at a separate location from the CBHC are the Adult CCS and YCCS services. Due to the unique staffing and licensure requirements to serve latency and adolescent age youth in a YCCS program, the YCCS services may be a part of the bidder's proposal, or, if not part of the bidder's proposal, the bidder must commit to formalized relationships with regionally located CBHCs who will be providing those services. When possible, the bidder must identify its regional YCCS provider if not proposing to provide YCCS themselves. Each YMCI team must have access to YCCS services. Responses to this RFP must demonstrate how the bidder will meet the RFP requirements and whether services will be provided by a single entity or through sub-contractual relationships with other provider entities.
6. In each CBHC, the adult component must offer AMCI services, and the youth component must offer YMCI services on-site, described in Section III. It is preferred that the CBHC offer these services directly; however, it is possible for the CBHC to subcontract with another organization to provide AMCI or YMCI services in the CBHC's catchment area. The requirement for co-location remains the same whether the AMCI or YMCI services are offered by the CBHC directly or through a subcontractor.
7. A CBHC must operate the services described herein under appropriate licensures: Massachusetts Department of Public Health (DPH) clinic with a mental health service designation, or a DPH-Licensed Hospital Satellite that provides outpatient mental health and substance use disorder services and be a Medicare-participating provider. The provider must have a substance use disorder service designation on their DPH clinic license and a Bureau of Substance Addiction Services (BSAS) Certificate of Approval or be a DPH-Licensed Hospital that provides substance use disorder services. The provider must have a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver. At the time of bidding, the bidder may be in the process of obtaining needed licensure and/or certification.
8. Adult CCS and YCCS must be licensed by the Department of Mental Health.

Please note, the bidder is responsible for staying apprised of the current DPH clinic and BSAS licensure amendment process.

C. CBHC Staffing Requirements

1. The CBHC must be adequately staffed to ensure delivery of the required comprehensive services while meeting appropriate licensure requirements.
2. The CBHC must be adequately staffed to respond to all referral sources in the catchment area, including from the 24/7 Behavioral Health Help Line, AMCI, and YMCI.
3. Minimum staffing requirements, staff composition, supervision, training, and documentation requirements can be found in the CBHC Performance Specifications. Refer to Appendix 2 for more information.

III. Crisis Services Components

A. Core Features of the Crisis Response Network

EOHHS' Roadmap promotes the creation of a stronger 24/7, community-based response system that reduces reliance on the emergency department (ED) for behavioral health crises by:

- creating more widely available behavioral health urgent appointments with evening and weekend hours, including through CBHCs and designated Behavioral Health Urgent Care providers;
- integrating crisis services within CBHCs that will deliver 24/7 community site-based and mobile crisis intervention and follow up as diversion from the ED;
- establishing YCCS to provide short-term, intensive 24-hour treatment, expanding a service currently only available for individuals aged 18 and older; and
- making expert consultation available to support crisis teams responding to individuals with Autism Spectrum Disorder (ASD) and Intellectual/Developmental Disabilities (IDD) (*note, this is not an expectation of the CBHC*).

YMCI will be the distinct youth emergency services component, separate from the AMCI, and will be managed through the youth component of the CBHC. The YMCI team, in conjunction with the YCCS, will offer short-term crisis stabilization beds for youth, up to and including age 18. Refer to Appendix 2c for EOHHS approved performance specifications and medical necessity criteria for YCCS.

AMCI, YMCI, Adult CCS, and YCCS services are guided by the Guiding Principles and Required Competencies referenced in Section II of this document.

1. The AMCI:

- a. Must be co-located within the CBHC, with adequate accommodations and procedures to appropriately provide clinical services, waiting, and treatment spaces separately for youth and adults.
- b. Must provide on-site and mobile crisis services to all locations in the designated catchment area, including private residences, 24/7/365. AMCIs should consider "teams" of two people as best practice for mobile responses to private residences.
- c. May provide behavioral health crisis evaluation services in hospital EDs; EOHHS anticipates that in early 2023 hospitals will take responsibility for the provision of behavioral health crisis evaluation services in their EDs with hand-offs to community-based AMCIs for follow-up as clinically indicated.
- d. Must provide follow-up for up to three days, for those individuals for whom 24-hour level of care is not necessary and for individuals receiving MOUD induction or

bridging services, including assessment of overdose risk and access to Narcan. Follow up may be provided by any team member, based on clinical need (e.g., master's-level clinician, bachelor's-level clinician, recovery coach, or certified peer specialists).

- e. Must facilitate access to services through the CBHC or, for individuals who are not engaged with an existing community-based provider, through appropriate providers of the individual's choice.
- f. Must provide urgent psychopharmacology services via AMCI psychiatry and/or the CBHC urgent psychopharmacology service.
- g. Must provide timely, safe, and appropriate transportation to Adult CCS if the program is not co-located or the AMCI services are provided on a mobile basis.
- h. Must find appropriate alternative placement if the Adult CCS does not have availability to accept referrals.
- i. Must deliver the services defined in the AMCI performance specifications. See Appendix 2b for additional details.

2. The YMCI:

- a. Must be co-located within the CBHC, with adequate accommodations and procedures to appropriately provide clinical services and waiting and treatment spaces separately for youth and adults. It is preferred that the CBHC offer these services directly; however, it is possible for the CBHC to subcontract with another organization to provide YMCI services in the CBHC's catchment area.
- b. May provide behavioral health crisis evaluation services in hospital EDs; EOHHS anticipates that in early 2023, hospitals will take responsibility for the provision of behavioral health crisis evaluation services in their EDs with hand-offs to community-based YMCIs for follow-up as clinically indicated.
- c. Must have a separate team of clinicians trained to work with children and youth, supervised by a professional trained to work with children and youth, including children under age 6. When necessary, YMCI and AMCI may share nursing, clerical, and other staff when appropriate and not disruptive to providing YMCI services as outlined.
- d. Must be able to offer urgent psychopharmacology services via YMCI and/or the CBHC urgent psychopharmacology service.
- e. Must deliver the services defined in the YMCI performance specifications. See Appendix 2c for additional details.

3. The Adult CCS:

- a. Must operate in conjunction with the AMCI service. It is preferred that the Adult CCS program be co-located at the CBHC site. If the bidder's proposal does not include co-location of the Adult CCS program, the bidder must provide detail on distance from the site and transportation planning to ensure seamless admission from the AMCI to the Adult CCS.
- b. Must accept referrals from AMCIs within 60 minutes, contingent on availability.
- c. AMCIs must provide timely, safe, and appropriate transportation to Adult CCS if the Adult CCS is not co-located with the CBHC, or the AMCI services are provided on a mobile basis.
- d. Must accept referrals from outside the CBHC catchment area if the program has availability.

- e. Must have staff 24/7/365, to conduct medical screening and to support referrals from AMCI of clients with co-occurring SUD and medical conditions who may require monitoring of withdrawal symptoms and initiation of MOUD.
 - f. Must be licensed by DMH.
 - g. Must deliver the services defined in the Adult CCS performance specifications. See Appendix 2d for additional details.
4. The YCCS:
- a. Must operate in conjunction with the YMCI service. CBHCs must either operate the YCCS component of the CBHC or must contract with another CBHC that provides YCCS within the region in which the CBHC operates.
 - b. Must be able to assess youth for and bridge to MOUD treatment if clinically appropriate.
 - c. Must accept statewide referrals but may give preference to referrals from regional providers to enable family work during admissions.
 - d. Must be licensed by DMH.
 - e. It is preferred that there will be a YCCS program located within each region. Program capacity should be based on anticipated needs. A CBHC may propose operating YCCS programs for children up to and including age 12, and for children ages 13 - 18. Program capacity is expected to be between nine and 15 youth.
 - f. If the bidder's proposal includes operating a YCCS which will not be co-located with the CBHC, the bidder must provide detail on distance from the CBHC and a plan for providing transportation to ensure seamless admission from the YMCI to YCCS.
 - g. If the bidder's proposal does not include operating a YCCS, the bidder must ensure that it will enter an MOU with the CBHC offering a YCCS the closest to their location. The bidder must provide details for how it will provide transportation and a seamless admission from the YMCI to the YCCS.
 - h. The YCCS must deliver the services defined in the YCCS performance specifications. See Appendix 2e for additional details.

B. Crisis Staffing Requirements

1. The AMCI and YMCI must be adequately staffed to respond to all referral sources in the catchment area, including from the 24/7 Behavioral Health Help Line and the CBHC.
2. The Adult CCS and YCCS must be adequately staffed to accept referrals from the AMCI and YMCI, or from the ED in the CBHC catchment area.
3. Minimum staffing requirements, staff composition, supervision, training, and documentation requirements can be found in the Performance Specifications for the respective program (AMCI, YMCI, Adult CCS, and YCCS). Refer to Appendix 2 for more information.

IV. Outreach and Engagement

A. Outreach Plans and Community Engagement

1. The CBHC must develop a detailed outreach plan that informs the entities in their catchment area of the availability of the CBHC's services for any member of the community who may need urgent or ongoing behavioral health treatment. The outreach plan should include documented protocols for communication processes and plans for routine meetings. Entities should include but not be limited to:
 - a. Hospital emergency departments and inpatient psychiatric units/facilities

- b. Organizations focused on recovery, such as Recovery Learning Centers and Recovery Support Centers
 - c. Organizations serving justice-involved clients, such as:
 - i. Providers of behavioral health supports for justice-involved individuals
 - ii. Probation and parole
 - iii. Courts
 - iv. Houses of correction
 - v. Local municipalities and police departments (including organizations that employ jail diversion clinicians)
 - vi. Department of Correction
 - vii. District attorney's offices
 - d. Case management supports, including providers of Community Support Programs (CSP), case management provided by state agencies, and other related case management supports
 - e. Community Partners (behavioral health and long-term services and supports)
 - f. Clinical providers such as primary care providers and Community Health Centers
 - g. Autism resource centers
 - h. Homeless service providers
 - i. Agencies serving youth, families, and older adults, such as:
 - i. Youth congregate care providers
 - ii. Schools
 - iii. Early education and childcare programs
 - iv. Family resource centers
 - v. DMH Family Support services
 - vi. Aging Services Access Points
 - vii. Councils on Aging
 - viii. Nursing facilities
 - j. Other community-based service organizations, such as providers of affordable and subsidized housing, child and adult protective services agencies.
2. The CBHC must engage in planning with state agencies and local law enforcement and/or EMS, inclusive of jail diversion co-responders, to accept police and ambulance drop-off where possible and appropriate.
 3. The AMCI and YMCI components must implement a written community relations plan and outreach at least quarterly to required partners and non-traditional referral sources, such as entities within the criminal justice system, including police departments, co-responders, emergency medical services providers, programs serving older adults, and local elected officials' offices.

V. Quality Measures and Reporting

A. Oversight and Reporting

The CBHC is responsible for conducting all clinical, medical, quality, administrative, and financial oversight functions across all the services provided by the CBHC and all locations where these services are provided. This is inclusive of all adult and youth services delivered and/or subcontracted, including the adult and youth components of the CBHC, AMCI, YMCI, Adult CCS, and YCCS services.

The CBHC will be required to provide reporting to MassHealth, or its designee, on the following:

- Staffing patterns
- Supervision
- Workforce retention
- Outcomes and quality reporting
- Enterprise Invoice/Service Management (EIM/ESM) data
- Written policies and procedures
- Adverse incidents
- Patient-reported outcomes measures, including patient satisfaction data
- Aggregate patient information, as requested
- Program operations and status reporting, as requested

Additional information on Quality Measures and Reporting Requirements may be found in the CBHC Performance Specifications. Please refer to Appendix 2 for more details.

B. Quality Measures

CBHC performance data will be collected on the following measures. During the first year, data will be collected and evaluated by EOHHS to establish baselines and set benchmarks. Once baselines and benchmarks are established, data will be collected and the payment model will include a pay for performance component based on CBHCs' performance on these metrics.

Measure/Reporting Requirement	Measure Steward
Follow-up after hospitalization for mental illness (FUH) adult and child/adolescent	NQF 0576
Initiation and engagement in treatment (IET) for those screening positive for alcohol and other drug use	NQF 4
Suicide risk assessment for adult and child/adolescent with major depressive disorder	NQF 1365, 104
Diabetes screening for adults with Schizophrenia or Bipolar Disorder who are using antipsychotic medications (SSD)	NQF 1932
Metabolic monitoring for children and adolescents on antipsychotics (APM)	NQF 2800
ED visits for individuals with mental illness, addiction, or co-occurring conditions	EOHHS

Additional reporting will be required on the following timeliness metrics and member experience data through member surveys. EOHHS will evaluate the data and determine if there will be a pay for performance component around reimbursement for these measures.

Timeliness Metrics

- Initial evaluations within 24 hours of first contact
 - Initial evaluations within 24 hours, during extended hours
- Crisis visits, including AMCI and YMCI, within 1 hour
- Urgent visits within 1 calendar day
 - Urgent visits within 1 calendar day, during extended hours
- Routine visits within 14 calendar days

VI. Payment Methodology

A. CBHC

1. The core, non-crisis CBHC services will be paid as a bundled flat rate per encounter. An encounter is only billable when a covered CBHC service is provided and may only be billed once per client per day. The rates have been developed accounting for expectations related to expanded hours, urgent care, appropriate evidenced-based treatment, peer/family supports, and care coordination. See Appendix 3 for procedure codes included under the bundled rate.
2. The rate for clients under the age of 21 is \$241.86.
3. The rate for clients 21 years and older is \$233.90.
4. CBHCs must bill with existing codes for services provided under the bundle, which will be zero paid. Additionally, they must bill a modifying code (to be determined) to bill for the encounter bundle for the day a client is seen, either for a clinic visit, home- or community-based visit, or telehealth visit.
5. Services provided outside the bundle must be billed separately. For other services contracted for that are provided outside the bundle, there is no change in billing processes.

B. AMCI

1. AMCI services will be paid at an initial evaluation first day rate and a 15-minute follow-up rate for the second and third days following initial evaluation (a three-day episode of care). The initial evaluation first day rate and follow-up rates are only billable when a covered AMCI service is provided and may only be billed once per client episode of care (i.e., three days). There will be separate rates for AMCI services provided within a CBHC and those provided in a mobile setting.
2. For a site-based AMCI evaluation:
 - a. The rate for the initial assessment (first day) is \$632.08.
 - b. The rate for follow-up AMCI services is:
 - i. \$39.70 for services rendered by a master's-level clinician; and
 - ii. \$30.57 for services rendered by a paraprofessional or bachelor's-level staff.
3. For a mobile-based AMCI evaluation:
 - a. The rate for the initial assessment (first day) is \$931.49.
 - b. The rate for follow-up AMCI services is:
 - i. \$44.33 for services rendered by a master's-level clinician; and
 - ii. \$33.94 for services rendered by a paraprofessional or bachelor's-level staff.
4. For an ED-based AMCI evaluation, AMCIs will be paid according to MBHP's and other MCEs' contracted rates. Note: EOHHS anticipates that in early 2023, hospitals will take responsibility for the provision of behavioral health crisis evaluation services in their EDs with hand-offs to AMCI for follow-up as clinically indicated.

C. YMCI

1. YMCI services will be paid at an initial evaluation first day rate and a 15-minute follow-up rate for the second through seventh days following initial evaluation (a seven-day episode of care). The initial evaluation first day rate and follow-up rates are only billable when a covered YMCI service is provided and may only be billed once per client episode of care (i.e., seven days). There will be separate rates for YMCI services provided within a CBHC and those provided in a mobile setting.
2. For a site-based YMCI evaluation:
 - a. The rate for the initial assessment (first day) is \$632.08.
 - b. The rate for follow-up YMCI services is:
 - i. \$44.33 for services rendered by a master's-level clinician; and
 - ii. \$33.94 for services rendered by a paraprofessional or bachelor's-level staff.
3. For a mobile-based YMCI evaluation:
 - a. The rate for the initial assessment (first day) is \$978.06.
 - b. The rate for follow-up YMCI services is:
 - i. \$44.33 for services rendered by a master's-level clinician; and
 - ii. \$33.94 for services rendered by a paraprofessional or bachelor's-level staff.
4. For an ED-based YMCI evaluation, YMCIs will be paid at rate equivalent to those set forth in 101 CMR 352.00: Rates of Payment for Certain Children's Behavioral Health Services. Note: EOHHS anticipates that in early 2023, hospitals will take responsibility for the provision of behavioral health crisis evaluation services in their EDs with hand-offs to YMCI for follow-up as clinically indicated.

D. Adult CCS

1. Adult CCS will be paid according to MBHP's and other MCEs' contracted rates.

E. YCCS

1. YCCS will be paid at a daily rate of \$744.58.

VII. Subcontractors

It is preferred that all components of the CBHC, including AMCI, YMCI, Adult CCS, and YCCS, are operated by a single entity. If a CBHC establishes a subcontract with other organization(s) to operate any of the required services within the CBHC system, the lead agency is fully responsible for meeting all the terms and requirements of the CBHC specifications. The lead agency is responsible for oversight of the subcontracted party(ies) and must have a plan for oversight which should include, but not be limited to:

1. Clinical supervision of staff;
2. Monitoring complaints and grievances;
3. Notifying EOHHS or other payers of any contract violations;
4. Developing corrective action plans as needed;
5. Monitoring performance measures, access to care, and quality of care activities, including but not limited to conducting record audits;
6. Compliance with performance specifications and program integrity;
7. Payment issues; and
8. Submitting required and ad hoc reports.

If two agencies establish a contractual agreement for the delivery of services of the adult component and youth components of CBHC services, the agreement shall include terms related to coordination of care and sharing of information related to treatment of families, transitions from youth to adult care, and any other areas of clinical overlap.

In instances when the organization serving as the lead agency in the CBHC subcontracts with another organization for any service component, the lead agency is responsible for reimbursing the subcontracted organization for services provided by the subcontractor.

VIII. Payers

In addition to contracting with MBHP, it is the expectation that MassHealth and all MassHealth-contracted Managed Care Entities, Accountable Care Partnership Plans, MCOs, Senior Care Options, and One Care plans will contract with the CBHCs. CBHCs may contract with other payers.

IX. Performance Requirements

A. CBHC Performance Specifications

All providers responding to this RFP to provide CBHC services agree to abide by the EOHHS approved performance specifications for CBHC services, which may be subject to EOHHS modification in the future. See the performance specifications located in Appendix 2a.

B. AMCI Performance Specifications

All providers responding to this RFP to provide AMCI services agree to abide by the EOHHS approved performance specifications for AMCI services, which may be subject to EOHHS modification in the future. See the performance specifications located in Appendix 2b.

C. YMCI Performance Specifications

All providers responding to this RFP to provide YMCI services agree to abide by the EOHHS approved performance specifications for YMCI services, which may be subject to EOHHS modification in the future. See the performance specifications located in Appendix 2c.

D. Adult CCS Performance Specifications

All providers responding to this RFP for Adult CCS services agree to abide by the EOHHS approved performance specifications for Adult CCS services, which may be subject to EOHHS modification in the future. See the performance specifications located in Appendix 2d.

E. YCCS Performance Specifications

All providers responding to this RFP for YCCS services agree to abide by the EOHHS approved performance specifications for YCCS services, which may be subject to EOHHS modification in the future. See the performance specifications located in Appendix 2e.

X. Technology, Privacy and Security

A. Technology

The CBHC shall have the capability to share digital health information safely and securely between providers and partners involved in an individual's or family's treatment. The CBHC is expected to maintain administrative information technology (IT) systems and health IT systems that will enable them to meet all requirements outlined in this RFP. These systems must ensure, through electronic means (including but not limited to: mobile app, application programming interface (API), web services, or portal), the communication and information exchange with all partners or subcontractors of the CBHC. The CBHC's information systems shall be able to support current EOHHS requirements and future program changes, which may include requiring capability to connect to an electronic notification service or to Mass Hlway services.

B. Privacy and Security

Providers must have Health Insurance Portability and Accessibility Act (HIPAA)-compliant equipment, policies, and procedures in place to ensure timely communication in both crisis and routine situations. This is essential to service delivery effectiveness as well as safety.

The CBHC must ensure a secure, HIPAA-, and 42 CFR Part 2-compliant exchange of information on clients, between the CBHC and EOHHS, and between all organizations and providers caring for CBHC clients. CBHCs are encouraged to embrace creative use of technology, such as HIPAA-compliant texting, mobile phone applications, and other innovative technologies to support discharge planning and treatment planning.

XI. Procurement Process

A. Timelines

RFP Component	Date
RFP release	Tuesday, February 1, 2022
Question submission begins	Tuesday, February 1, 2022
Question submission deadline	Tuesday, February 15, 2022
Bidders' conference	Friday, February 18, 2022
FAQ release date	Friday, February 25, 2022
Letter of Intent deadline	Friday, March 4, 2022
RFP response deadline	Wednesday, April 13, 2022
DSRIP proposals due	Wednesday, April 13, 2022
Award date	Wednesday, May 25, 2022
Anticipated Implementation	January 1, 2023

B. Bidders' Conference

A bidders' conference will be conducted to allow potential bidders the opportunity to ask clarifying questions about the RFP.

The bidders' conference is not mandatory; however, potential bidders are encouraged to have one or two representatives at the conference. We recommend having a copy of the RFP available during the conference to reference during the discussion.

Date: Friday, February 18, 2022

Time: 11 – 12:30 p.m.

Location: Register at

https://beaconhealthoptions.zoom.us/webinar/register/WN_RwPKEi8XS7680mR6uyJ6cQ.

C. Written Questions

Clarifying questions concerning this RFP will be accepted in writing. They must be sent by February 15, 2022, to CBHC@beaconhealthoptions.com. Questions will not be answered on an individual basis.

D. Frequently Asked Questions (FAQ)

Responses to frequently asked written questions and frequently asked questions from the bidders' conference will be posted by close of business on February 25, 2022, at <https://www.masspartnership.com/provider/cbhcrfp.aspx>. It is the responsibility of the bidder to check the website for updates.

E. Letters of Intent

Any bidder planning to submit an RFP response must submit a non-binding letter of intent by 5 p.m. on March 4, 2022, to CBHC@beaconhealthoptions.com. Bidders must utilize the Letter of Intent (LOI) form located in Appendix 4 for this purpose.

- Letter of Intent forms must be submitted by email. Faxed forms will not be accepted.
- If there are cities and/or towns for which no LOIs have been submitted, MBHP will inform all bidders of these gaps. MBHP will extend the deadline, as needed, for submission of LOI and RFP responses for those areas only.

F. Response Submission Deadline and Requirements

In order for responses to be considered, each bidder must meet all the following submission requirements for each geographic area on which the provider is bidding:

1. Submit an electronic copy of the response via email, including all required attachments; and
2. Deliver one original bound hard copy and one unbound hard copy of the completed response and all required attachments in a package or box labeled with the bidder's name, address, and catchment area(s).

Complete both of the above submissions **no later than** 5 p.m. on April 13, 2022, to the following:

1. **Electronic copies via email to:** CBHC@beaconhealthoptions.com

2. **Hard copies to:**

Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Attn: CBHC procurement

Staples or paper clips should **not** be used in any part of the response, including the attachments. It is acceptable to use binder clips to bind the one required unbound copy of the response.

- Any response not meeting the response deadline in full, including both the electronic and hard copies, will not be accepted or considered.
- Faxed transmissions are not acceptable.
- Submissions by postal mail must be received by the stated deadline.

G. Evaluation of Responses

A selection committee will review the responses received by the submission deadline and make the final selections, with the approval of EOHHS. Each proposal will receive a score based on the narrative response. The selection of a CBHC provider is based on the proposal with the highest score using a consistent point system. In addition to the total score, consideration will be given to other factors, including the committee's review of financial documents, corrective action plans and/or sanctions, tenure of the bidder's presence, and services in its region. If no acceptable proposals are received for a particular geographic area, the selection committee reserves the right to put the region back out for submission of proposals by posting a notice on the MBHP website.

The following table summarizes the scoring scale against which each proposal will be evaluated:

Questions Section	Maximum Points
XIII.A. Intro	20
XIII.B. and C. AMCI/YMCI/CCS YCCS	160 40
XIII.D. CBHC	225
XIII.E. Quality	40
XIII.F. Payment	25
XIII.G. Subcontracts	N/A
XIII.H. Technology	30
XIII.I. Fiscal	N/A
Maximum Total Points	540

XII. Response Submission Requirements

All questions contained within this section must be answered and all required attachments provided.

A. Format of Response

1. All responses must be in the following format:
 - a. Type-written, Times New Roman, 12-point font, single-spaced, one-inch margins
 - b. 8 1/2 x 11-inch white paper, single-sided

- c. Question number (and title if applicable), followed by response. For example:
 - 2.1.1 CBHC services
 - 2.1.1.1 (response)
 - 2.1.1.2 (response)
- 2. Page limits are identified for each of the response sections below. The narrative response section must be page numbered, with page numbers located in the lower right-hand corner of the response. Proposals with a narrative response section that does not meet the response specification requirements outlined above will NOT be accepted or considered. Attachments are not included in the page limits. However, bidders should be judicious in their use of attachments and include only those required; bidders may add optional attachments only if they will help reviewers evaluate their proposals in a more complete fashion.
- 3. Bidders may not submit any non-written material (e.g., thumb drives). Attachments **MUST** be on letter-size paper. Glossy brochures or other attachments not on letter-size paper should not be included as part of the submission. If these are included, they will be removed from the response, and they will not be considered as part of the response. The **ONLY** exception will be audited financial statements, which may be on legal-size paper, though it is preferred for those documents to be on letter-sized paper.
- 4. The response must be divided in sections, in the following order:
 - a. **Cover sheet**
 - i. Complete the cover sheet found in Appendix 5.
 - b. **Narrative response**
 - i. Begin with a divider page labeled "Narrative Response."
 - ii. Answer all questions in Section XIII.A-H, as outlined in Section B below.
 - iii. Maximum page limit: 75
 - c. **Fiscal response**
 - i. Begin with a divider page labeled "Fiscal Response."
 - ii. Answer all questions in Section XIII.I.
 - d. **Attachments** (*Please place a divider page at the beginning of the Attachments and between each of the following sections of Attachments.*)
 - i. Narrative Response Attachments
 - ii. Fiscal Response Attachments

B. Narrative Response Requirements

- 1. Your response should cover all components of the service you are bidding for, whether provided by your organization or a subcontractor. Separate responses submitted by subcontractors will not be accepted.
- 2. General guidelines:
 - a. Specific responses detailing what you have done and plan to do will be the most helpful in evaluating your proposal.
 - b. Providing bullets, tables, or charts in lieu of narrative is welcome if such a format better enables you to provide specific information in a succinct fashion.
 - c. Please make clear throughout the response whether you are describing current versus proposed practice at your organization.

XIII. RFP Questions and Bidder Response

A. Introduction and Organizational Background

1. Cover Letter: Please must submit the cover letter form included as Appendix 5 with your organization's response.
2. Narrative introduction of your organization, including:
 - 2.1. A short summary of your organization's mission;
 - 2.2. A short summary about your organization's clinical, operational, and quality structure;
 - 2.3. Please describe the cultural and linguistic demographics of the CBHC area you are proposing to cover and your agency's ability to meet the needs of that community
 - 2.4. The number of MassHealth members that your organization currently serves;
 - 2.5. Your organization's MassHealth Provider ID Service Location (PID/SL) number(s); the address, and the tax ID number of all sites, including the parent entity and any other sites or programs operated by that parent entity. Please indicate which site(s) will participate in the CBHC;
 - 2.6. Please provide information about your licensure:
 - 2.6.1. Licensed by the Department of Public Health (DPH) with a mental health designation
☐ Yes ☐ No
 - 2.6.2. Licensed as DPH Hospital Satellite that provides outpatient mental health and substance use disorder services
☐ Yes ☐ No
 - 2.6.3. Licensed by the DPH Bureau of Substance Addiction Services (BSAS)
☐ Yes ☐ No
 - 2.6.4. Substance use disorder service designation on DPH clinic license and a BSAS Certificate of Approval
☐ Yes ☐ No
 - 2.6.5. DPH-Licensed Hospital that provides substance use disorder service
☐ Yes ☐ No
 - 2.6.6. Have a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver
☐ Yes ☐ No
3. Accreditation and certifications:
 - 3.1. Accredited by a national organization
☐ Yes ☐ No
 - 3.2. If yes, please list accreditation(s) and/or certifications, including if you are currently or have been a Certified Community Behavioral Health Center (CCBHC).
4. Is your organization a Behavioral Health Community Partner (BHCP)?
5. Please specify the catchment area(s) and/or part of the catchment area(s) for which you are bidding. See Appendix 1 for a list of CBHC catchment areas. If you are bidding on part of a catchment area, please specify which cities and towns you are bidding on.
6. Please describe the structure of your CBHC. Will all CBHC services (including the adult and youth components of the CBHC, AMCI, YMCI, Adult CCS, and YCCS services) be provided by your organization directly? If you are subcontracting with any other organizations to deliver CBHC services, please identify for which services and how you will be structuring these subcontracts.
7. Please confirm that AMCI and YMCI services will be co-located at the CBHC site.

8. Will Adult CCS and YCCS (if applicable) be co-located with AMCI and YMCI respectively? If not, please describe the rationale and plan for location.
9. Please describe how services for youth and for adults will be physically separated within the CBHC.

B. AMCI and YMCI

1. **AMCI and YMCI Services:** Please describe the experience your organization (or your subcontractor) has had with providing crisis services, including the specific service, population, payer, and duration of operation of such services. Please address both ESP and MCI services in your response, unless otherwise specified. Include the following: Experience in triaging, dispatching and managing resources to respond quickly to fluctuations in demand in a crisis environment, across multiple venues, and the specific strategies you shall utilize to do as an AMCI/YMCI.
 - 1.1. Experience your organization has with providing screening and assessment for suicidality, working with clients on a safety plan, and what methodology is used in treating for suicidality.
 - 1.2. Experience your organization has had with providing services on a mobile basis in individuals' homes and other natural settings in the community, including the specific service, population, and duration of your organization's operation of such services.
 - 1.3. Specific strategies you have used and/or plan to use to establish a culture among your staff and within your community that value the provision of mobile services in the community as the preferred service delivery model. Describe any challenges you anticipate in doing so and strategies you will use to mitigate these challenges.
 - 1.4. What measures will you employ to ensure staff utilize the community-based location and the mobile response to community locations, including private residences, as the first and likely response, 24/7/365?
 - 1.5. Please describe your AMCI's staffing plan, including information about how you will meet the requirements as described in Appendix 2 Performance Specifications. Include a sample schedule that indicates adequate staffing for both mobile response and the community-based location, 24/7/365. Please give examples of strategies that you have utilized to address workforce issues, particularly for hard-to-fill positions and/or shifts.
 - 1.6. Please describe your YMCI's staffing plan, including information about how you will meet the requirements as described in Appendix 2 Performance Specifications. Include a sample schedule that indicates adequate staffing for both mobile response and the community-based location, 24/7/365. Please give examples of strategies that you have utilized to address workforce issues, particularly for hard-to-fill positions.
 - 1.6.1. Please provide resumes from current staff in your organization at director-level positions and above who have five or more years of experience providing behavioral health crisis services to youth and families and who would be involved in your organization's provision of YMCI services.
 - 1.7. How will you promote and ensure the safety of staff who are providing 24/7 community-based evaluations, including to private residences and/or at the community-based location?
 - 1.8. Please describe any training programs or affiliations with any programs to allow students working toward certifications, degrees and/or licensure, to learn about the various opportunities for employment within your organization.

- 1.9. Please describe how you will ensure your organization will focus on providing crisis intervention, rather than primarily determining level of care.
- 1.10. Please describe your procedures for accepting and managing police drop-offs. Discuss youth and adult drop-offs separately.
- 1.11. How will you conduct outreach to referral sources that typically utilize law enforcement (911) or direct clients to EDs for crisis resolution to increase their understanding of, and use of, mobile crisis intervention through AMCI or YMCI?
- 1.12. Please describe your plan for educating the community, including clients, families, community resources, and referral sources, about the unique offerings of AMCI services and the unique offerings of YMCI services.
- 1.13. Please describe strategies that your organization will implement to minimize the number of clients requiring inpatient level of care, (resulting members awaiting placement) through the primary use of community-based crisis care. Please address adults and youths separately.
- 1.14. Describe your protocol for providing follow-up care coordination to all individuals seen in a crisis encounter, whether they are part of a CBHC or not.
- 1.15. Please describe training that your organization provides or will be developing to ensure competency in serving the populations described in Section II, Guiding Principles and Required Competencies. Provide specific details to delineate training for serving youths versus adults and for special populations.
- 1.16. Please describe your agency's work to implement the **National Culturally and Linguistically Appropriate Services (CLAS) Standards**.
- 1.17. Please describe your organization's experience utilizing telehealth for provision of clinical services, particularly AMCI and YMCI.
- 1.18. Please describe how you will ensure a client's medical stability at initial triage and throughout the client's stay at the community-based location.
- 1.19. Please describe your organization's experience assessing the need for MOUD, inducing MOUD, and providing bridging services when required.
- 1.20. How will your organization implement the provision of MOUD through AMCI services, 24/7/365?
- 1.21. How will your organization ensure that follow-ups occur for all clients receiving MOUD induction or bridging services, including assessment of overdose risk and access to Narcan?
- 1.22. Please describe how you will provide medical screening for clients who require inpatient level of care. Include a description of roles and responsibilities for making medical screening determination.
- 1.23. How will you ensure a one-hour response time, available 24/7/365 throughout the geographic area you are applying for, from the time of readiness for assessment? Do you anticipate any challenges meeting this requirement for any towns or cities in your catchment area, and if so, how will you mitigate those challenges?
- 1.24. If you are awarded a contract that was previously held by another AMCI or YMCI provider, please describe a plan to ensure a seamless transition and no disruption in services.
- 1.25. How will you ensure that the AMCI and YMCI collaborate when working with families in crisis?
- 1.26. MBHP requires completion of daily encounter forms for every individual served.

- 1.26.1. Describe how your organization will ensure completion of encounter forms according to MBHP policies and procedures, including staff training and complete and timely submission to MBHP.
- 1.26.2. Describe the system in place to quickly remedy any issue with timely and accurate encounter form submissions.

2. **Additional YMCI Questions**

- 2.1. Please provide evidence of your competence and experience working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services, including crisis intervention. This might include descriptions of contracts for the provision of these services at various levels of care, clinical tools used to complete a crisis assessment of children and families, and/or data reflecting the number of children and adolescents served in the past year.
- 2.2. Please describe how you will utilize family partners in the YMCI service, their role in delivering the service, and how they collaborate with the YMCI clinician.
- 2.3. Please provide a description of policies, procedures, and/or clinical protocols developed specifically for the provision of behavioral health crisis services to youth and families, including treatment strategies that differ from the strategies used for adults and how long these policies, procedures, and clinical protocols have been in effect. Please include information on how decisions are made on whether to see a client in their community or at a community-based location.
- 2.4. Please describe specifically how you will ensure compliance with the Runaway Assistance Program (RAP) protocol.

C. **Adult CCS/YCCS**

1. **Adult CCS:** Please provide a brief program description that summarizes your planned Adult CCS, addressing, at a minimum:
 - 1.1. Program philosophy and culture;
 - 1.2. Target population;
 - 1.3. Service delivery mode and flow of services;
 - 1.4. Programming (e.g., educational groups, activities, activities of daily living assistance);
 - 1.5. Location – will your Adult CCS be co-located within the CBHC? If not, please explain where it will be located and the distance from the CBHC site.
 - 1.5.2. If not co-located, how will transportation be provided to the Adult CCS site?
 - 1.6. Description of physical site including:
 - 1.6.1. number of single rooms
 - 1.6.2. number of bathrooms, including number of showers
 - 1.6.3. wheelchair accessibility
 - 1.6.4. treatment areas
 - 1.6.5. meeting space
 - 1.6.6. common areas
 - 1.7. Describe your Adult CCS staffing plan, including information about how you will meet the requirements as described in Appendix 2 Performance Specifications.
 - 1.7.1. Include a sample schedule that indicates adequate staffing for a minimum of six beds, 24/7/365.
 - 1.8. Describe your organization's experience assessing the need for MOUD, inducing MOUD and providing bridging services when required.

- 1.9. How will the Adult CCS assess for signs of substance withdrawal? What tools will be utilized?
- 1.10. How will your organization implement the provision of buprenorphine and oral naltrexone at the Adult CCS, 24/7/365? Describe your protocol for induction.
- 1.11. What is your plan for distribution of Narcan?
- 1.12. Provide evidence of formal, documented linkages to Opioid Treatment Programs; if not yet in place, describe and timeframe for implement these arrangements.
- 1.13. Please describe strategies to mitigate barriers to Adult CCS admission, including the following:
 - 1.13.1. Rapid referral process that is available 24/7/365
 - 1.13.2. Streamlined decision-making with goal of “getting to yes”
 - 1.13.3. Ability to offer services to clients experiencing minor withdrawal issues
 - 1.13.4. Ability to offer services to clients experiencing medical co-morbidity
 - 1.13.5. Exclusionary criteria
2. **YCCS** – If your organization is bidding to offer YCCS, please respond to questions 2.1-2.5. If your organization is not bidding to offer YCCS, please respond to 2.6 and 2.7.
 - 2.1. Please indicate which age group you would like to serve in YCCS (up to and including age 12, or ages 13 - 18).
 - 2.2. Please provide a brief program description that summarizes your planned YCCS addressing, at a minimum:
 - 2.2.1. Program philosophy and culture;
 - 2.2.2. Target population;
 - 2.2.3. Service delivery mode and flow of services;
 - 2.2.4. Programming (e.g., educational groups, activities, activities of daily living assistance);
 - 2.2.5. Location – will your YCCS be co-located within the CBHC? If not, please explain where it will be located and the distance from the CBHC site.
 - 2.2.5.1. Please describe how transportation will be provided.
 - 2.2.6. Please provide a description of physical site including:
 - 2.2.6.1. number of single rooms
 - 2.2.6.2. number of bathrooms, including number of showers
 - 2.2.6.3. wheelchair accessibility
 - 2.2.6.4. treatment areas
 - 2.2.6.5. meeting space
 - 2.2.6.6. common areas
 - 2.2.6.7. how the space will be sufficient for separate provision of clinical services such as individual and group counseling sessions, sensory spaces intended for self-soothing and self-calming, and accommodate the need for visitation, leisure, and group/individual recreational activities
 - 2.2.7. Describe your YCCS staffing plan, including information about how you will meet the requirements as described in Appendix 2e Performance Specifications.
 - 2.2.7.1. Include a sample schedule that indicates adequate staffing 24/7/365.
 - 2.3. Please describe strategies to mitigate barriers to admission, including the following:
 - 2.3.1. Rapid referral process - 24/7/365
 - 2.3.2. Streamlined decision-making with goal of “getting to yes”
 - 2.3.3. Ability to offer services to clients experiencing medical co-morbidity

- 2.3.4. Exclusionary criteria
- 2.4. Please describe your organization's experience in operating a 24/7/365 site for youth.
- 2.5. Please describe your organization's ability to coordinate appointments within 24 hours of admission for the following assessments:
 - 2.5.1. Assessment of fire-setting and/or sexual offending behaviors
 - 2.5.2. Neurological evaluation
 - 2.5.3. Neuro-psychological testing
 - 2.5.4. Medication-assisted treatment
 - 2.5.5. Nutritional counseling
 - 2.5.6. Psychological testing
 - 2.5.7. Substance use disorder assessment and treatment planning
- 2.6. If your organization is not providing YCCS services, please confirm your understanding that you will be required to enter into an MOU with the CBHC offering the closest YCCS. Where possible please indicate which CBHC you will be partnering with to provide YCCS services.
- 2.7. Please describe how your organization will provide or coordinate transportation to the YCCS covered under the MOU.

D. CBHC Services

CBHC Core Services: Describe your plan for offering the core CBHC services. Refer to the CBHC performance specifications in Appendix 2 for detailed descriptions of each service. Please provide specific answers related to core services for both adults and youth.

1. Behavioral health urgent care services for adult and youth clients
 - 1.1. How will these services be staffed?
 - 1.2. Where will these staff be located?
 - 1.3. What is the process for coordinating with AMCIs and YMCIs?
 - 1.4. How will psychiatric consultation, urgent psychopharmacology intervention, and medication management be offered?
2. Access to buprenorphine and naltrexone, including same-day induction, for clients age 16 and older
 - 2.1. How many prescribers at your organization have experience prescribing buprenorphine?
 - 2.2. How will scheduling be managed to allow same-day induction?
 - 2.3. How will you provide a warm handoff to an opioid treatment program or office-based addiction treatment program?
 - 2.4. If you will be offering MOUD through partnership, describe how services will be coordinated.
 - 2.5. Does your organization administer injections of naltrexone? If not, what partnerships do you have in place with providers who offer this service?
3. Does your organization have the capacity to prescribe Clozapine?
4. Medical screening and coordination with primary care for adult and for youth clients
 - 4.1. Describe how medical screenings will be conducted. Identify which will be done directly by the CBHC and which will be handled via a partnership with a medical practice.
 - 4.2. Please confirm that you have the ability to provide urine toxicology screens at each site.
 - 4.3. Confirm that you have lab agreements in place for all other services.

- 4.4. Describe your process for coordinating and sharing information with primary care practices and specialty medical providers.
5. Access to services for adult and youth clients: Describe your plan for addressing each of the below required access parameters. Where noted, additional answers with further detail should be provided for each bullet. Refer to Section II III and Appendix 2 for detailed descriptions of each service. Please provide specific answers related to access.
 - 5.1. Same-day access
 - 5.1.1. Describe your scheduling/staffing model to ensure same-day access.
 - 5.2. Urgent access
 - 5.2.1. Describe your scheduling/staffing model to ensure same-day access for pharmacotherapy, group therapy, MOUD induction, crisis counseling/psychotherapy, and peer support services.
 - 5.2.2. How will you ensure that all routine and urgent treatment options are utilized prior to engaging AMCI or YMCI?
 - 5.3. Describe your plan for your after-hours triage line that will respond to clients outside business hours.
 - 5.4. Transportation assistance
 - 5.4.1. How will you determine which clients require transportation assistance?
 - 5.5. Language and cultural competencies
 - 5.5.1. Describe how you ensure cultural humility in your organization's service delivery, responsive to individual client needs, and available in other languages, including American Sign Language (ASL).
 - 5.5.2. Describe how your organization works to reduce and eliminate racial and ethnic health disparities.
 - 5.5.3. How does your organization evaluate how well you are meeting the cultural and linguistic needs of your clients?
 - 5.6. Telehealth delivery modality
 - 5.6.1. Describe how telehealth will be incorporated into services delivered through your CBHC.
 - 5.7. Describe your process for monitoring to ensure that access standards are met.
6. Care coordination for adult and youth clients: Describe your care coordination process. Refer to Appendix 2 for detailed descriptions of care coordination expectations. In particular, please describe the following:
 - 6.1. Your treatment planning process;
 - 6.2. How you will support clients as they move through different levels of care;
 - 6.3. How you will provide connections to community-based social services and other providers/supports and create two-way referral pathways;
 - 6.4. How you will coordinate with state and local agencies;
 - 6.5. How you will coordinate with the client's health plan;
 - 6.6. How you will look at gaps in external care coordination and how they can be improved;
 - 6.7. How you will work with your local law enforcement partners to assertively reduce unnecessary arrests and transports to emergency departments and divert individuals to CBHCs or other appropriate community-based alternatives;
 - 6.8. How you will ensure readiness to accept safe and secure client drop-offs from law enforcement; and

- 6.9. For youth clients ages 16 - 21, please describe your process for developing transition plans. Please describe how you will support youth 16-20 as they prepare to transition from youth to adult services.
7. Access to services outside the CBHC: Describe how you will facilitate access to needed services that are not included in the CBHC encounter bundle. Describe how access will be facilitated and coordinated for each service:
 - 7.1. Methadone treatment when needed and preferred by a client;
 - 7.2. Laboratory services for necessary screening and testing;
 - 7.3. Specialty services for special populations including: older adults, including geriatric psychiatry; clients involved with the criminal justice system; clients with ASD/ID; veterans; and youth in the care and custody of the Commonwealth;
 - 7.4. Evidence-based practices for family therapy, such as structural family therapy and functional family therapy;
 - 7.5. Adolescent Community Reinforcement Approach (A-CRA); and
 - 7.6. First Episode Psychosis Coordinated Specialty Care.
8. Communication protocols
 - 8.1. Describe the formal communication agreements you have or will have with these providers listed in Section II.
 - 8.2. Provide examples of:
 - 8.2.1. Workflows and standard protocol for client release of information that are in compliance with HIPAA and 42 CFR Part 2; and
 - 8.2.2. Communication protocol/data exchange protocols.
 - 8.3. Describe your plan for outreach to entities in your region (including EDs, Recovery Learning Centers, CBHI providers, CPs, Family Resource Centers, schools, childcare, and other youth-serving organizations) to make them aware of your services.
9. Staffing
 - 9.1. CBHC management: Please provide job descriptions for the following positions, and resumes for identified candidates for the positions if available.
 - 9.1.1. Clinical director
 - 9.1.2. Medical director
 - 9.1.3. Attach an organizational chart that indicates where these and other key CBHC staff shall sit within the organization at an administrative and supervisory level.
 - 9.2. How will you ensure that there are no disincentives for providing the full array of services required under this model according to the access standards?
 - 9.3. Please provide an overview of the cultural and linguistic makeup of your agencies staff including support staff and senior leadership.
10. Training and supervision
 - 10.1. Provide an overview of training and supervision at your proposed CBHC. This should include:
 - 10.1.1. Describe how your training will incorporate person- and family-centered, recovery-oriented, evidence-based, and trauma-informed care; as well as coordination with primary care.
 - 10.1.2. How will you ensure that all CBHC staff, across all programs, are adequately trained in and understand the philosophy of crisis intervention and how to offer interventions prior to contacting the AMCI or YMCI?

- 10.1.3. How will you ensure that all CBHC staff understand all of the components of the CBHC?
- 10.1.4. Will your organization commit to only hiring peer staff who have completed their respective certification and/or training programs?
- 10.2. What training will all staff receive to ensure their understanding of the roles and responsibilities of professional peers in the treatment continuum?

E. Quality Measures and Reporting

1. How does your organization use outcome measures to measure clinical progress?
2. How does your organization measure client satisfaction?
3. Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of a CBHC contract and service delivery system.
4. Briefly describe how your organization employs quality management tools and strategies to measure, monitor, and continuously improve quality of clinical care and service delivery.

F. Payment

1. Describe how your organization will move from a fee-for-service system to encounter-based reimbursement for services bundled into the CBHC encounter payment.
2. What internal systems are in place or need to be developed for this change?
3. Outline your projected timeline for being prepared to implement encounter-based reimbursement for the CBHC bundle.
4. What do you anticipate challenges to be, and how will you address them?
5. For at least the first year of this arrangement, CBHCs will be required to submit claims for all services that are provided, including those that are included as part of the bundle, as well as the claim for the encounter itself. Claims for services that are included as part of the bundle will be zero paid. Please describe how your organization is prepared for this requirement.

G. Subcontracts

1. For any service component for which your organization plans to enter into subcontract arrangements with other provider organizations, detail:
 - 1.1. The name of the subcontracting organization;
 - 1.2. If not yet identified, delineate the criteria you shall utilize for selecting a subcontractor;
 - 1.3. The service component(s) for which you plan to subcontract with that organization; and
 - 1.4. Specify if the subcontract will encompass the given service component for the entire catchment area and population, or if it is only for a specific population, certain cities or towns within the catchment area, or other subset.
2. Please describe how your organization will, as the contracted CBHC, oversee, monitor, and hold the subcontracted provider(s) accountable for all aspects of service delivery, including clinical, quality, and administrative.
3. Please describe how your organization will, as the contracted CBHC, ensure seamless and real-time electronic information exchange with any subcontracted provider organizations.

H. Technology, Privacy, and Security Specifications and Response Requirements

1. **Communications:** Please describe your communications by answering the following questions:
 - 1.1. Describe the telephone system set-up to receive calls.
 - 1.2. Describe who will be receiving calls and what access levels they have.
 - 1.3. Describe the technology equipment you will provide to all CBHC staff (e.g., cell phones, laptops, tablets, and/or desktop computers).
 - 1.4. Describe security measures to ensure client data will not be compromised.
 - 1.5. Identify the unique communications challenges you would expect in operating a CBHC and the specific strategies you plan to implement to ensure timely and effective communication to facilitate quality, service coordination, and safety.
 - 1.6. Describe what digital tools are in place for client engagement and to share elements of care planning, such as safety plans.
 - 1.7. Describe your system for offering services via telehealth.
 - 1.8. Do you offer services via telehealth through a product that employs end-to-end encryption and complies with HIPAA standards? Please describe.
 - 1.9. Please describe your emergency back-up system in the event of a telephone outage.
2. **Provider Information Systems**
 - 2.1. Please confirm that your organization has the capacity to perform the following functions, using industry-standard, HIPAA-compliant file formats, and to implement these functions, as of the implementation date:
 - 2.1.1. Electronic submission of claims:
☐ Yes ☐ No
 - 2.1.2. Electronic submission of encounter forms (AMCI and YMCI services only):
☐ Yes ☐ No
 - 2.1.3. Electronic funds transfer:
☐ Yes ☐ No
 - 2.1.4. Electronic health records:
☐ Yes ☐ No
 - 2.2. Please describe your organization's capability to communicate and share information electronically across providers.
3. **Data and Information Management**
 - 3.1. For the following areas, please indicate whether your Management Information System (MIS) is capable of producing reports in each topic area. Then note whether your organization currently uses these reports for ongoing management and/or quality improvement purposes.

	MIS Capability	Currently in Use
Financial Reports	<input type="checkbox"/>	<input type="checkbox"/>
Utilization Reports	<input type="checkbox"/>	<input type="checkbox"/>
Clinician Profiling	<input type="checkbox"/>	<input type="checkbox"/>
Client Profiling	<input type="checkbox"/>	<input type="checkbox"/>
Quality Measurements	<input type="checkbox"/>	<input type="checkbox"/>
Statistical Analysis	<input type="checkbox"/>	<input type="checkbox"/>

- 3.2. Where will data be stored: locally, cloud, hybrid cloud, other?

- 3.3. Will data be housed outside of the United States?
- 3.4. Are employees trained on how to handle and report a security Incident?
- 3.5. Do you conduct annual security training?
- 3.6. Do you log and track security training?

I. Fiscal Specifications and Response Requirements

1. Calendar year program budget response requirements

- 1.1. Budget: submit a proposed program budget for two years, outlining program capacity, anticipated expenditures, and all funding sources. The two-year budget is intended to capture both the start-up period prior to full operation and a full year of operations post start-up. If two years does not capture a full 12 months at full operating levels, the budget should be extended as needed.
 - 1.1.1. Please include all anticipated expenditures and revenue.
 - 1.1.2. Revenue from operations must be supported by volume and rate assumptions.
 - 1.1.3. Any services expected to be subcontracted to others must be disclosed and explained in adequate detail.
 - 1.1.4. Funding sources should delineate as either DSRIP start-up funding (see Section XIV below), funding from operating revenues, or other revenues or other sources of funding (cash).
 - 1.1.5. DSRIP-funded expense should be detailed by nature of expense.
 - 1.1.6. Expenses should delineate direct expenses and indirect. Direct expenses should indicate new expense versus those direct expenses already being incurred by your organization which will transfer to CBHC program. Indirect expense should include description and amount by type of indirect service.
 - 1.1.7. Please detail the number of FTEs associated with each payroll line item.

2. Budget narrative response requirements

- 2.1. Submit a budget narrative that further defines and explains the program budget. The budget narrative provides an opportunity to highlight what is unique or different about your program. The narrative must include the following:
 - 2.1.1. Assumptions used in program budget;
 - 2.1.2. How revenues will be billed and collected from all expected payors (including, MBHP, other MCEs, Medicaid Fee-for-Service, Medicare, and other insurance);
 - 2.1.3. Number of hours considered full-time equivalent (for example, 35, 37.5, 40); and
 - 2.1.4. Other supporting assumptions.

3. Business component response requirements

- 3.1. MBHP and EOHHS are committed to ensuring that CBHCs are financially viable. Financial viability is defined as the ability to adequately support the specific operations of each service or program that is under consideration for contracting for the start-up period through the full duration of the contract. Please demonstrate fiscal viability by providing:
 - 3.1.1. The type of legal entity your organization is (e.g., not-for-profit corporation, limited partnership, general partnership, trust, etc.)
 - 3.1.2. Audited financial statements
 - 3.1.2.1. Required attachment: independently audited financial statements for the two most recent fiscal years

- 3.1.2.2. Narrative: Briefly address any qualified opinions contained in the audited financial statements.
- 3.1.3. Cash Flow
 - 3.1.3.1. If budget schedules do not fully represent anticipated cash flows, a separate cash flow schedule for the budget period (two years) should be included. Sources of cash flow other than operations and DSRIP funding should be disclosed.
- 3.1.4. Risk Analysis
 - 3.1.4.1. Recognizing that actual results do not always follow budgets as initially planned, provide a description of the greatest risks associated with the budget and how your organization will programmatically and financially respond to material unfavorable deviations from the budget.
- 3.1.5. Government Action
 - 3.1.5.1. Required attachment, if applicable: documentation of any government action notice of non-compliance, notice of deficiency, or sanction within the past five years, and status of response to such notice or sanction. Please include audit and any survey findings.
- 3.1.6. Other Situations
 - 3.1.6.1. Narrative, if applicable: If your organization has been placed on any other corrective action plan or has had any other sanctions or findings in the past five years, indicate the nature of the situation and status.

XIV. DSRIP CBHC Infrastructure Development Funds

A. Background

As behavioral health providers seek to improve access and provide more integrated, collaborative, and comprehensive care, additional supports may be needed to further align and integrate the community behavioral health system with the value-based healthcare system supported by Delivery System Reform Incentive Payment (DSRIP) investments. The CBHC Infrastructure Development Funds, which are funded by the MassHealth DSRIP Alternative Payment Methods (APM) funds, are intended to support providers who are selected to serve as CBHCs as they shift their clinical and business models to support encounter-based care. This shift will allow for the delivery of multiple behavioral health services on a single date of service or within a defined period of time that are billed as a single encounter; the building and strengthening of communication channels across levels of care; the delivery of goal-oriented, evidence-based treatment with attention to equity and cultural humility; and the provision of timely access to appropriate treatment for all MassHealth members.

Project(s) proposed through the DSRIP investment must address the requirement of the CBHC to ensure that clients with behavioral health needs receive care in the least-restrictive, most-appropriate settings through expanding access to and timeliness of outpatient and non-24-hour diversionary behavioral health treatment, integrating behavioral health and primary care, and integrating and coordinating mental health and substance use disorder treatment services. Project(s) proposed through this investment must also support EOHHS' priorities in advancing providers' capacity to successfully participate in APM arrangements and to work with ACOs

and CPs in improving health outcomes and reducing the total cost of care (TCOC) of MassHealth members.

Total expenditures on all projects funded as a result of the DSRIP investment will not exceed \$10.4 million. Funding amounts for any DSRIP bidder that is awarded DSRIP funds will depend on the scope of the DSRIP bidder's project(s), the number of contracts awarded, and other factors, and are not anticipated to exceed **\$750,000** per Contract.

B. Procurement Information

1. DSRIP Bidder Qualifications

- a. In addition to all other requirements, a DSRIP bidder must be awarded a contract to serve as a CBHC.
 - b. Number of contract awards and contract amounts
 - i. MBHP may enter into any number of contracts necessary to achieve the goals described in this RFP. Contracts entered into as a result of this RFP shall be for a fixed amount of funding, which are not anticipated to exceed \$750,000 per Contractor. Final contract amounts shall be determined and announced following the evaluation of responses. MBHP anticipates making payments in one installment following contract execution.
 - ii. MBHP makes no guarantee that a contract will result from this RFP or that any contract awarded pursuant to this RFP entitles the contractor to any other present or future funding or contract opportunities.
 - iii. If additional funds become available during the contract term, MBHP reserves the right in its sole discretion to increase the maximum obligation to some or all of the contracts executed as a result of this RFP, or to execute contracts with DSRIP bidders who did not become contractors in the initial selection process.
2. **Supporting Documentation:** MBHP will request evidence of appropriate expenditures and other supporting documentation related to DSRIP bidder's use of these funds.

C. Project Descriptions

Projects proposed as part of a DSRIP bidder's response to this RFP should be innovative and must enhance the DSRIP bidder's capabilities to provide more integrated, collaborative, equitable, and comprehensive behavioral health treatment, with attention to cultural humility, to improve access to such services such that they are provided in the most-appropriate, least-restrictive settings, and to participate in the value-based healthcare system supported by DSRIP investments through APM participation. DSRIP bidders may propose projects in no more than three of the following categories:

1. Proactive Model Innovations to Support Access (see Section 1 below)
2. Capacity Building for Medical Screening and Coordination with Primary Care (see Section 2 below)
3. Capacity Building and Infrastructure for Encounter-Based Care (see Section 3 below)
4. Training and Adoption of Evidence-Based Practices (see Section 4 below)
5. Partnerships and Infrastructure for Clinical Integration (see Section 5 below)

DSRIP bidders may propose to use funding for the allocation of staff time toward the projects. DSRIP bidders that propose to use funding for staff time shall describe their intended cost

allocation to staff time in their budget narrative. DSRIP bidders may also propose to use funding to support legal consultation associated with a project. Proposed projects that include purchase or license of software and equipment must also include staff training, development of workflows, and other implementation activities associated with such software and equipment.

Funding may not be used for the following purposes:

- To pay for initiatives, goods, or services that are duplicative with initiatives, goods, and services funded by other federal, state, and/or local funding;
- To pay for any MassHealth service, including the purchase of pharmaceuticals. Funds may not be used to support personnel FTE allocation in a duplicative manner with payments provided for covered services;
- To provide goods or services not allocable to approved plans/budgets;
- To pay for construction or renovations;
- To pay for malpractice insurance; or
- To pay for revenue maximization efforts.

1. Proactive Model Innovations to Support Access and Equity

Projects proposed in this category must support innovative infrastructure, implementation, and business development processes to improve access to behavioral healthcare and to ensure the services are culturally and linguistically appropriate, supportive, equity-focused, and person-centered. Projects proposed in this category must address at least one of the following:

- a. Implementation of tele-behavioral health in crisis and ambulatory behavioral health settings
 - i. For DSRIP bidders who do not already have such infrastructure in place, projects proposed in this area may include:
 - 1) Purchase and implementation of HIPAA-compliant software for the delivery of behavioral health services via telehealth; and
 - 2) Purchase of equipment necessary to provide behavioral health services via telehealth.
 - ii. DSRIP bidders who meet the requirements of XIVC1ai may also propose projects that include:
 - 1) Investment in software, infrastructure, and staff training to implement the delivery of behavioral health services via telehealth;
 - 2) Development of clinic protocols for offering and rendering behavioral health services via telehealth;
 - 3) Development of workflows to support the delivery of behavioral health services via telehealth in the clinic setting;
 - 4) Development of tele-behavioral health training for clinic staff; and
 - 5) Execution of tele-behavioral health training for clinic staff.
- b. Open access models
 - i. DSRIP bidders may propose to use funding to support transformation or enhancement of the DSRIP bidder's ability to provide open access or same-day appointment availability for outpatient or non-24-hour diversionary behavioral health services. Projects proposed in this area must include, at a minimum, support for transformation or enhancement of the bidder's ability to provide open access or same-day appointment availability for psychiatry and ability to support ambulatory withdrawal management. Projects may include

changes to clinic workflows, staff training, and business process improvement.

- c. Capacity for mobile deployment
 - i. DSRIP bidders may propose to use funding to support building capacity for mobile deployment of outpatient clinicians in community-based settings such as schools, childcare, homes, and residential settings. Projects may include changes to clinic workflows, staff training, software, infrastructure, equipment, and business process improvement.
- d. Programs to support police/co-responder outreach and collaboration to inform improvements to police drop off
- e. Training and technical assistance to ensure the capacity to treat all populations equitably and that all available services and responses are timely, supportive, and clinically and culturally appropriate
- f. Programs to advance health equity that draw upon evidenced-based practices or other best practices

2. **Capacity Building for Medical Screening and Coordination with Primary Care**

Projects proposed in this category must advance provider capacity to provide basic medical screening and coordination with primary care treatment that will support behavioral health treatment. Projects may include:

- a. building capacity to conduct medical monitoring of pharmacotherapy for behavioral health conditions;
- b. identifying and implementing screening tools for health indicators based on client presentation and referring clients to primary care and/or specialized providers for further assessment or treatment, as clinically appropriate;
- c. developing protocols related to medication reconciliation to support the management of behavioral health and physical health co-morbidities;
- d. implementation of appropriate electronic-based infrastructure to order lab work; and
- e. development of medical screening protocols.

3. **Capacity Building and Infrastructure for Encounter-Based Care**

Projects proposed in this category must support the development of internal business processes that advance the transition from fee-for-service billing to billing for encounter-based care. Projects must address at least one of the following:

- a. *Financial readiness*: DSRIP bidders may propose to use funding to purchase tools and train staff on their use, or to pay for staff or consulting to support financial analysis to understand cost by lines of business, or to develop analytic tools and business models for hybridizing services currently purchased separately and braiding revenue streams.
- b. *Operational readiness*: DSRIP bidders may propose to use funding to invest in infrastructure and staff time necessary to support reconfiguration of clinical teams and financial resources to move towards encounter-based care, or to invest in programmatic changes to support the delivery of and billing for encounter-based care.
- c. *Preparing the organization for the implementation of Alternative Payment Models*: DSRIP bidders may propose to use funding for additional staff or training of existing staff to lead the work efforts related to the transition to encounter-based care, or for training of clinical leadership and supervisory staff across all lines of business to work in a new integrated encounter-based model.

- d. *Infrastructure to manage data collection*: DSRIP bidders may propose to use funding for infrastructure for data collection, analyses, and outcome evaluations that can inform decisions related to the transition to encounter-based care, or for investments in modifications to practice management, electronic medical records, and billing software to align infrastructure to support billing for encounter-based care in the clinic setting.

4. **Training for and Adoption of Evidence-Based Practices**

Projects proposed in this category must advance the delivery of evidence-based practices (EBPs) in the clinic setting for all outpatient and non-24-hour diversionary behavioral health services delivered by the DSRIP bidder. Projects may include:

- a. Assessment of the use of EBPs, the delivery of trauma-specific care, and the delivery of care for special populations by the DSRIP bidder;
- b. Development of EBP curriculum or scheduling of trainings for the DSRIP bidder's staff;
- c. Training in delivery of trauma-specific care, and integrated care for substance use disorders, including but not limited to office-based opioid treatment (OBOT) models of care;
- d. Development and implementation of the Zero Suicide framework;
- e. Training in the delivery of care for special populations including justice-involved populations and youth involved with DCF;
- f. Development or purchase of training materials;
- g. Renting external space to conduct training;
- h. Hiring trainers;
- i. Development of trainings;
- j. Execution of training; and
- k. Paying for staff to attend external training.

5. **Partnerships and Infrastructure for Clinical Integration**

Projects proposed in this category must support partnerships for clinical integration and must address at least one of the following:

- a. *Strengthen partnerships*: DSRIP bidders may propose to use funding to support partnerships with other providers and organizations such as, but not limited to, primary care providers, other behavioral health providers including AMCI and Adult CCS providers, emergency medical services, emergency departments, law enforcement, schools, childcare, and ACOs and CPs, as appropriate. Projects may include:
 - i. Establishment of memorandums of understanding or other partnership agreements with external entities;
 - ii. Development of standard processes for obtaining consent for release of information from clients;
 - iii. Establishment of formalized referral relationships and protocols for clearance, admission, discharge, and diversion with external providers;
 - iv. Identification of team leads and main points of contacts for managing integrated care planning, care coordination (including direct handoffs during transitions of care), and referral management;
 - v. Development of data management protocols for data shared from external entities;
 - vi. Development of standards and workflows for data sharing; and

- vii. Development of intake protocols, infrastructure, and staffing to support rapid needs assessment, triage, and access to services within or across organizations.
- b. *Integration of substance use disorder treatment providers*: DSRIP bidders may propose to use funding to support integration of substance use disorder treatment providers into the DSRIP bidder's practice model. Projects may include:
 - i. Recruiting and training for clinical providers for the purpose of delivering integrated evidence-based treatment for substance use disorder;
 - ii. Developing standard processes for obtaining consent for release of information from clients;
 - iii. Establishment of formalized referral relationships and protocols for clearance, admission, discharge, and diversion with external providers;
 - iv. Identification of team leads and main points of contacts for managing integrated care planning, care coordination, including direct handoffs during transitions of care, and referral management;
 - v. Development of data management protocols for data shared from external entities;
 - vi. Development of standards and workflows for data sharing; and
 - vii. Development of intake protocols, infrastructure, and staffing to support rapid needs assessment, triage, and access to services within or across organizations.
- c. *Software for data integration and care collaboration*: DSRIP bidders may propose to use funding to purchase software, implementation, and infrastructure for data integration and care collaboration to enhance care coordination and strengthen partnerships necessary to support clinical integration. Eligible software must meet the following criteria:
 - i. Ability to integrate with the DSRIP bidder's EHR system and with at least one EHR system used by other medical providers (e.g., primary care, emergency department);
 - ii. Ability to send and receive secure electronic messaging;
 - iii. Ability to facilitate the exchange of electronic care plans; and
 - iv. Ability to provide alerts for admission, discharge, or transfer of clients.

D. Response Submission Requirements

1. Timeline

The timeline in Section XI applies to this submission process.

2. Response Contents

The DSRIP bidder's response must contain the following:

- a. A Programmatic Response Form for each project for which the bidder is bidding. DSRIP bidders must use the accompanying Programmatic Response Form attached as Appendix 6.
- b. A Funding Response Form for each project for which the DSRIP bidder is applying. DSRIP bidders must use the accompanying Funding Response Form attached as Appendix 7.

E. Programmatic Response

1. Programmatic Response Form

- a. Instructions for completion of the Programmatic Response Form
 - i. For each proposed Project, DSRIP bidders must complete a separate Programmatic Response Form (Appendix 6) in its entirety.
 - ii. The Response must describe the project for which the DSRIP bidder is applying and describe how funding will be used to advance specific goals of the proposed project identified by the DSRIP bidder. The DSRIP bidder should specifically describe how the proposed project will be implemented.
 - iii. Completed Programmatic Response Forms may not exceed 10 pages. Any supporting documentation requested in the Form will not be counted in calculating the DSRIP bidder's page limits.
 - iv. Pages of the Programmatic Response Form should be double-sided and single-spaced. Minimum font size is 11. Minimum margin size is ¾ inch.
 - v. Relevant subsections of the DSRIP bidder's Programmatic Response Form(s), as modified and approved by MBHP, shall be attached to any final contract executed between MBHP and the DSRIP bidder.
- b. Contents of the Programmatic Response Form(s):
 - i. DSRIP Bidder Information: The DSRIP bidder shall provide the DSRIP bidder's name and address as well as the information for two contacts in the chart at the top of the form.
 - ii. Project Type(s): The DSRIP bidder shall select the type of project(s) for which it is bidding. Project descriptions can be found in Section XIV.C.
 - iii. Abstract: The DSRIP bidder shall provide a brief abstract of the proposed project. The abstract shall include:
 - 1) Clearly defined project goals;
 - 2) The dollar amount of funding being requested; and
 - vi. A minimum of three concrete metrics (e.g., number of clients served via innovative access model; number of staff trained in evidence-based practices; volume of exchanges using care collaboration software; degree of integration of substance use disorder providers into DSRIP bidder's organization) and anticipated outcomes.
- c. Project Description
 - i. The DSRIP bidder shall provide a detailed description of each proposed project and how the bidder will accomplish each proposed project. The description for each project shall include:
 - 1) A description of the project's goals;
 - 2) A description of proposed deliverables the DSRIP bidder will generate during the project; and
 - 3) A work plan that identifies major work streams, including the deliverables associated with each work stream and a timeline for all activities the DSRIP bidder proposes to perform during the contract term, and outlines the proposed resource allocation for the work plan's execution and completion.
 - ii. A description of the DSRIP bidder's plan of sustainability in order to continue these efforts beyond the contract term. This description shall include:
 - 1) Information about other funding opportunities the DSRIP bidder may leverage to sustain the project after the contract term, including, but not limited to, funding opportunities through innovative contracts and partnerships with MCEs and CPs; and

- 2) A description of any tools, resources or processes that will be developed as a result of the project that the DSRIP bidder will continue to use after the end of the contract term.
- iii. If the DSRIP bidder is proposing a project which involves the purchase of software, the bidder will provide background information on the proposed software vendor including:
 - 1) Existing work with Medicaid providers (including in which states, duration of contract, whether the project(s) yielded successful outcomes);
 - 2) Evidence of success working with providers in the Commonwealth as measured by number of monthly active users, number of sites onboarded, and care data exchanged;
 - 3) Demonstrated understanding of local regulatory environment and product customization to accommodate state-based policy, including presence of customized features specifically designed to meet regulatory standards, program specifications, and outcome measures unique to the Commonwealth; and
 - 4) Demonstrated success implementing software with providers across a variety of disciplines (e.g., primary care, emergency department, behavioral health, social service, and community-based entities).
- d. Non-Duplication of Funding
 - i. The DSRIP bidder shall disclose whether it has previously participated or is currently participating in any EOHHS funding program that may be applicable to this program;
 - ii. If the DSRIP bidder has previously participated or is currently participating in any EOHHS funding program(s), the DSRIP bidder shall describe how no element of the DSRIP bidder's proposed project is duplicative of any work funded by those other programs. Specifically, if the DSRIP bidder has previously been awarded funding for activities or investments that are part of the DSRIP bidder's proposed project, the DSRIP bidder must demonstrate that the funding requested in the DSRIP bidder's response will support new activities, reach different goals, or build upon the progress of the other programs through which the DSRIP bidder has received funding. The DSRIP bidder shall also describe progress the bidder has made on activities or investments that are part of the DSRIP bidder's proposed project using the funds previously awarded; and
 - iii. DSRIP bidders who are participating in any programs associated with other DSRIP-funded initiatives including the MassHealth ACO Program, Community Partners Program, or Statewide Investments for Workforce Development must describe in their response how the intended use of BH Innovation Funds complements but does not duplicate other DSRIP-funded investments or activities.

2. Funding Response Form

- a. The DSRIP bidder shall complete the Funding Response Form (Appendix 7) in its entirety for each proposed project. The DSRIP bidder shall detail the costs associated with the activities and deliverables proposed in the Project Description, up to the maximum funding requested on the Programmatic Response Form. In

- completing the Funding Response Form, the bidder should add additional rows within the designated funding categories, as necessary.
- b. DSRIP bidders shall submit the Funding Response Form in native format (i.e., as an Excel file). The DSRIP bidder's Funding Response Form, as modified and approved by EOHHS, shall be attached to any final contract executed between MBHP and the bidder.
 - c. If the DSRIP bidder has undergone a name change, tax ID number change, or address change in the last year, the bidder must complete and submit a letter on organization letterhead stating what has changed (e.g., from XXX Street to YYY Street).

F. Response Evaluation Process

1. The selection committee for the CBHC as described above will evaluate the proposals.
2. **Initial Review:** All responses shall be initially reviewed to determine compliance with the general response submission instructions in Section XIV.D. Responses that meet those requirements shall have their Programmatic (XII.E) and Funding (XII.E) responses reviewed and evaluated by the committee against the criteria below.
3. **Evaluation Criteria:** The selection committee shall evaluate each response for comprehensiveness, appropriateness, feasibility, clarity, effectiveness, and innovation.
 - a. Among other things, the committee may consider in its evaluation: what the DSRIP bidder has requested; the overall funding available; the project size requested; demonstrated organizational leadership support; strong and dedicated project and data management capacity; the quality and clarity of project objectives and budget; and anticipated impact of the proposed programs in relationship to this procurement's priorities of ensuring appropriate behavioral healthcare through expanding access to and timeliness of outpatient and non-24-hour diversionary treatment, integrated behavioral health and primary care, and integration and coordination of mental health and substance use disorder treatment services. MBHP may set the contract amounts in its discretion and may vary the contract amounts by contractor.
4. **Clarifications:** The selection committee may seek clarification from the DSRIP bidder if it determines some element of a DSRIP bidder's response requires clarification.

Appendices

Appendix 1 Listing of Massachusetts Cities and Towns by Region and Catchment Area

Appendix 2 Performance Specifications

2a CBHC

2b AMCI

2c YMCI

2d Adult CCS

2e YCCS

Appendix 3 Listing of Procedure Codes Included in Bundled Rate

Appendix 4 Letter of Intent Form

Appendix 5 Cover Letter Form

Appendix 6 Programmatic Response Form

Appendix 7 Funding Response Form