**COMMONWEALTH OF MASSACHUSETTS**
**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**
**DEPARTMENT OF MENTAL HEALTH**

# REQUEST FOR INFORMATION
# RFI - 2009-8210-CBFS-01
# COMMUNITY BASED FLEXIBLE SUPPORTS
**May 30, 2008**

## SECTION I OVERVIEW

The Department of Mental Health (DMH) intends to re-procure its adult community mental health service system in stages over the next three (3) years beginning in the fall of 2008. DMH is committed to developing a service system that truly embraces the values of Recovery and Resiliency through Partnership with clients and family members, emphasizing rehabilitation, person-centered and client driven care. The system must be flexible and responsive to changing client needs. It must foster recovery and wellness, individual choice and rehabilitation.

DMH is evaluating its construct of the adult services contracting system. In doing so, DMH is redesigning services and determining how it can manage the provision and purchase of services that support innovation, flexibility and accountability.

The first stage of the redesign will introduce a new service code for DMH called Community Based Flexible Supports. To provide for increased flexibility, creativity and individualization in service delivery the following previously discrete service codes will be merged into this single service code.

- ***3059 Community Rehabilitative Support***
- ***3049 Adult Residential Services***
- ***3013 Rehab Treatment in the Community***
- ***3048 Respite Care Services***

In collapsing several “program” or “service types” for which DMH currently contracts separately, DMH expects to purchase a broader continuum of care and allow for greater integration of services. DMH will require that service providers respond to the changing needs and goals of clients rather than matching clients to existing programs. This will help to reduce duplication of services and eliminate existing service gaps. Greater flexibility in purchasing will allow for service levels to be adjusted more readily, enable DMH and providers to better manage financial resources and ensure that services are community based and linguistically competent.

Finally, DMH is examining the implications of separating funds and services related to shelter and housing from funds related to clinical rehabilitation and recovery services. It is believed that this would better facilitate the movement of clients into less restrictive settings resulting in better client care as well as potential cost savings.

In FY'07 DMH spent approximately $225M dollars on these services and served approximately 13,700 unduplicated clients.

Attached to this RFI, as Attachment A, is the service code description for Community Based Flexible Supports. DMH is in the process of developing program standards for this service code. Standards are "statements of expectation that define the structures and processes that must be in place in an organization to enhance the quality of care." The standards will describe the specific core services and the delivery components. All providers of Community Based Flexible Supports will be required to meet all identified program standards.

The Community Based Flexible Supports procurement will be funded from DMH purchase of service accounts. DMH is operating in a budget neutral environment and must fund Community Based Flexible Supports within legislative appropriations. In addition, the Commonwealth will continue to rely on DMH for obtaining Federal Financial Participation for those Medicaid Rehabilitative Services that are provided as a part of Community Based Flexible Supports.

In purchasing Community Based Flexible Supports, there will be an emphasis on purchasing quality rehabilitative services and associated defined outcomes. DMH intends to implement an outcome based procurement model (see Section IV). Outcomes will be tied both to client accomplishments and overall program goals. In addition, DMH intends to pay providers a fair price for the services that they provide. To implement such changes in the current budgetary environment, there must be new strategies for program design, utilization and financing.

DMH is issuing this RFI to receive input on key program design issues including elements of program standards necessary to foster DMH's overarching goal of Recovery and Resiliency through Partnership with clients and family members and the other procurement goals set forth in Section II; methods for purchasing and reimbursing services; and outcome measures.

## SECTION II PROCUREMENT GOALS

DMH's goal of promoting ***Recovery and Resiliency through Partnership*** is fostered by the principles of: meaningful client and family involvement; self- and family-direction; dignity and respect; culturally and linguistically competent care; elimination of disparities; use of evidence-based practices; and operational efficiencies. To accomplish this goal, clients and family members must be full participants in their service planning and delivery with a continual focus on recovery. Services must have a foundation in rehabilitative, clinical, and

recovery philosophies. Interventions must be based on sound rehabilitative and clinical practices.

Specifically, through the Community Based Flexible Supports procurement and service redesign, DMH wants to accomplish the following objectives:

1. Improve integration of services and continuity of care;
2. Promote age appropriate rehabilitative and recovery oriented practices;
3. Promote adoption of evidence based and best practices;
4. Integrate within the system of care clinical, rehabilitative, and recovery expertise;
5. Respond to the cultural and linguistic needs of clients served;
6. Foster incorporation of the values of strength-based, person-centered planning and treatment and the importance of continuous reassessment to assure goal attainment;
7. Incorporate the importance of wellness practices and activities into all aspects of the service continuum;
8. Create flexibility to respond appropriately to the needs of special populations;
9. Provide services in the most clinically appropriate manner;
10. Facilitate the utilization of social, educational or other community based services (such as family, friends and cultural, recreational, spiritual and civic institutions) that can assist clients to function optimally in their community ;
11. Pay providers a fair price for the services that they provide and ensure that such compensation supports the fulfillment of contract responsibilities and objectives;
12. Maintain existing revenue streams and improve DMH's ability to enhance third party reimbursement opportunities;
13. Eliminate duplication of effort in the service system to ensure optimal use of state appropriated funds;
14. Minimize DMH and providers' administrative costs to optimize the resources are directed to treatment and care provision;
15. Ensure a smooth transition from the current procurement system;
16. Develop a system that supports utilization management and financial oversight, strengthen accountability in the use of public funds to care for DMH clients; and
17. Include client based outcomes.

A strength-based assessment process that is person centered is the foundation for determining needs and planning services with clients and families. The person served is at the center of the development of a plan of care, based on the person's hopes, strengths, preferences, goals and desired outcomes.

Recognizing that each individual has his or her own goals for achieving recovery and wellness, it is expected that the redesigned system will emphasize a shared partnership among clients, peer workers, providers and DMH that will assist each client in:

- identifying his/her vision of recovery;
- identifying his/her strengths and the strategies he/she has used or could use to successfully maintain him/herself, and persons for whom he/she has caretaking responsibility, in the community;

- integrating his/her identified strengths and strategies into an action (treatment) plan which facilitates recovery and honors the individual's choices and preferences;
- identifying, accessing and using community based recovery resources (e.g., Recovery Learning Communities, self- help groups, warm lines) as well as natural community resources and supports (e.g., community organizations, churches, library);
- assessing, on an ongoing basis, where he/she is in the stages of recovery;
- identifying the impact of health related issues on his/her quality of life;
- identifying, accessing and using community based options for enhanced wellness related activities; and
- recognizing that growth involves taking risk and supporting clients through that process.

DMH intends to have peer and family support services available in all types of DMH funded, operated and licensed services. Peer workers are paid staff persons with a mental health or co-occurring disorder who have been trained to use their lived experience and recovery experiences to support their peers in identifying and achieve specific life goals and recovery. They are skilled in promoting self-determination, personal responsibility and empowerment inherent in recovery, and assist people with mental illnesses to regain control over their lives and their recovery processes. The integration of Peer Workers brings a focus on recovery to clients, staff and the culture of the organization.

Family support workers are usually paid staff persons who have a child, adolescent or adult family member with a mental health or co-occurring disorder who have been trained to provide support and advocacy for family members whose loved ones are currently being served in the mental health system.

Peer Workers fill four broad functions: support, education, assistance in identifying and utilizing recovery interventions and advocacy. The job description for Peer Workers is customized to fit the needs of a given setting, and consist of some subset of the following duties:

- Provide advocacy, support, and education to clients during intake and transition processes across the spectrum of services and transition to independence.
- Serve as a member of clients' treatment team and assists the clients to communicate the goals of their personal recovery action plans to treatment teams.
- Provide training to clients in recovery and wellness management and life development plans.
- Assist and/or support clients in the development of their personal recovery action plans and life development plans or wellness plans.
- Provide peer support and peer counseling to individuals or groups.
- Advocate for clients and support their development of self-advocacy skills.
- Facilitate clients' linkage to community services and networks.
- Help provider staff understand the clients' perspectives/stresses/pressures through training and consultation.
- Facilitate clients' usage of local Recovery Learning Community resources.

## SECTION III METHODS FOR PROCURING SERVICES

DMH anticipates that Community Based Flexible Supports initially will be purchased through the issuance of one Request For Response (RFR). Although some services may be purchased on a state-wide basis for economic and programmatic reasons, most services will be purchased at the DMH Area and/or Site level. DMH has six (6) Areas. An Area is a geographic subdivision within the state that is responsible for providing access to comprehensive mental health services for individuals within its boundaries. Each Area is headed by an Area Director who is supported by an Area Office. Areas are further divided into "Sites" that are administered by Site Directors at Site Offices. There are twenty-eight (28) DMH Sites. Attached to this RFI, as Attachment B, is a listing of the DMH Areas and Sites and the towns that they serve.

DMH is considering using one or a combination of the following three (3) models for purchasing Community Based Flexible Supports. It is possible that more than one model will be used. DMH will always need flexibility in purchasing services for special populations and/or to meet special needs of clients. To ensure this, it may be necessary to use a combination of purchasing methods.

### Model A

Areas/Sites will purchase services as they presently do. Areas/Sites will determine the Community Based Flexible Supports needs of their client population and will purchase the different needed components and buy a variety of defined programs to meet those needs. A program may be very specific in nature and/or it may be very broad. As to each program purchased, a provider will be required to serve a set number of clients and to have a set program budget. Each contract will have a maximum obligation amount.

### Model B

DMH will seek providers that can provide the full array of Community Based Flexible Support services either directly or through subcontracts to specified DMH Areas or Sites. A provider awarded a contract will provide all of the Community Based Flexible Supports services required by a defined number of DMH clients in the applicable Area/Site in accordance with the clients' needs. The services provided are to address the needs identified in the clients' Individual Service Plans and/or Program Specific Treatment Plans. An Area/Site may utilize one or more providers under this model, depending on the client population, to be served.

It is anticipated that the client population referred to any one provider will consist of the full mix of clients in the Area/Site requiring Community Based Flexible Support services. The provider will be required to provide services to clients who need intensive services as well as those who require less intensive supports only. A provider will be expected to adapt the mix of Community Based Flexible Support services provided to individual clients to meet their

changing needs and goals as they move toward the overall goal of recovery. It is also anticipated that throughout the duration of the applicable contracts there will be changes in caseloads as clients enter and leave DMH care and/or the applicable service area. Based on DMH standards, providers will have the flexibility to determine their own staffing needs. For billing purposes, DMH is considering defining a discrete unit of service for each service component category listed in Attachment A. Contracts under this model may or may not have maximum obligation amounts.

### Model C

DMH will certify providers that can provide all or some of the components of Community Based Flexible Supports to all or a certain defined DMH Area and/or Site. DMH will describe the services that need to be provided in each component and the qualifications a provider will need to meet. All providers determined qualified to provide a component would be listed on a Master Service Agreement for that component. Referrals will then be made to providers based on clients' needs and choices. DMH may define a discrete unit of service for each service component category listed in Attachment A. Contracts under this model will not have maximum obligation amounts.

## SECTION IV OUTCOME MEASURES

Based on the overarching goal of *Recovery and Resiliency through Partnership*, DMH defines itself as a person and family centered agency focused on the priorities of community integration, recovery, health and wellness, and access. DMH has developed a quality framework (Attachment C) which it intends to utilize in planning, monitoring and improving all DMH-funded and state-operated services. This quality framework will assist DMH, with the involvement of providers, clients, family members and other advocates and stakeholders, to develop interventions and processes to improve the service delivery system, and ultimately the personal outcomes achieved by clients and their families.

DMH has identified core outcomes and measures (Attachment C, Slide 3), which will be used as the foundation for monitoring and improving DMH-funded and state operated services. DMH is considering developing a client-level provider reporting system to collect and monitor data in support of core client and system outcomes. It is expected that the client level provider reporting system will replace the current Performance Based Contracting reporting system. These data will be utilized at the client, program and system level. One of the uses may be for utilization management on an ongoing basis in order to match the client's services to the client's changing needs and goals. Providers will also be expected to engage in quality improvement activities in collaboration with DMH.

## SECTION V RFI QUESTIONS FOR RESPONSE

### A. Service Code

1. **Service Mix.** Are the four (4) service codes identified in Section I the right ones to combine? If not, explain how the proposed Community Based Flexible Supports service code should be structured and why. Are there other existing DMH service codes that should be added?

2. **Group Homes.** Do you think that 24/7 group homes should be included in the Community Based Flexible Supports service code or re-procured separately? Do you think their inclusion would allow for greater coordination of care and for service levels to be more readily adjusted and for providers to better manage resources?

3. **Facility-Based Respite Services.** Given the ability of the Community Based Flexible Supports service code to increase supports (e.g., ability to flexibly deploy staffing) as needed and the community based nature of the services, will there still be a need for facility based respite services and/or what changes should be made to facility based respite services?

### B. Standards

1. **Strength-Based and Person Centered.** In the delivery of Community Based Flexible Supports, what innovations and changes would you suggest to ensure that the services actively support and encourage self determination, maximize natural supports, assist and respect client driven life decision making and that integrate client identified strengths and strategies into an action (treatment) plan which facilitates recovery? What program standard(s) would you like to see DMH establish in this regard?

2. **Risk Management.** How can DMH support providers in managing client risk in the community? How can DMH assist providers to ensure that Rogers Orders, Representative Payees, etc. are only used when needed and are not used to supplant client driven decision making?

3. **Integration of Services.** What strategies would you suggest for ensuring that providers of Community Based Flexible Supports effectively collaborate and plan with DMH, other DMH providers, and the acute mental health system including outpatient services serving the same clients? Be specific about collaboration activities, needed meetings and communications and where the responsibility for such should lie. What program standards would you like DMH to establish in this regard? What barriers to integration should be examined and addressed?

4. **Peer and Family Support.** How best can peer and family support be integrated into the delivery of Community Based Flexible Supports? What type of guidance and technical assistance should DMH be prepared to offer providers to ensure the

successful integration of peer and family support into Community Based Flexible Supports? What program standard(s) would you like to see DMH establish in this regard?

5. **Medical Health Care**. DMH will require Community Based Flexible Supports providers to promote healthier lifestyle changes and support clients in making good health and healthcare decisions, particularly in the areas of smoking, physical activity, and nutrition This would include client engagement with primary medical providers. What program standard(s) for Community Based Flexible Supports would you like to see DMH establish in this regard?

6. **Evidence Based Practices.** To implement Evidence Based Practices or models promoting rehabilitation, resiliency and recovery, staff must receive training and ongoing support/supervision in implementing these models. Are there approaches to train, support, and mentor staff in these models and practices that might be a more efficient and effective approach than each provider training/supporting their own staff?

7. **Cultural and Linguistic Competency.** What specific actions and strategies would you suggest for ensuring that Community Based Flexible Supports are provided in a culturally and linguistically competent manner? Do your strategies depend on the model that is used for procuring the service? What program standard(s) would you like to see DMH establish in this regard? What are your recommendations for how the recruiting of multicultural/bilingual staff and/or the provision of training could be done most effectively and efficiently? Do you have any suggestions other than hiring multicultural/bilingual staff to ensure that the cultural and linguistic needs of DMH's clients are met? Specifically address how DMH can improve access for the ethnically and linguistically diverse populations.

8. **Standards**. Are there standards you would recommend for any of the different service components of Community Based Flexible Supports?

## C. Models for Procuring Services

1. **Model Preference**. Of the three (3) models for procuring services described in Section III, identify the advantages and disadvantages of each model and prioritize the models for DMH adoption in purchasing Community Based Flexible Supports.

2. **Procurement Goals**. Do you believe one of the three models for procuring services would be better than the others in meeting the procurement goals set forth in Section II? If so, which one and why? Do you think one of the proposed procurement models would be better than the others at facilitating the movement of residential clients to less restrictive settings in a timely manner? Would one restrict such movement more than the others?

3. **Provider Impact**. Describe how the selection of one of these models will impact your agency. Could you provide all the components of Community Based Flexible Supports? Would you need to sub-contract to provide some of the components? Would you be willing to serve as a subcontractor for another provider? Do you think any one of these methods would create a greater financial risk to your agency than another? In some of the models there may be no contract Maximum Obligations. What would the implications be for you if ready payment were no longer an option?

4. **Clinical Rehabilitation and Recovery Expertise.** Given the existing resources available for Community Based Flexible Supports, explain how under the three models for procuring services clinical expertise could be infused more consistently into the delivery of all service components. Do you think one of the models would be better than the others in ensuring this optimal clinical expertise and involvement in the care of clients?

5. **Utilization Management**. How can DMH ensure that clients' services will change as their needs change and/or that Providers will reallocate their resources, staffing, housing, etc. as the needs of the clients they are serving change? If contracts offer a variety of services at a range of frequencies and intensity and durations, how can the need to adjust these services up or down or change services be assessed on an ongoing basis? What should the contractual mechanisms be for discharging or providing fewer services and for adding new clients? How should capacity be defined (for example, number of clients served or units of services)?

## D. Methods for Reimbursement

1. **Preferred Methods**. What do you believe would be the best method for compensating providers under each of the different procurement models and why?

2. **Varied Rates or Blended Rate**. Should there be different rates of reimbursement for each component (or even within components) of Community Based Flexible Supports or would you bundle some of them to make unit(s) of service? Would this allow a greater opportunity to provide services more flexibly to meet client needs, assuming that the rates are reflective of the actual cost of service delivery? What would you recommend for the unit(s) of service? The new model will require providers to accept clients with various levels of need. Describe the pros and cons of a blended rate structure versus multiple rate structure.

3. **Service Impact.** If the implementation of fair rates supports DMH in achieving our procurement goals but results in less services, what recommendations would you make for addressing this implication? Can a particular approach to procuring or reimbursing services reduce or eliminate gaps or duplication of services clients may receive?

4. **Incentives.** Identify types of incentives that could be offered to providers to encourage excellent service outcomes.

5. **Third Party Revenues and/or Improved Efficiencies.** Do you believe there are ways for DMH to expand use of Medicaid Rehabilitative Services Option within Community Based Flexible Supports? Describe the possibilities, benefits and disadvantages of requiring all providers to meet DMH and Medicaid Rehabilitative Service Standards. Are there other options for expanding third party reimbursement for Community Based Flexible Supports? If so, please explain and indicate if one of the proposed procurement models would be better than another at maximizing third party revenue. Does the recommended mix of services within Community Based Flexible Supports provide any prospects for improved efficiencies (e.g., reduce administrative costs related to contract management and compliance review and reporting)? Would you recommend adding or deleting other service components to maximize the opportunity for reimbursement enhancement and/or efficiencies?

6. **Invoicing.** What do you foresee are the challenges, barriers and benefits to your organization if DMH used an invoicing system similar to the system used by Medicare, Medicaid and other third party payers where the providers invoice by service components? Does the current proposed consolidation of activity/service codes change the administrative costs related to contract management and compliance review and reporting? Do any of the proposed procurement methods increase or decrease contract paperwork? Do structural or operational barriers exist within the current purchase of service invoicing system that prevents providers from performing services efficiently? What are they?

## E. Outcome Measures

1. **Outcomes.** Identify client, family and system outcomes you think should be used for measuring Community Based Flexible Supports.

2. **Data Collection.** What method and frequency of data collection do you suggest? What current practices exist in the collection and monitoring of client and system outcome data? Does your agency have the technological capacity for web-based reporting? What does DMH need to consider in establishing a client-level provider reporting system?

3. **Assessment/Treatment Planning.** If outcomes are driven by the client’s goals and movement along a client’s path of recovery and increases in quality of life rather than measures of process, length of stay, time or frequency, there will need to be periodic assessments. This will measure the client’s current status along varied domains including: recovery, vocational, parenting, risk issues, treatment and trauma histories, etc. These assessments would lead to the development of the treatment plans and changes in services, intensity and frequency. Given this information, would requiring standard treatment plans for all services provided to DMH clients be reasonable? What factors would make this more or less manageable or useful? Would

establishment of treatment planning parameters, e.g., timeframe, participants, elements, be reasonable and useful? To ensure consistency across the DMH adult community based rehabilitative services system and across the varied treaters with whom a client may interact, DMH may issue a standard set of assessment tools and standards regarding requirements for implementation. What factors would make this more or less manageable or useful?

4. **Service Utilization.** Because utilization of services will be essential to measuring outcomes how should DMH measure and manage service utilization? Does one of the procurement models enhance a provider's ability to manage utilization and improve a provider's ability to use DMH funds more effectively in monitoring service utilization?

## F. Housing

**Background:** DMH strives to ensure that a full range of housing options are available to DMH clients, including the homeless. In this effort, DMH seeks to facilitate client's choice in housing; support clients in assuming the rights and responsibilities of tenancy; and helping clients receive services tailored to their needs.

A majority of DMH clients live in an integrated fashion, in the community, in their own homes and receive flexible, supportive housing services. DMH's community system of care also includes residences owned by entities other than DMH which provide group living arrangements. This housing stock includes properties such as Chapter 689/167 that was developed by DHCD in conjunction with DMH and owned currently by local housing authorities; properties owned by private landlords and leased to service providers; and service provider owned property. In some instances, DMH has committed services in order to allow providers to leverage funding through federal sources such as HUD, or other state sources such as the Facility Consolidation Fund to purchase housing stock. The challenge now is to expand the continuum of housing to include more independent and integrated units that further promote recovery and resiliency.

**1.** Which of the models for purchasing services described in Section III would be most effective in fully utilizing existing housing stock as described in this section? What barriers do any of the models create in terms of maintaining the current portfolio?

**2.** How can existing housing stock be utilized to support DMH's ongoing initiative to create more age appropriate, independent, fully integrated housing opportunities for our clients in the community? With respect to your portfolio of real estate how might you adapt to promote integrated, independent housing? Could housing be separated completely from service dollar expenditures? Would you support a rate structure that compensates separately or recognizes distinctly the cost of operating the residential facility from the cost of providing for distinct client needs? What do you think would be the ramification if instead of

purchasing housing (e.g., group homes) DMH purchased levels of "supervision" or "staffing for the provision of a safe environment for the client in the community"?

**3.** How can group residences be converted to a supported housing model, or otherwise unbundled from 24 hour, on-site staffing? Are there specific challenges to adapting properties you own to meet this need?

## G. Implementation –Transition

1. **Transition.** What timeframe do you recommend for terminating existing contracts for the old service codes and transitioning clients to the new Community Based Flexible Supports? What contract requirements would you propose to add to the existing contracts and the ones that would be issued as a result of the RFR to ensure continuity of care and a smooth implementation? What measures would you recommend to minimize the impact of changes to a new reimbursement method? What types of training do you think are required to shift to a more recovery based philosophy and provision of service and what role will this play in the implementation and transition?

2. **Implementation**. What barriers to successful implementation and operations do you see? How can they be addressed?

3. **Contract Duration**. Generally, when DMH procures services, it awards contracts that have an initial duration of five (5) years with DMH having five (5) options to renew for one year. What do you think would be a reasonable duration for the contracts to be awarded as a result of the Community Based Flexible Supports RFR? What factors should DMH consider in determining a reasonable duration?

## H. Conclusions

1. Do you have any suggestions or comments regarding the procurement of Community Based Flexible Supports that are not addressed by the preceding questions? If yes, please provide such suggestions or comments.

2. Are there decisions being made for the procurement of Community Based Flexible Supports that you think will impact the re-procurement of the remaining adult community based rehabilitative services? If so, please identify them.

3. Are there current administrative or regulatory requirements within DMH control that you feel are impediments to a more flexible and integrated service system? Please specify what these changes are and whether if removed or altered you would recognize a cost savings that could be redirected to service delivery expansion and/or enhancement.

## SECTION VI RFI RESPONSE INSTRUCTIONS

### A. Response Format

Parties responding to the RFI should prepare a typewritten response that includes the RFR Coversheet that is attached to this RFI as Attachment D.

The set of questions should be answered in order of appearance and numbered (e.g., A.1) according to the RFI number for the set of questions. Please restate the questions you are answering. Respondents are not required to respond to every question; respond to as many as you fee1 appropriate. Responses, including attachments thereto, should be clearly labeled and referenced by name in the RFI response.

Do not include marketing or promotional material with your response. This information will be disregarded on review. Please keep your responses to key points to help facilitate review.

### B. RFI Submission Deadline

**The deadline for receipt of RFI responses is July 31, 2008 by 4:00 p.m.** Responses can be submitted by hardcopy or electronically. Electronic submissions are preferred. Hardcopy responses must be submitted to:

Denise Arsenault
Department of Mental Health
Central Office
25 Staniford Street
Boston, MA 02114

Hardcopy submittals should consist of one original and five copies and if possible an electronic copy on a CD ROM. Electronic responses must be submitted by e-mail in a format readable by Word 2003 or Excel 2003 to: denise.arsenault@state.ma.us
Electronic responses should use the words "RFI Response" in the e-mail subject line.

No part of a response can be returned. Receipt of a response will not be acknowledged.

### C. Reasonable Accommodation

Respondents with disabilities or hardships who seek reasonable accommodations in responding to this RFI must communicate such requests by e-mail or telephone to Denise Arsenault (denise.arsenault@state.ma.us; (617) 626-8025). Requests for accommodation will be addressed on a case by case basis. DMH reserves the right to reject unreasonable requests.

## SECTION VII ADDITIONAL RFI INFORMATION

### A. Use of Information

Information received in response to this RFI will be reviewed and assessed by the DMH Procurement Management Team and DMH Executive Staff to determine whether DMH could benefit from incorporating any one or more of the ideas received into the design of Community Based Flexible Supports and/or any Request for Response(s) issued by DMH. Respondents are invited to respond to any or all of the RFI questions.

This RFI and any information received in response do not obligate DMH in any way. RFI input does not guarantee that services will be reconfigured or that respondent will receive contracts during the bidding cycle. The issuance of this RFI does not obligate DMH to include any of the RFI provisions or responses in any RFR. Responding to this RFI is entirely voluntary, it will not affect DMH's consideration of any proposal submitted in response to any subsequent RFR issues by DMH, and it will not serve as an advantage or disadvantage to the respondent in the course of any RFR that may be issued.

Responses to this RFI become the property of the Commonwealth of Massachusetts and are public records under the Massachusetts Public Records Law, M.G.L. c. 66, §10, and c. 4, §7(26).

### B. RFI Access

This RFI has been distributed electronically using the Commonwealth Procurement Access and Solicitation System (Comm-PASS). Comm-PASS is an electronic mechanism used for advertising and distributing the Commonwealth of Massachusetts' procurements and related files. No individual or organization may alter (manually or electronically) the RFI or its components except for those portions intended to collect the respondent's response. Interested parties may access Comm-PASS at [http://www.comm-pass.com](http://www.comm-pass.com).

### C. RFI Amendments

Interested parties are solely responsible for checking Comm-PASS for any addenda or modifications that are subsequently made to this RFI. The Commonwealth and DMH accept no liability and will provide no accommodation to interested parties who fail to check for amendments to the RFI.

### D. Questions About the RFI

Questions specific to Comm-PASS should be made to the Comm-PASS Help Desk at: comm-pass@osd.state.ma.us or by telephone at 1-888-MA-STATE. Written questions regarding the RFI may be submitted to Denise Arsenault either by e-mail or fax. No verbal questions will be accepted. Questions must be submitted by 4 PM, June 12, 2008, to:

denise.arsenault@state.ma.us;
Fax number (617) 626-8014.

Questions submitted electronically should use the words "RFI Questions" in the e-mail subject line.

DMH will review the questions received before the deadline and, at its discretion, prepare written answers to questions of general interest. The answers will be posted on the Comm-PASS website on or about June 27, 2008. **Respondents are urged to check Comm-PASS regularly for updates and amendments to the RFI**.

## E. Thank You

DMH appreciates the time and consideration you invest in responding to this RFI.

***ATTACHMENTS***

*Attachment A Service Code Description for Community Based Flexible Supports*
*Attachment B Listing of the DMH Areas and Sites and the towns that they serve*
*Attachment C DMH Quality Framework*
*Attachment D RFI Coversheet*