STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF DRUG AND ALCOHOL SERVICES

Nicholas A. Toumpas
Commissioner

Diane M. Langley
Director

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December 8, 2014

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

Sole Source

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug and Alcohol Services, to amend existing **Sole Source** agreements with two of fifteen vendors by increasing the price limitations by $296,844, from $22,333,404 to $22,630,248 in the aggregate, for a continuum of substance abuse treatment services statewide, effective date of Governor and Executive Council approval through June 30, 2015. There is no change to the original end date of June 30, 2015. These agreements were originally approved by Governor and Executive Council on June 20, 2012, (Item 108 and 102), and were subsequently amended on June 5, 2013, (Item 102A), and on June 18, 2014, (Item 99). 46% Federal, 54% General.

Summary of contracted amounts by vendor:

Contractor	Current Budget	Increase/ Decrease Amount	Revised Modified Budget
Child & Family Services, Manchester, NH	$ 260,409	$ 0	$ 260,409
Concord Hospital, Concord, NH	$ 223,218	$ 0	$ 223,218
Families First of the Greater Seacoast, Portsmouth, NH	$ 86,766	$ 0	$ 86,766
Families in Transition, Manchester, NH	$ 997,590	$ 0	$ 997,590
Grafton County, North Haverhill, NH	$ 208,233	$ 0	$ 208,233
Greater Nashua Council on Alcoholism, Nashua, NH	$ 4,070,835	$ 0	$ 4,070,835
Headrest, Inc., Lebanon, NH	$ 754,350	$ 0	$ 754,350
Horizons Counseling Center, Inc., Gilford, NH	$ 568,728	$ 0	$ 568,728
Manchester Alcoholism Rehabilitation Center, Manchester, NH	$ 3,361,797	$ 0	$ 3,361,797
The Mental Health Center of Greater Manchester, Inc., Manchester, NH	$ 81,342	$ 0	$ 81,342
Phoenix Houses of New England, Inc., Providence, RI	$ 4,372,470	**$ 97,819**	$ 4,470,289
National Council on Alcoholism and Drug Dependence of Greater Manchester, Manchester, NH	$ 1,297,404	$ 0	$ 1,297,404
Southeastern New Hampshire Alcohol and Drug Abuse Services, Dover, NH	$ 3,989,508	$ 0	$ 3,989,508
Tri-County Community Action Program, Berlin, NH	$ 1,835,715	**$199,025**	$ 2,034,740
The Youth Council, Nashua, NH	$ 225,039	$ 0	$ 225,039
Totals	$22,333,404	$296,844	$22,630,248

Funds to support this request are available in the following accounts in SFY 2015, with authority to adjust amounts within the price limitation without further approval from Governor and Executive Council.

05-95-49-491510-2989 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, GOVERNOR COMMISSION FUNDS

State Fiscal Year	Class/Account	Class Title	Current Modified Budget	Increase/ Decrease	Revised Modified Budget
2015	102-500734	Contracts for Prog Svc	$4,387,176	$65,305	$4,452,481
		Subtotal	$4,387,176	$65,305	$4,452,481

05-95-49-491510-2990 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, CLINICAL SERVICES

State Fiscal Year	Class/Account	Class Title	Current Modified Budget	Increase/ Decrease	Revised Modified Budget
2015	102-500734	Contracts for Prog Svc	$17,946,228	$231,539	$18,177,767
		Subtotal	$17,946,228	$231,539	$18,177,767
		Grand Total	$22,333,404	$296,844	$22,630,248

EXPLANATION

These **sole source** actions are requested to ensure the continued provision of a statewide continuum of substance abuse treatment services for SFY 2015. Two anticipated vendors declined to contract for the provision of these services, creating a coverage gap. These two amendments close the coverage gap, ensuring services are available statewide for the remainder of SFY 2015. In June 2014, the Department sought Governor and Executive Council approval for amendments with 15 of the affected vendors out of the original 17 that were formerly providing services. Two vendors chose not to continue their agreements, creating a gap in available services in the Monadnock and North Country regions. Tri County Community Action Program and Phoenix Houses of New England, Inc. have agreed to increase their service capacity for these regions ensuring that area residents in need of these services have sufficient access. In combination, the full statewide continuum of services will be provided to the population served. The entire statewide continuum of services includes community based outpatient, intensive outpatient, residential, transitional living, and recovery support services, along with specialized treatment services for pregnant and parenting women and their children.

Funds provided through these agreements are used to support services for individuals who are not eligible for Medicaid or the NHHPP, and services not otherwise covered by Medicaid or the NHHPP. The target population for the services provided through these agreements are for individuals that are either unable to pay for services or able to pay only part of the cost of services, who have or are suspected of having an alcohol or other drug abuse problem, and who are residing in NH.

Should the Governor and Executive Council determine to not authorize this request individual access to these services for these two regions will continue to be diminished as a result of lower provider capacity – leaving people that suffer from substance use disorders waiting for services that could mean the difference between sobriety and overdose. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment service may place that Block Grant in jeopardy.

Area served: Statewide

Source of Funds: 46% Federal Funds from Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant, CFDA #93.959, Federal Award Identification Number TI010035-14 and 54% General.

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Diane M. Langley
Director

Approved by:

Nicholas A. Toumpas
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Substance Use Disorder Treatment and Recovery Support Services Contract

This 3rd Amendment to the Substance Use Disorder Treatment and Recovery Support Services contract (hereinafter referred to as "Amendment 3") dated this 12th day of November, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Phoenix Houses of New England, Inc. (hereinafter referred to as "the Contractor"), a non-profit corporation with a place of business at 99 Wayland Avenue, Suite 100, Providence, RI 02906.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, (item # 108), and amended by an agreement (Amendment #1 to the Contract) approved on June 5, 2013, (Item # 102A), and further amended by an agreement (Amendment #2 to the Contract) approved on June 18, 2014 (Item #99), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 of the Agreement, the State may amend the Contract by written agreement of the parties;

WHEREAS, the State and the Contractor have agreed to add new services to the Agreement;

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

1) Amend Form P-37, Block 1.8 to read $4,470,289
2) Delete Exhibit A Amendment #2 and replace with Exhibit A Amendment #3
3) Delete Exhibit B Amendment #2 and replace with Exhibit B Amendment #3
4) Delete Exhibit C and replace with Exhibit C Amendment #1
5) Add Exhibit C-1
6) Delete Exhibit G and replace with Exhibit G Amendment #1

Contractor Initials: _____
Date: 11/24/14

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/9/14
Date

Diane Langley
Director

Phoenix Houses of New England, Inc.

11/24/14
Date

NAME PATRICK B. McENEANEY
TITLE SR. VP, REGIONAL DIRECTOR

Acknowledgement:
State of RHODE ISLAND, County of PROVIDENCE on NOV. 24, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

ENA E PARADYSZ
Name and Title of Notary or Justice of the Peace

ENA E. PARADYSZ
Notary Public-State of Rhode Island
My Commission Expires
May 31, 2017

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/10/14
Date

Name: Megan A. Yight
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

_____
Date

_____
Name:
Title:

Contractor Initials: _____
Date: 11/24/14

Exhibit A Amendment #3

Scope of Services

A. Population Served

Services are available to New Hampshire residents who meet diagnostic, financial, and other eligibility criteria for Department of Health and Human Services supported substance use disorder services as defined in Section C, Clients Eligible for Treatment Services.

B. The Contractor shall provide treatment services as identified below:

Service Table - An "X" denotes that the Contractor shall provide that service(s) to eligible individuals in accordance with all applicable laws, rules, and regulations and terms and conditions of this Agreement.

Required Services	*Treatment Services*
X	***Outpatient Treatment (ASAM Level 1)*** - Substance abuse treatment services provided in individual and group counseling sessions in a non-residential setting. Clients may be enrolled in outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Outpatient Treatment (ASAM Level 1) – Pregnant & Parenting Women*** – Outpatient Treatment as identified above provided to pregnant & parenting women.
X	***Intensive Outpatient Treatment (ASAM Level 2.1)*** – A combination of individual and group substance abuse treatment services conducted in an outpatient setting for a minimum of 3 hours of direct client treatment services per day for a minimum of three days per week. Clients receiving less than this level of service should be enrolled in an outpatient program. Clients may be enrolled in intensive outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Intensive Outpatient Treatment (ASAM Level 2.1) – Pregnant & Parenting Women*** - Intensive Outpatient Treatment as identified above provided to pregnant & parenting women.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living)*** – Residential substance abuse treatment services are designed to support individuals in the early stages of recovery that need this residential level of care and/or are homeless. The goal of these programs is to prepare clients to become self-sufficient in the community. Clients may be enrolled in low-intensity residential treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days. Residents typically work in the community and may pay a portion of their room and board.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living) – Pregnant Women*** - Low-Intensity Residential Treatment as identified above provided to

Contractor Initials: BR
Date: 11/14/19

	pregnant & parenting women.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent)*** - Short-term residential substance abuse treatment designed to assist individuals who require a more intensive level of service in a structured setting and/or individuals that may be homeless. Admission is on a voluntary basis. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent) - Pregnant Women*** - High-Intensity Residential – Adult and Medium Intensity Residential – Adolescent as identified above provided to pregnant women.
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5) - Residential treatment services for pregnant and parenting women and their children. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Recovery Support Services:*** Group or individual services that are consistent with an individual's recovery plan that prevent relapse and enhance or remove barriers to recovery. Examples of recovery support services include, but are not limited to: assisting clients with enrollment in Medicaid, the New Hampshire Health Protection Program (NHHPP), or private insurance, anger management, financial management, communication skills, spiritual support, parenting skills, health management, case management, organization and time management, recovery coaching, recovery mentoring, stress management, and vocational services. Programs may focus on a single recovery support service or provide a curriculum that includes an array of recovery support services. Types of Recovery Support Services are listed below:
X	• Continuous recovery monitoring services are regular follow-ups with clients to assess the status of the client's recovery, identify any needs the client may have and help the client to address those needs, and provide early intervention for client's who have relapsed or who's recovery is otherwise at risk.
	• Enhanced Services are specialized services that remove barriers to a client's participation in treatment. Examples of these services are child care while a parent is participating in treatment or transportation to and/or from the treatment site.
X	***Recovery Support Services*** as identified above provided to pregnant & parenting women.

C. Required Services

Priority Admission:

1) The Contractor shall give admission preference to pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour time frame.
2) Individuals with a history of injection drug use including the provision of interim services within 14 days.
3) Individuals with a primary diagnosis of a substance use disorder, which may also include a co-occurring mental health disorder.
4) Individuals on medication-assisted treatment for co-occurring substance abuse and mental health disorders or various opiate replacement therapies, including, but not limited to, methadone, buprenorphine and naltrexone.

Required Outreach:

New Hampshire Department of Health & Human Services (DHHS) programs receiving federal treatment Block Grant funds requires that Contractors must publicize services available to pregnant or parenting women and injection drug users in need of substance abuse treatment and that these individuals receive preference for admission to treatment. This may be done as follows, but is not limited to, street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers and social service agencies. The Contractor will submit their outreach plans to DHHS through the Bureau of Drug and Alcohol Services (BDAS) within 60 days of contract effective date.

Health Facilities Administration Licensing Requirements:

Housing programs with substance abuse treatment services at the same location will need to secure necessary licensing as a Residential Rehabilitation Facility by the DHHS Bureau of Health Facilities Administration, as appropriate, see He-P 807 at the following link: (http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html). Any contractor with an American Society of Addiction Medicine (ASAM) (October 2013) Level 3.3 or higher level program must secure this licensing for all Level 3 programs housed within the same facility as the Level 3.3 program. In the case of residential treatment and housing at the same site, residential programs should plan to treat no more than 16 pregnant or parenting women at any given time to comply with federal Medicaid restrictions on Institute for Mental Diseases (IMD) exclusion criteria. This restriction would not apply to programs in which the client's residence is in a separate location from the treatment program.

Capacity Reporting:

The Contractor must contact BDAS, as agent for DHHS, when their capacity has reached 90% within 5 business days. The Contractor must refer pregnant women to the State when the Contractor has insufficient capacity to provide services to any such pregnant women who seek the services of the program. Sending e-mail to the BDAS Clinical Services Unit Administrator may complete this notification process.

Access to Services:
The Contractor shall respond to calls requesting treatment and/or transitional living program services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within 2 business days following the day the call was received.

The Contractor is required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.

Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client should be referred to a DHHS funded provider where they are able to access interim services.

Contractors receiving grant funds from DHHS will not discriminate against clients who are using legitimate medications to assist their recovery and will not have policies that allow them to refuse admission to treatment or to discharge clients from treatment based on the use of appropriately prescribed medications and various opiate replacement therapies, including, but not limited to, methadone and buprenorphine, as well as other forms of medication-assisted treatment for co-occurring substance abuse and mental health disorders.

Clients Eligible for Treatment Services:
In order to be eligible for DHHS supported services, a client must meet all eligibility criteria described below. Eligibility determination shall be conducted as follows:

1. Substance Use Disorder, Financial Eligibility & Residency Screening: The contractor shall complete the eligibility screening module in the Web Information Technology System (WITS) to determine if the client meets residency, financial, and substance use disorder potential eligibility requirements:
    a. Residency: The client must be a resident of New Hampshire or homeless in New Hampshire to be eligible for DHHS supported services; and
    b. Financial Eligibility: The client's income must be below 400% of Federal Poverty Level (FPL) to be eligible for DHHS supported services based on the sliding fee scale described below. Once the screening has been completed, the contractor shall print the associated attestation and have the client sign this document. A copy of the signed attestation shall be maintained in the client file. The client's financial eligibility shall be reassessed no less than every 120 days.; and
    c. Potential for a Substance Use Disorder: The client must screen positive for a potential substance use disorder to be eligible for DHHS funded services.
2. Evaluation: The contractor shall conduct a full substance abuse evaluation, which includes administration of either the Addiction Severity Index (ASI) in WITS or Global Appraisal of Individual Needs (GAIN).
    a. Substance Use Disorder: This evaluation shall be used to determine if the client meets Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) criteria for a substance use disorder. Clients who meet DSM5 criteria for a substance use disorder are eligible for DHHS funded services. Client who do not meet these criteria are not eligible for DHHS funded services.

b. Level of Care: For clients who have met all other eligibility requirements, this evaluation shall be used to determine the appropriate level of care for the client based on ASAM (October 2013) criteria. The client is eligible for DHHS funded services at the assessed level of care unless such a level of care is unavailable or the client chooses to enter a lower level of care. If the assessed level of care in unavailable, the client may choose to enter the next higher level of care.

3. Medicaid/NHHPP Eligibility: The contractor shall determine whether or not the client is eligible for Medicaid/NHHPP coverage for the identified level of care. If the client is not eligible for Medicaid/NHHPP coverage for the identified level of care, the client may be eligible for DHHS funded services. If the client is eligible for Medicaid/NHHPP coverage for the identified level of care, the client is not eligible for DHHS funded services.
4. Insurance Coverage: The contractor shall determine whether or not the client has insurance that will cover services at the identified level of care. If the client does not have insurance that will reimburse for these services at a rate equal to or greater than the DHHS rate, the client is eligible for DHHS funded services. If the client has insurance that will reimburse for these services at an amount equal or greater to the DHHS reimbursement rate, the client is not eligible for DHHS funded services. The contractor may not charge the combination of the client, any 3rd party payor, and DHHS more than the maximum charge allowed. These parties shall be charged in the following order:
    a. The maximum allowed charge will be billed to the client's insurer, if applicable.
    b. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
    c. The balance of the maximum allowed charge after deducting the client's portion and the insurance payment, if applicable, shall be charged to DHHS.

Sliding Fee Scale:

The contractor shall not charge the combination of the client, any 3rd party payor and BDAS an amount greater than the maximum rate allowed for each service. All reasonable efforts shall be made to collect payment of bills. A client's inability to pay shall not preclude admission to the program and treatment.

- Client Income is 0% - 138% of FPL: 100% of the allowed charge less any amount paid for by insurance.
- Client Income is 139% - 149% of FPL: 92% of the allowed charge less any amount paid for by insurance.
- Client Income is 150% - 199% of FPL: 88% of the allowed charge less any amount paid for by insurance.
- Client Income is 200% - 249% of FPL: 75% of the allowed charge less any amount paid for by insurance.
- Client Income is 250% - 299% of FPL: 60% of the allowed charge less any amount paid for by insurance.
- Client Income is 300% - 349% of FPL: 43% of the allowed charge less any amount paid for by insurance.
- Client Income is 350% - 399% of FPL: 33% of the allowed charge less any amount paid for by insurance.

With respect to minority age individuals, a minor child shall not be denied services as a result of the parent's unwillingness to pay the fee or the minor child's decision to receive confidential services pursuant to RSA 318-B:12-a.

Waiting List Management:
When a person who is pregnant or an injection substance abuser seeks treatment and there are no appropriate treatment services available within the required time frame as outlined below, interim services **must** be made available. The Contractor agrees to maintain the wait list management system in WITS that includes a unique patient identifier and include information on dates of requests for admission to treatment, provision of interim services and source for those services, referrals made for treatment or interim services, and disposition of clients on the waiting list.

- The waiting list must contain a mechanism that identifies and counts the number of applicants who present and are determined to be appropriate for substance abuse treatment but are unable to be placed as there is no capacity;
- Maintain contact with individuals awaiting admission; and,
- Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area.

The Contractor shall remove a client awaiting treatment from the waiting list only when one of the following conditions exists:

- Such persons cannot be located for admission into treatment *or*
- Such persons refuse treatment.

Specific Interim Services for Pregnant Women, Women with Dependent Children and Injection Drug Users:
The Contractor agrees to contact the BDAS Clinical Services Unit if a pregnant women and women with dependent children or individuals with a history of injection drug use, cannot be accepted into treatment within specific time frames, and agrees that interim services will be provided or facilitated by the Contractor. Interim services for pregnant women must include counseling on the effects of alcohol and drug use on the fetus, referrals for prenatal care, and counseling and education about HIV and tuberculosis. Interim services for injection drug users must also include counseling and education in the risks of needle sharing, about the risks of transmission to sexual partners and infants, and referral for HIV, Hepatitis C and tuberculosis screening/testing. All interim services shall be documented in the client's clinical record in the WITS system.

Interim Services for other Clients:
The Contractor shall provide, or refer the client to, interim services until level of service identified in the level of care assessment is available and/or the client is willing and assessed as being sufficiently motivated to take advantage of the proposed level of service or interim services. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client shall be referred to a DHHS funded provider where they are able to access interim services.

Services to pregnant and parenting women:
The Contractor further agrees that childcare will be made available to women who are in treatment with their dependent children, either through on-site care or through arrangements with an off-site legal childcare provider. Other services required are as follows:

- The family is treated as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
- The Contractor shall provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care.
- The Contractor shall provide or arrange for childcare while the women are receiving services even if the children are not in their custody, as long as parental rights have not been terminated.
- The Contractor shall provide or arrange for primary pediatric care for the women's children, including immunizations.
- The Contractor shall provide or arrange for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting, and childcare while the women are receiving these services.
- The Contractor shall provide or arrange for therapeutic interventions for children in custody of women in treatment, which may, among other things, address the children's developmental needs, their issues of sexual and physical abuse, and neglect.
- The Contractor shall provide or arrange for sufficient case management and transportation services to ensure that the women and their children have access to the services provided for above.
- If a pregnant, pregnant injection drug using or Injection Drug Using person refuses treatment or says (s)he is not interested in treatment, the wait list report shall be completed with the engagement activities attempted.
- If a pregnant, pregnant injection drug using or Injection Drug Using person no shows or cancels treatment, interim services must be provided, as stipulated above and the wait list report shall be completed that demonstrates the activities of follow up, engagement and substance abuse treatment services offered.

Relationship(s) with Primary Health Care:
The Contractor shall arrange and coordinate services and exchange of information with other health care providers and agencies which:

- Identifies the client's current Primary Care Provider (PCP) at screening and/or intake.
- If the client has no current PCP, the Contractor shall identify available provider(s) in the client's local area such as a federally qualified community health center, community health center, or other local health services.
- Obtains client/patient authorization to communicate with PCP office.
- If no authorization is completed initially, the Contractor shall educate client as to the importance of engaging the PCP in ongoing care and address the client's concerns as part of treatment, with goal of obtaining authorization before discharge.
- Sends the discharge summary to PCP and offers to discuss recovery issues with the provider.
- Arranges (or has the client arrange) a post-discharge appointment with PCP for the client/patient for follow-up of the substance use disorder.

Tobacco Cessation:
The Contractor shall have policies and procedures for both client and Contractor staff, that not only creates a tobacco-free environment as required by law, but to offer tobacco cessation tools and programming. Tobacco use, in and of itself, shall not be grounds for administrative discharge from the program. Initially, all clients shall be assessed for motivation in stopping the use of tobacco products. Providers may tap into resources such as the DPHS Tobacco Prevention & Control Program (TPCP) and

the certified tobacco cessation counselors available through the QuitLine. Other resources for providers include:

Breathe New Hampshire
145 Hollis St., Unit C
Manchester, NH 03101
603-669-2411 (phone) or 1-800-835-8647

The New Hampshire Medicaid program covers:

- Nicotine Replacement Therapy (NRT) Gum,
- NRT Patch,
- NRT Nasal Spray,
- NRT Lozenge,
- NRT Inhaler,
- Varenicline (Chantix),
- Bupropion (Zyban),
- Group Counseling and/or
- Individual Counseling. Up to 12 individual counseling sessions are covered per year through a mental health provider (Note: These sessions would NOT be in addition to other mental health counseling sessions under Medicaid). Pregnant women also have the option of group counseling. For more information, visit the website at: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm

Tuberculosis:
The Contractor shall make available tuberculosis services (defined as screening, counseling, testing, and treatment) directly, or through other providers, to each client receiving treatment. In the case of an individual denied admission due to lack of capacity, the substance abuse treatment Contractor will refer the individual to another provider of tuberculosis services if appropriate. All Contractor providing residential services shall make available, either on-site or through agreements with health care providers, tuberculosis services, including screening, testing, counseling and referral for medical treatment.

Physical location and facilities:
For the purpose of providing the services described in Section II of the Scope of Services, the Contractor shall obtain and maintain a suitable space complying with all fire, health, and safety codes to include handicapped accessibility and being wheelchair accessible.

The Contractor shall obtain written prior approval of DHHS, acting through BDAS, before entering into any agreement concerning relocation of the service site.

Culturally and Linguistically Appropriate Standards of Care:
DHHS recognizes that culture and language have considerable impact on how consumers access services. Culturally and linguistically diverse populations experience barriers in efforts to access services. To ensure equal access to quality services, DHHS expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. When feasible and appropriate, provide clients of Limited English Proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. The Contractor is responsible for reasonable accommodations in arranging for interpreter services for hearing impaired clients.
5. The Contractor offers consumers or clients a forum through which those individuals have the opportunity to provide feedback to the Contractor regarding cultural and linguistic issues that may deserve response.

The Contractor will submit a detailed description of the language assistance services they will provide to persons with Limited English Proficiency to ensure meaningful access to their programs and/or services, within ten (10) days of the contract effective date.

Compliance with State and Federal Laws:

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. All services provided pursuant to this Contract shall be subject to the most current proposed or formalized rules and regulations promulgated by DHHS, pursuant to RSA 541-A.
2. The Contractor shall maintain adherence to federal and state confidentiality laws specifically: 42 CFR Part 2B, N.H. RSA 318 B:12 and N.H. RSA 172:8-A and the Health Insurance Portability and Accountability Act (HIPAA): *http://www.hhs.gov/ocr/privacy/*
3. The Contractor shall meet the standards outlined in NH Administrative Rule He-A 300, Certification and Operation of Alcohol and other Drug Disorder Treatment Programs. This administrative rule is currently expired and under revision. The Contractor should plan to meet the requirements as outlined in the expired rule until the revisions are completed. He-A 300 can be viewed on the RFP link to this document *http://www.dhhs.nh.gov/business/rfp/index.htm*.
4. The Contractor shall, upon the direction of the State, provide court-ordered evaluation in their catchment area and a sliding scale fee shall apply and the inability to pay shall not interfere with the completion and submission of the court-ordered evaluation and shall, upon the direction of the State, offer treatment to those individuals pursuant to RSA 172:13.
5. Contractors considering research, including research conducted by student interns, using individuals served by this contract as subjects must adhere to the legal requirements governing human subjects' research. Contractors must inform the DHHS via contact with BDAS prior to initiating any research involving subjects or participants related to this contract. In addition, research conducted on subjects served by this contract may need to be approved by the New Hampshire Department of Health & Human Services Committee for the Protection of Human Subjects (NH DHHS CPHS) see *http://www.dhhs.nh.gov/irb/*

Client Stabilization:

The Contractor will be expected to arrange for medical clearance for all clients receiving treatment services supported by DHHS administered by BDAS to assure that they are not at risk for acute withdrawal from alcohol and certain drugs. The Contractor shall be expected to provide a range of integrated services that include withdrawal management services that follow detoxification guidelines outlined in Treatment Improvement Protocol (TIP) #45, Detoxification and Substance Abuse Treatment and ASAM guidelines.

Clinical Services:
The Contractor shall provide the following:

a. A minimum of one (1) substance abuse counselor on site each day of the week during primary treatment hours. The substance abuse counselor shall have a bachelor's degree or equivalent in social work/psychology, guidance or nursing and/or a certificate in the field of addiction studies from an approved educational institution or educational/life experience.
b. A minimum of one (1) substance abuse support staff on site each day of the week during all hours not covered by a substance abuse counselor. The substance abuse support staff must have a high school or General Equivalency Diploma (GED). Preference is given to individuals who have completed additional courses or taken training in substance use disorders or other health fields.
c. An intake/admission coordinator on site Monday through Friday of each week. The intake/admission coordinator shall have one (1) years' work experience in the field of addiction studies.
d. A full-time Executive Director, not filling any of the positions described above.

Evaluation:
The contractor shall conduct a full substance abuse evaluation, which includes administration of either the ASI or GAIN to determine eligibility for services. This evaluation must be updated every 120 days or when the client transitions to a different level of care.

Assessment of Risk for Self-Harm/Suicide: The Contractor shall have policies and practices for assessing risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and at discharge, and a process for referral when necessary to include referrals to mental health services.

The Contractor shall develop policies, programs and protocols in accordance with SAMHSA guidelines as outlined in the Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs). These publications can be downloaded from http://www.kap.samhsa.gov/products/manuals/index.htm .

Use of Best Practices: The Contractor is required to use the Addiction Severity Index (ASI) or Global Appraisal of Individual Needs (GAIN) assessment tools, the SAMHSA/NIDA MATRS treatment-planning model and the WITS electronic case management system.

Care Coordination:
The Contractor is required to assess each client's need/appropriateness for residential transitional living services and to **refer all clients for care coordination services** made available through the Access to Recovery (ATR) initiative administered by the BDAS so long as this initiative remains available on behalf of DHHS that would commence following the initial course of treatment. Contractors are required to address motivational issues with clients for them to participate effectively in the care coordination and recovery support services. Contractors are required to have clients sign the "ATR Client Participation Agreement" (made available by BDAS), indicating that they either agree or opt out of participating in these services. The contractor will facilitate all clients who agree to participate in these services to complete the Client Participation Agreement and upon obtaining a signed release of information, refer

clients to an ATR Care Coordinator Program at least two weeks prior to anticipated date of discharge (dis-enrollment) from services. Assessing the need for aftercare services is expected to take place while the client is involved within the most recent episode of care, with a referral being made and accepted by the care coordination service prior to the client being discharged.

The Contractor must provide the following for use by the care coordination program:

- Private space for interviewing/meeting with clients.
- Access to internet (either wired or wireless) in the meeting space
- Telephone in the meeting space and
- A contact person at the Contractor's site for logistics.

It is the expectation of the BDAS at DHHS that, upon completion of appropriate signed releases, the Contractor will provide the care coordination program with necessary information from the clinical record (evaluation, treatment plan, progress notes, etc.) for the care coordination program to develop a service plan with the client.

All alcohol and other drug treatment providers under contract with the BDAS on behalf of DHHS are required to address with all clients, the need for continuing services. This includes clinically managed low-intensity treatment programs under contract with the BDAS on behalf of DHHS as well as care coordination and recovery support services made available through DHHS contracted providers; the ATR initiative administered by BDAS, so long as this initiative remains available; and/or any other resources that become available to pay for these services that would commence following the initial course of treatment. The referral for these services should take place prior to discharge from the initial course of treatment.

Relevant Policies and Guidelines:
The services provided for in this agreement shall be in addition to the services provided for in any other agreement between the State of New Hampshire, any of its agencies, or any of its officers, and the Contractor.

Without limiting the generality of any other provisions of this agreement, the Contractor shall cooperate fully with, and answer all questions of representatives of the State conducting any periodic or special review of the performance of the Contractor or any inspection of the facilities of the Contractor.

Publications Funded Under Contract:
All products produced under this contract are in the public domain. All products (written, video, audio) produced, reproduced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution, or use. The Contract shall credit DHHS on all materials produced under this contract.

Student Internships:
The Contractor shall establish policies and procedures related to student interns that address minimum coursework, experience and core competencies for those interns having direct contact with individuals served by this contract. Student interns shall complete an approved ethics course prior to beginning the internship.

Staff Licensing Requirements:
The ratio of licensed to non-licensed service providers shall be as follows:
Agencies must have at least one Licensed, or Masters Licensed, Alcohol and Drug Counselor (LADC/MLADC) for each two unlicensed counselors providing substance abuse treatment services and a sufficient number of MLADCs or LADCs with the Licensed Clinical Supervision (LCS) credential to adequately provide for clinical supervision of all clinical staff. This requirement shall be met by the Contractor no later than six (6) months after the date of the Contract effective date.

Updated resumes, which clearly indicate the staff member is employed by the Contractor, including current positions of staff supported by funds provided through this Contract, shall be forwarded to the BDAS as agent for DHHS. The documentation shall include a copy of the New Hampshire Alcohol and Drug Counselor License.

Staff Certification Requirements:
In addition to the requirements for LADCs, all Contractor milieu staff in residential settings and transitional living programs and staff providing recovery support aftercare group services shall be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification under RSA 330-C (http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-330-C.htm). Certification must be completed within six (6) months of the contract's approval date.

Staff providing recovery support services are expected to be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification. Peer recovery support services made available through Recovery Community Organizations (RCOs), under agreement with BDAS on behalf of DHHS, shall be provided by individuals certified by those organizations (CRSW not required for peer recovery support services).

Supervision:
Ongoing clinical supervision will include weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress. When enough candidates are under supervision, group supervision may be included to help optimize the learning experience.

The content of supervision must include knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee, including the core functions as described in the Twelve Core Functions of Alcohol and Drug Counseling.

The content of supervision must also include the standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.

Staffing Changes:
BDAS as agent for DHHS shall be notified of changes in key personnel with updated resumes that clearly indicate the staff member is employed by the Contractor submitted within five (5) working days. Key personnel are those staff for whom at least 10% of their work time is spent providing alcohol or other drug abuse treatment services.

1. New Hires: The Contractor shall notify BDAS on behalf of DHHS in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. A resume of the employee, which clearly indicates the staff member is employed by the Contractor, shall accompany this notification.

2. Vacancies: The Contractor shall notify BDAS on behalf of DHHS in writing within 14 calendar days, if at any time, any site funded under this agreement does not have adequate staffing to perform all required services for more than one month.

Other Requirements:
The Contractor shall attend trainings and/or meetings as requested by DHHS.

ATR and Recovery Support Services:
All DHHS funded treatment and recovery support service providers must also be approved Access to Recovery (ATR) providers, so long as the ATR initiative remains available, as this will be the source of funding for these recovery support services through the Voucher Management System (VMS). Information on becoming an ATR provider can be found on the DHHS website: http://www.dhhs.nh.gov/dcbcs/bdas/atr/becomingprovider.htm

Regional Network Participation:
The Contractor will designate administrative level staff to regularly participate in the Regional Network and contribute to overall regional network strategic planning, monitoring, evaluation, and cross systems communication efforts. The Contractor is highly encouraged to serve on one of the work groups and contribute to data collection, regional strategic planning and evaluation. Participation will be measured by the annual Partner Survey (http://www.partnertool.net/) administered by NH Center for Excellence under contract with BDAS as agent for DHHS.

Performance Measures:
All treatment programs under contract with BDAS on behalf of DHHS are required to report on the National Outcome Measures (NOMs) established by the SAMHSA, as required in the Federal Substance Abuse Prevention and Treatment Block Grant, via the WITS (electronic case management) system. The Department of Health and Human Services reserves the right to consider Contractor performance across all of the domains in future funding decisions.

Data and Reporting Requirements:
1. Without limiting the generality of any other provisions of this agreement, the Contractor shall provide any periodic or special reports required by the DHHS.
2. The Contractor shall notify BDAS, as an authorized agent of DHHS, whenever the Contractor has reached ninety percent capacity to admit new clients. In addition the Contractor shall have a waiting list management policy in accordance with the SAPT Block Grant requirements. This 90% notification process will become automatic when this operation is fully functional in WITS.
3. The Contractor shall notify DHHS through BDAS, within one working day, if sufficient capacity is not available to provide treatment services to a pregnant woman, parenting woman or injection drug user within the required time frames and a referral elsewhere is not successful and interim services cannot be provided.

4. The Contractor shall comply with all research and/or information systems development activities for the electronic case management/Web Information Technology System (CM/WITS) conducted by, or authorized by, DHHS.
5. The Contractor shall administer any client surveys, client evaluations including the addiction Severity Index (ASI) or the Global Appraisal of Individual Needs (GAIN), client treatment outcome instruments, the M.A.T.R.S. Treatment Planning Tool, as required by DHHS.
6. The Contractor must have the ability to communicate and submit required reports via the Web-based submission system and/or e-mail, for treatment s and recovery support services and interim services. All required clinical and documentation activities shall be entered in WITS unless specifically granted an exception by BDAS on behalf of DHHS.

Critical Incident/Sentinel Event Reporting:
The Department's Sentinel Event policy is contained in the following link: http://www.dhhs.nh.gov/dcbcs/sentinel.htm

Division of Community Based Care Services (DCBCS) Sentinel Event Notification:
The preceding events require the immediate verbal notification to the BDAS Assistant Administrator or Clinical Services Unit Administrator upon the discovery of a sentinel event involving an individual(s) receiving services through a DHHS substance use disorder treatment Contractor.

Since the initial and immediate verbal notification of a sentinel event is likely to include protected health information (PHI) as identified below, the Contractor of services to individuals receiving services funded by the DHHS shall disclose PHI in a private and secure manner. Contractors and vendors should not leave voice-mail messages, but instead make direct telephone contact with the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee. If direct telephone contact is not possible, a voice mail message may be left without protected health information, such as medications and relevant medical and psychiatric diagnoses. As soon as possible after the initial verbal notification, the Contractor will mail or fax a completed *Sentinel Event Reporting Form* as directed in this protocol.

Notification shall include the following:
1. Name and phone number of the individual reporting.
2. Name, date of birth (DOB), medications and all relevant medical and psychiatric diagnoses of individual(s) involved;
3. Location, date, and time of event;
4. Description of the event including what, when, where, how, and other relevant information and identification of any other individuals involved;
5. Legal status of the individual involved with regard to guardianship and power of attorney;
6. Community, guardian, family and/or families' knowledge of the event; and
7. Contractor contact person and contact information.

It shall be the responsibility of the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee to notify the DCBCS Quality Improvement Director by e-mail as soon as the BDAS Clinical Administrator or designee becomes aware a Sentinel Event has occurred. The DCBCS Quality Improvement Director shall make immediate notification to the Commissioner. Internal e-mails within the Department may contain PHI and all Department employees will utilize safeguards to ensure the privacy

of the PHI as stated in the DHHS General Manual Health Insurance Portability and Accountability Act (HIPAA) policy #504.

Each DCBCS contractor recognizes its responsibility to report evidence of neglect, abuse or exploitation to the appropriate regulatory agencies as required by RSA 161-F: 42-57 and RSA 169-C:29. In any case of known or suspected neglect, abuse or exploitation, the Contractor aware of the situation shall follow all applicable rules relative to individual rights protection procedures.

Written follow up information is to be forwarded by the reporting Contractor to the appropriate BDAS Administrator listed below within 72 hours by completing the *Sentinel Event Reporting Form.* To protect clients' confidential information, reporting Contractors should submit the *Sentinel Event Reporting Form* either by fax to the BDAS Assistant Administrator or the BDAS Clinical Services Unit Administrator by a mail service that provides delivery confirmation.

Bureau of Drug and Alcohol Services
Assistant Administrator
105 Pleasant Street
Concord, NH 03301
Or by fax to the BDAS Administrator's Office at 271-6105;

Follow-up information is the responsibility of the Contractor and should be submitted in a way as to protect clients' confidential information such as by mail with delivery confirmation and should include:

1. The *Sentinel Event Reporting Form(www.dhhs.nh.gov/dcbcs/documents/sentinelform.pdf)*;
2. Additional details as they are learned or if the status of the situation changes; and,
3. Copies of newspaper articles.

Additionally, DHHS requires critical incident reporting. The Contractor shall report all critical incidents/sentinel events to the BDAS Clinical Services Unit Administrator immediately via telephone. Every effort shall be made to reach the BDAS administrator directly. If a voice message is necessary, sufficient provider contact information shall be provided so that DHHS is able to reach the reporter, or other responsible staff, immediately.

A critical incident includes, but is not limited to, any child or adult protective services report to the Division of Children, Youth and Families (DCYF), or the Bureau of Elderly and Adult Services (BEAS), respectively, regarding any incident involving 1) a staff/employee to youth or client, 2) youth to youth, or 3) client to client. This includes incidents that occur while a client is on leave, or on a pass, from the Contractor and may be off site at the time the incident occurred.

A sentinel event is an unexpected occurrence involving the death or serious physical or psychological injury, or risk thereof, signaling the need for immediate investigation and response.

Death or any serious injury or medical emergency regarding staff or clients that requires emergency medical attention (EMT or other emergency personnel at the Contractor's site, or a hospital emergency room visit), or any crime reportable to law enforcement, or any other serious incident must also be reported to DHHS as described below.

Reportable sentinel events include, but are not limited to, any occurrence that meets any of the following criteria:

1. An unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition.
2. Homicide or suicide of any individual receiving DHHS funded care, treatment or services, that had been discharged from a Department funded program or facility within 30 days of the event, or has been evaluated by a service Contractor within the preceding 30 days;
3. Sexual assault or rape of any individual receiving DHHS funded care, treatment or services by another client or employee of any Department funded program or facility where there is an act that was witnessed or there is sufficient clinical evidence obtained by the Contractor to support allegation of nonconsensual sexual contact.
4. Unauthorized departure of an individual receiving DHHS funded services, from a facility providing care, resulting in death or permanent loss of function.
5. Medication error that results in death, paralysis, coma, or other permanent loss of function.
6. Delay or failure to provide DHHS funded Contractor services that result in death or permanent loss of function.
7. Abuse as a result of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one individual by another.
8. Neglect as a result of the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness.
9. Assault of or by a client of the Contractor that results in the injury of the person or another person of such severity that medical attention is required.
10. Arson resulting in property loss.
11. High profile events, which may include media coverage and/or police involvement.

On-Site Reviews:

1. The Contractor shall allow a team or person authorized by DHHS to periodically review the Contractor's systems of governance, administration, data collection and submission, clinical, and financial management in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include, but not be limited to, client record reviews to measure compliance with this exhibit.
3. The Contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. DHHS staff shall contact the Contractor in advance of the site visit, so that the Contractor shall have sufficient time to prepare any guidance/reporting systems or logs that will be reviewed at the site visit.

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Method and Conditions Precedent to Payment

The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A Amendment #3, Scope of Services, and in accordance with Exhibit B Amendment #3.

For the period of July 1, 2014 to June 30, 2015, funding for this Agreement is funded by various sources as a percentage of the total amount of $1,555,309 as follows:

- 46 % Federal Funds from the Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959);
- 22 % General Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Funds; and
- 32 % General funds.

I. Payment Methodology

The Contractor shall be reimbursed for providing and delivering the services listed in Exhibit A Amendment #3, paragraph B. The following terms and conditions detailed in this Exhibit B Amendment #3 shall apply to all services unless expressly stated otherwise.

The Contractor shall agree to use and apply all contract funds from the State for costs and expenses as detailed in the Service Reimbursement Table below. Allowable costs and expenses shall be determined by the State in accordance with applicable state and federal laws and regulations. Starting in State Fiscal Year 2015 (effective July 1, 2014) the contractor will receive a payment for each service at the rates and within the limits described below. For clients receiving DHHS supported services, the contractor may not charge the client, any 3rd party payor, and DHHS a combined rate that is more than the rate established by BDAS for that level of service or any other fees. These parties shall be charged in the following order:

1. The maximum allowed charge will be billed to the client's insurer, if applicable.
2. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
3. The balance of the maximum allowed charge after deducting the client's portion and the insurance payment, if applicable, shall be charged to DHHS.

Service Reimbursement Table - A check mark indicates the services and corresponding rates the Contractor will be reimbursed for.

Check mark indicates applicable service	Service	DHHS Established Rate	Service Limit
X	Evaluation	$225	1 every 90 days
X	Outpatient – Individual	$18.75/unit***	$190 of combined individual & group/week
X	Outpatient – Group	$5.00/unit	
X	Intensive Outpatient*	$80.00/day	$320 (4 days)/week
X	Low-Intensity Residential – Adult	$100.00/day	$700 (7 days) /week

Contractor Initials: _____
Date: 11/24/14

X	Low-Intensity Residential – Adolescent	$128.00/day	$896 (7 days) /week
X	High-Intensity Residential – Adult	$130.00/day	$910 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Room & Board Only	$66.00/day	$462 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Clinical Services	$162.60/day	$1138.20 (7 days) /week
X	Medium Intensity Residential – Adolescent	$170.00/day	$1190 (7 days) /week
	Recovery Support Services		
X	Individual	$15.00/unit	$160 of combined individual & group/week
X	Group	$5.00/unit	
X	Continuous Recovery Monitoring – Attempted**	$15.00/contact	$60 of combined attempted and completed/month for the first 6 months post discharge
X	Continuous Recovery Monitoring – Completed	$15.00/contact	
	Enhanced Services	Varied	

* Providers may bill the per diem rate for Intensive Outpatient Treatment services only on those days when the client attends individual and/or group counseling associated with the program. It is expected that each day of attendance includes a minimum of 3 hours of group and/or individual counseling services.

**Attempted Contact is at least 3 attempts to contact a client over the course of at least one week.

*** A unit is equal to 15 minutes of service

It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period. Utilization and array will also be monitored by the Department via WITS. Failure to meet this requirement may result in amendment to or termination of the contract. At a minimum, contractors must provide the array of services they contracted to provide for in SFY14; at least three percent (3%) of the funding for the period of July 1, 2014 to June 30, 2015 must be utilized for Outpatient and/or Intensive Outpatient Services.

1. **Performance Incentives:**

A. Access to Services:

Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received and shall conduct initial eligibility screening as soon as possible, ideally at the

time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact. For each client who screens eligible for services and starts receiving services, whether for the identified level of care or interim services, within 10 business days following the eligibility screening, the treatment contractor will receive an incentive payment of $75.00. Access incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

B. Completion:

For each client who is discharged from the program because they have completed treatment or transferred to another treatment provider as recorded in the Discharge Type field of the WITS Discharge Module, the treatment contractor will receive an incentive payment of $75.00. Completion incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

C. Client Outcomes:

If a client who was discharged from the program meets at least 3 of the Outcome criteria below in the 3rd and/or 6th month post-discharge, as evidenced by the WITS Follow-Up module, the treatment contractor will receive an incentive payment in the amount of $50. The 3rd month post discharge is considered to be 60 – 120 days post discharge. The 6th month post discharge is considered to be 150 – 210 days post discharge. Outcomes incentives will be calculated and paid on a monthly basis for clients meeting criteria in the previous calendar month. It is expected that at least 50% of discharged clients will be contacted for 3 and/or 6 month follow-up over the contract year.

i. Abstinence: The client reports reduced or no substance use in the past 30 days.
ii. Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school.
iii. Crime and Criminal Justice: The client reports no arrests in the past 30 days.
iv. Stability in Housing: The client reports being in stable housing.
v. Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

D. Performance Incentive Payout Limits:

Performance incentives are limited to no more than 6% of the total contract amount annually. The total amount paid out during the contract year will never exceed the total contract amount. DHHS is not obligated to make payment for any incentives that occur outside of the current contract year; however, incentives may be carried over to future contract years at the discretion of DHHS.

2. Failure to Meet Deliverables:

The Contractor shall comply with all contract requirements as detailed in Exhibit A Amendment #3 section B, Required Services. Upon determination that Contractor may not be meeting the required deliverables, within two (2) weeks BDAS will provide a written correction action plan. Within two (2) weeks of notification of the corrective action plan, Contractor will provide a written remedial plan. BDAS will monitor the corrective actions for 60 days. Failure to meet requirements of the corrective action plan within 60 days may result in withholding of any or all payments or termination of the contract.

3. Invoicing & Billing:

All billing shall be completed via the WITS system according to protocols established by BDAS.

The Contractor shall have written authorization from the State prior to using contract funds to purchase or lease any equipment with a cost in excess of two thousand five hundred dollars ($2500) and with a useful life beyond one year.

II. Allocation of Funding:

It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period, and at least three percent (3%) of the funding for the period of July 1, 2014 to June 30, 2015 must be utilized for Outpatient and/or Intensive Outpatient Services. Utilization and array will also be monitored by the Department via WITS. The contractor is prohibited from spending down more than the sum of the total contract amount that includes the cost of the client services and related incentives.

III. Availability of Alternative Funding:

The New Hampshire Department of Health and Human Services may terminate or amend the contract should alternate third party payors, including Medicaid, the New Hampshire Health Protection Program and/or insurance available on the New Hampshire Insurance Exchange cover any of the services included in this contract.

IV. Limitations and restrictions of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds:

The Contractor agrees to use the SAPT funds as the payment of last resort.

Restrictions on SAPT Block Grant on State and Contractor expenditures include:
The State may not:

- Provide inpatient hospital services except under those conditions outlined in the regulations.
- Make cash payments to intended recipients of substance abuse services.
- Purchase or improve land.
- Purchase, construct, or permanently improve buildings or other facilities.
- Purchase major medical equipment.
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds. (in-kind)
- Provide financial assistance to any entity other than a public or non-profit private entity.
- Provide individuals with hypodermic needles or syringes.
- Expend more than the amount of Block Grant funds expended in FFY91 for treatment services provided in penal or correctional institutions of the State.

The Contractor shall not:

- Use any federal funds provided under this contract for the purpose of conducting testing for the etiologic agent for Human Immunodeficiency Virus (HIV) unless such testing is accompanied by appropriate pre and post-test counseling.
- Use any federal funds provided under this contract for the purpose of conducting any form of needle exchange, free needle programs or the distribution of bleach for the cleaning of needles for intravenous drug abusers.

V. Charitable Choice:

Federal Charitable Choice statutory provisions ensure that religious organizations are able to equally compete for Federal substance abuse funding administered by SAMHSA, without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries (see 42 USC 300x-65 and 42 CFR Part 54 and Part 54a, 45 CFR Part 96, Charitable Choice Provisions and Regulations). Charitable Choice statutory provisions of the Public Health Service Act enacted by Congress in 2000 are applicable to the SAPT Block Grant program. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

VI. Notwithstanding paragraph 18 of the General Provisions of this Agreement P-37, an amendment limited to adjusting amounts within the budgets and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of Governor and Executive Council.

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SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A Amendment #3, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. Subparagraph 14.1.1 of the General Provisions of this contract, is deleted and the following subparagraph is added:

14.1.1 Comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $1,000,000 per occurrence with additional general liability umbrella coverage of not less than $5,000,000.

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name: PHOENIX HOUSES OF NEW ENGLAND, INC

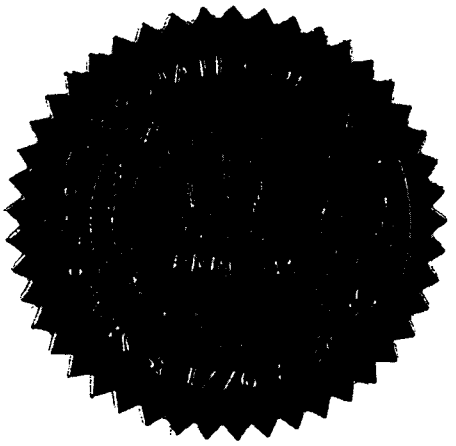
11/24/14
Date

Name: PATRICK B MCENEANEY
Title: SR. V.P, REGIONAL DIRECTOR

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that PHOENIX HOUSES OF NEW ENGLAND, INC., a(n) Rhode Island nonprofit corporation, registered to do business in New Hampshire on June 14, 1972. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 11th day of April, A.D. 2014

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, _____Peter H. Hurley_____, do hereby certify that:
(Name of the elected Officer of the Agency; cannot be contract signatory)

1. I am a duly elected Officer of ____Phoenix Houses of New England, Inc._____.
(Agency Name)

2. The following is a true copy of the resolution duly adopted at a meeting of the Board of Directors of

the Agency duly held on ____May 15, 2014_____:
(Date)

RESOLVED: That the __Senior Vice President, Regional Director_____
(Title of Contract Signatory)

is hereby authorized on behalf of this Agency to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The forgoing resolutions have not been amended or revoked, and remain in full force and effect as of

the 25th day of NOVEMBER, 2014.
(Date Contract Signed)

4. ___Patrick B McEneaney___ is the duly elected _Senior Vice President, Regional Director_____
(Name of Contract Signatory) (Title of Contract Signatory)

of the Agency.

_____
(Signature of the Elected Officer)

STATE OF Rhode Island

County of _Providence_____

The forgoing instrument was acknowledged before me this 25th day of Nov., 2014,

By Peter H. Hurley.
(Name of Elected Officer of the Agency)
PETER H. HURLEY

Ena E Paradysz
(Notary Public/Justice of the Peace)

NOTARY SEAL

Commission Expires: __5/31/17_____

ENA E. PARADYSZ
Notary Public-State of Rhode Island
My Commission Expires
May 31, 2017

PHOEHOU-01 BONESKIV

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/2/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 1185020 IOA Northeast, NY, Inc. 18 Columbia Turnpike, Suite 210 Florham Park, NJ 07932	CONTACT NAME: Vincent Boneski PHONE (A/C, No, Ext): (973) 559-6850 FAX (A/C, No): (973) 559-6855 E-MAIL ADDRESS: Vincent.Boneski@ioausa.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : LEXINGTON INSURANCE COMPANY — 19437
INSURED Phoenix Houses of New England 99 Wayland Ave. Ste 100 Providence, RI 02906	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR			6797782	07/01/2014	07/01/2015	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$ 10,000,000
	EXCESS LIAB X CLAIMS-MADE			6797781	07/01/2014	07/01/2015	AGGREGATE	$ 10,000,000
	DED X RETENTION $ 10,000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N / A (Mandatory in NH)						E L EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E L DISEASE - EA EMPLOYEE	$
							E L DISEASE - POLICY LIMIT	$
A	Medical Professional			6797782	07/01/2014	07/01/2015	Each Incident	1,000,000
A	Medical Professional			6797782	07/01/2014	07/01/2015	Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

State of New Hampshire is included as additional insured (Except Worker Compensation) where required by written contract and allowed by law.

CERTIFICATE HOLDER

State of New Hampshire Div of Public Health Svcs
29 Hazen Drive
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF LIABILITY INSURANCE 3/30/2015

DATE (MM/DD/YYYY) 3/28/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Lockton Insurance Brokers, LLC 725 S. Figueroa Street, 35th Fl. CA License #0F15767 Los Angeles CA 90017 (213) 689-0065	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED 1364887 Phoenix House of New England Inc. 99 Wayland Avenue, Suite 100 Providence, RI 02906-4313	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : New Hampshire Insurance Company — 23841 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES PHOHO01 CERTIFICATE NUMBER: 10495291 REVISION NUMBER: XXXXXXX

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY			NOT APPLICABLE			EACH OCCURRENCE	$ XXXXXXX
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ XXXXXXX
	CLAIMS-MADE OCCUR						MED EXP (Any one person)	$ XXXXXXX
							PERSONAL & ADV INJURY	$ XXXXXXX
							GENERAL AGGREGATE	$ XXXXXXX
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ XXXXXXX
	POLICY PRO-JECT LOC							$
	AUTOMOBILE LIABILITY			NOT APPLICABLE			COMBINED SINGLE LIMIT (Ea accident)	$ XXXXXXX
	ANY AUTO						BODILY INJURY (Per person)	$ XXXXXXX
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$ XXXXXXX
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$ XXXXXXX
								$
	UMBRELLA LIAB OCCUR			NOT APPLICABLE			EACH OCCURRENCE	$ XXXXXXX
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ XXXXXXX
	DED RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N / N/A If yes, describe under DESCRIPTION OF OPERATIONS below		N	WC 025052519 (NH, VT)	3/30/2014	3/30/2015	X WC STATU-TORY LIMITS OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES /(Attach ACORD 101, Additional Remarks Schedule, if more space is required)
10 days notice of cancellation for non-payment of premium. This certificate supersedes previous version issued on 3/19/2012.

CERTIFICATE HOLDER

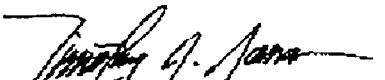
10495291

State of New Hampshire
Department of Health & Human Services

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



Financial Statements and Supplementary
Information Together With
Report of Independent Certified Public Accountants

PHOENIX HOUSES OF NEW ENGLAND, INC.

June 30, 2014 and 2013

PHOENIX HOUSES OF NEW ENGLAND, INC.

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

To the Board of Directors of
Phoenix Houses of New England, Inc.:

We have audited the accompanying financial statements of Phoenix Houses of New England, Inc. ("PH New England"), which comprise the statements of financial position as of June 30, 2014 and 2013, and the related statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's responsibility for the financial statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform our audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to PH New England's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of PH New England's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements referred to above present fairly, in all material aspects, the financial position of Phoenix Houses of New England, Inc. as of June 30, 2014 and 2013, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary Information
Our audits were conducted for the purposes of forming an opinion on the financial statements of PH New England as of and for the years ended June 30, 2014 and 2013, taken as a whole. The supplementary information included on pages 18 and 19 is presented for purposes of additional analysis and is not a required part of the financial statements. Such supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures. These additional procedures included comparing and reconciling the information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Grant Thornton LLP

New York, New York
November 12, 2014

PHOENIX HOUSES OF NEW ENGLAND, INC.
Statements of Financial Position
As of June 30, 2014 and 2013

ASSETS	2014	2013
CURRENT ASSETS		
Cash and cash equivalents	$ 248,729	$ 303,027
Due from government agencies, net of allowance of approximately $562,000 and $297,000 in 2014 and 2013, respectively	2,746,436	2,680,260
Current portion of contributions receivable, net (Note 4)	81,931	107,751
Other receivables, net of allowance of approximately $480,000 and $393,000 in 2014 and 2013, respectively	1,065,899	743,450
Prepaid expenses and other assets	223,786	229,990
Current portion of note receivable (Note 5)	5,000	5,000
Total current assets	4,371,781	4,069,478
Contributions receivable, net (Note 4)	23,604	-
Notes receivable, net of current portion (Note 5)	165,000	170,000
Property and equipment, net (Note 6)	4,727,447	4,555,608
Total assets	$ 9,287,832	$ 8,795,086
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 1,192,935	$ 959,525
Due to government agencies	45,613	7,461
Current portion of capital lease obligation (Note 6)	12,160	11,206
Current portion of long-term debt (Note 7)	22,519	21,504
Revolving loan fund (Note 8)	100,000	100,000
Total current liabilities	1,373,227	1,099,696
Due to Parent (Note 3)	2,317,921	2,181,067
Capital lease obligation, net of current portion (Note 6)	1,353	13,513
Long-term debt, net of current portion (Note 7)	212,996	235,309
Total liabilities	3,905,497	3,529,585
Commitments and contingencies (Note 13)		
NET ASSETS		
Unrestricted	5,273,028	5,126,412
Temporarily restricted (Note 10)	109,307	139,089
Total net assets	5,382,335	5,265,501
Total liabilities and net assets	$ 9,287,832	$ 8,795,086

The accompanying notes are an integral part of these financial statements.

PHOENIX HOUSES OF NEW ENGLAND, INC.
Statement of Operations and Changes in Net Assets
For the year ended June 30, 2014

	Unrestricted	Temporarily Restricted	Total
OPERATING REVENUES AND SUPPORT			
Government contract revenue	$ 14,246,899	$ -	$ 14,246,899
Client and third-party revenue (Note 9)	8,105,160	-	8,105,160
Donated goods	240,391	-	240,391
Grants and contributions	134,037	109,200	243,237
Special event revenue	17,117	-	17,117
Other revenue	69,865	-	69,865
Net assets released from restrictions - operations	138,982	(138,982)	-
Total operating revenues and support	22,952,451	(29,782)	22,922,669
EXPENSES (Note 12)			
Salaries	11,445,842	-	11,445,842
Employee benefits and payroll taxes	3,399,469	-	3,399,469
Consulting and contractual services	1,108,525	-	1,108,525
Resident sustenance	966,127	-	966,127
Occupancy costs	2,002,955	-	2,002,955
Vehicle costs	275,210	-	275,210
Communications	609,724	-	609,724
Office and program supplies	664,435	-	664,435
Insurance	252,888	-	252,888
Travel	274,902	-	274,902
Interest	13,808	-	13,808
Miscellaneous	218,482	-	218,482
Repairs and maintenance	584,810	-	584,810
Depreciation and amortization	487,457	-	487,457
Adminstrative charges from Parent	519,200	-	519,200
Total operating expenses	22,823,834	-	22,823,834
Income (loss) from operations	128,617	(29,782)	98,835
OTHER ITEMS			
Depreciation on non-operational assets	(34,001)	-	(34,001)
Total other items	(34,001)	-	(34,001)
Excess of (deficiency in) revenues over expenses	94,616	(29,782)	64,834
OTHER CHANGES IN NET ASSETS			
Contributions restricted for capital initiatives	-	52,000	52,000
Net assets released for capital initiatives	52,000	(52,000)	-
Changes in net assets	146,616	(29,782)	116,834
Net assets, beginning of year	5,126,412	139,089	5,265,501
Net assets, end of year	$ 5,273,028	$ 109,307	$ 5,382,335

The accompanying notes are an integral part of this financial statement.

PHOENIX HOUSES OF NEW ENGLAND, INC.
Statement of Operations and Changes in Net Assets
For the year ended June 30, 2013

	Unrestricted	Temporarily Restricted	Total
OPERATING REVENUES AND SUPPORT			
Government contract revenue	$ 14,482,032	$ -	$ 14,482,032
Client and third-party revenue (Note 9)	6,772,080	-	6,772,080
Donated goods and services	215,422	-	215,422
Grants and contributions	145,599	-	145,599
Special event revenue, net of costs of direct benefits to donors of approximately $16,000	98,642	-	98,642
Other revenue	28,616	-	28,616
Net assets released from restrictions - operations	17,118	(17,118)	-
Total operating revenues and support	21,759,509	(17,118)	21,742,391
EXPENSES (Note 12)			
Salaries	11,294,149	-	11,294,149
Employee benefits and payroll taxes	2,877,578	-	2,877,578
Consulting and contractual services	1,123,706	-	1,123,706
Resident sustenance	867,372	-	867,372
Occupancy costs	1,768,977	-	1,768,977
Vehicle costs	315,240	-	315,240
Communications	642,234	-	642,234
Office and program supplies	646,739	-	646,739
Insurance	263,107	-	263,107
Travel	283,480	-	283,480
Interest	19,782	-	19,782
Miscellaneous	256,579	-	256,579
Repairs and maintenance	433,595	-	433,595
Depreciation and amortization	528,702	-	528,702
Adminstrative charges from Parent	512,000	-	512,000
Total operating expenses	21,833,240	-	21,833,240
Loss from operations	(73,731)	(17,118)	(90,849)
OTHER ITEMS			
Depreciation on non-operational assets	(49,882)	-	(49,882)
Total other items	(49,882)	-	(49,882)
Excess of expenses over revenues and changes in net assets	(123,613)	(17,118)	(140,731)
Net assets, beginning of year	5,250,025	156,207	5,406,232
Net assets, end of year	$ 5,126,412	$ 139,089	$ 5,265,501

The accompanying notes are an integral part of this financial statement.

PHOENIX HOUSES OF NEW ENGLAND, INC.
Statements of Cash Flows
For the years ended June 30, 2014 and 2013

	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	$ 116,834	$ (140,731)
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Provision for doubtful accounts	352,061	285,319
Depreciation and amortization	521,458	578,584
Foregiveness of notes receivable	5,000	-
Contributions restricted for capital expenditures	(52,000)	-
Changes in operating assets and liabilities:		
Due from government agencies	(331,697)	(669,461)
Contributions receivable	2,216	26,212
Other receivables	(408,989)	547,740
Prepaid expenses and other assets	6,204	(30,791)
Accounts payable and accrued expenses	233,410	111,310
Due to government agencies	38,152	(47,485)
Due to Parent	136,854	(433,226)
Net cash provided by operating activities	619,503	227,471
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of property and equipment	(693,297)	(424,539)
Net cash used in investing activities	(693,297)	(424,539)
CASH FLOWS FROM FINANCING ACTIVITIES		
Contributions restricted for capital expenditures	52,000	-
Principal payments on capital lease	(11,206)	(23,088)
Principal payments on long-term debt	(21,298)	(20,334)
Net cash provided by (used in) financing activities	19,496	(43,422)
Net increase (decrease) in cash and cash equivalents	(54,298)	(240,490)
Cash and cash equivalents, beginning of year	303,027	543,517
Cash and cash equivalents, end of year	$ 248,729	$ 303,027
Supplemental disclosure of cash flow information:		
Interest paid	$ 13,808	$ 19,782

The accompanying notes are an integral part of these financial statements.

1. ORGANIZATION

Phoenix Houses of New England, Inc. ("PH New England") is a Section 501(c)(3) not-for-profit organization, exempt from federal income taxes under Section 501(a) of the Internal Revenue Code (the "Code"). PH New England is also exempt from state and local taxes under similar provisions. PH New England was established in order to operate therapeutic treatment centers for the rehabilitation of drug and substance abusers throughout New England.

Phoenix House Foundation, Inc. (the "Parent") is the sole member of PH New England and the following affiliated organizations: Phoenix Houses of New York, Inc. and Affiliates (which consists of Phoenix Houses of New York, Inc. and Phoenix Houses of Long Island, Inc.); Phoenix Houses of California, Inc. and Affiliates (which consists of Phoenix Houses of California, Inc.; Phoenix Houses of Los Angeles, Inc.; Phoenix House Orange County, Inc.; and Phoenix House San Diego, Inc.); Phoenix Houses of the Mid-Atlantic, Inc. and Affiliate (which consists of Phoenix Houses of the Mid-Atlantic, Inc. and Phoenix Houses of Mid-Atlantic Property Management, Inc.); Phoenix Programs of Florida, Inc.; Phoenix Houses of Texas, Inc.; American Council for Drug Education, Inc.; Center on Addiction and the Family, Inc.; and Phoenix Houses of New Jersey, Inc.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The accompanying financial statements have been prepared using the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Accordingly, the net assets of PH New England and changes therein are classified and reported based upon the existence or absence of donor-imposed restrictions as follows:

- Unrestricted net assets represent expendable resources that are used to carry out PH New England's operations and are not subject to donor-imposed stipulations.

- Temporarily restricted net assets represent resources that contain donor-imposed restrictions that permit PH New England to use or expend such resources only as or when specified. Restrictions are satisfied either by the passage of time or by actions of PH New England.

- Permanently restricted net assets contain donor-imposed restrictions that stipulate that such resources be maintained permanently. PH New England had no permanently restricted net assets at June 30, 2014 and 2013.

Cash and Cash Equivalents

PH New England considers all highly liquid financial instruments, which principally consist of money market funds, with original maturities of three months or less from the date of purchase to be cash equivalents.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. The allowance for doubtful accounts on accounts receivable and the fair value of donated goods represent significant accounting estimates reflected in the accompanying financial statements. Actual results could differ from those estimates.

Donated Goods

Donated goods are recorded as revenues and assets (at fair value when received) and expenses (when used) on the statement of operations and changes in net assets. Food stamps are recorded at face amount, which is the same as fair value, as revenues and assets and are charged to resident sustenance when expended.

Property and Equipment

Property and equipment are stated at cost, if purchased, or if donated, at fair value at the date of gift, less accumulated depreciation and amortization. PH New England capitalizes assets acquired for greater than $1,000 and with useful lives greater than one year. Depreciation is computed on the straight-line basis over the estimated useful lives of the assets as follows:

Buildings and improvements	4 - 40 years
Furniture, fixtures and equipment	3 - 7 years
Computer equipment and vehicles	3 - 5 years

Furniture, fixtures and equipment acquired under capital lease arrangements are amortized on the straight-line method over the shorter of the lease term or the estimated useful life of the asset.

Statement of Operations and Changes in Net Assets

PH New England's operating income includes all unrestricted revenues and expenses. Other items include depreciation on non-operational assets. The statement of operations and changes in net assets also includes the caption "excess of (deficiency in) revenues over expenses," which is the performance indicator. Other changes in net assets which are excluded from the performance indicator, consistent with industry practice, include restricted contributions (including assets acquired using contributions which by donor restriction are to be used for the purposes of acquiring such assets).

Revenue and Support

Contributions (including unconditional promises to give) are recorded at fair value when received. Revenues and expenses relative to special events are recognized upon occurrence of the respective event. Contributions received with donor stipulations that limit the use of the donated assets are reported as either temporarily or permanently restricted support. Unconditional promises to give, with payments due in future years, are reported as either temporarily restricted or permanently restricted support and discounted to present value. When a donor restriction expires, that is, when a time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified to unrestricted net assets and reported on the

statement of operations and changes in net assets as net assets released from restrictions. Contributions restricted by donors for the acquisition of property and equipment are released from their restrictions when the respective assets are acquired or constructed and placed into service. Such contributions and related releases are reported below the operating indicator, "excess of (deficiency in) revenues over expenses.

Special Events Revenue

Special events revenue consists of proceeds from fund-raising events, reported net of direct donor benefits, if any. Revenue and related expenses are recognized upon occurrence of the respective events to which they pertain. For the years ended June 30, 2014 and 2013, direct benefits to donors totaled approximately $0 and $16,000, respectively.

Government Contract Revenue

PH New England's contracts and other program funding arrangements with government agencies are classified as part of operating activities within the unrestricted net asset category and revenue is recognized when earned. PH New England operates under various contracts with government agencies which generally cover a one-year period, subject to annual renewal. The terms of these contracts allow the grantors the right to audit the costs incurred thereunder and adjust contract funding based upon, among other things, the amount of program income received. Any costs disallowed by the grantor would be absorbed by PH New England and any adjustments by grantors would be recorded when amounts are known; however, it is the opinion of management that disallowances, if any, would not be material to the accompanying financial statements.

Client and Third Party Revenue

Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed based on pre-determined rates. Medicaid and managed Medicaid approximated 33% and 29% of total client and third-party revenue for the years ended June 30, 2014 and 2013, respectively. Contracts have been entered into with commercial insurance carriers and reimbursement is based on contracted rates.

Laws and regulations governing healthcare programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near-term. Noncompliance with such laws and regulations could result in fines, penalties, and exclusion from such programs. The federal government and many states have aggressively increased enforcement under Medicaid antifraud and abuse legislation. PH New England believes that it is in compliance, in all material respects, with all applicable laws and regulations and, is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquires have been made, compliance with such laws and regulations can be subject to future government review and interpretation.

Noncompliance with such laws and regulations could result in repayments or amounts improperly reimbursed, substantial monetary fines, civil and criminal penalties and exclusion from the Medicaid program.

Concentration of Credit Risk

Financial instruments that potentially subject PH New England to concentrations of credit risk consist principally of cash and cash equivalents. PH New England maintains its cash and cash equivalents in various bank deposit accounts that, at times, may exceed federally insured limits. PH New England's cash and cash equivalents have been placed with high credit quality financial institutions at June 30, 2014 and 2013, and PH New England believes the risk of nonperformance by these financial institutions is remote.

PH New England provides drug and alcohol rehabilitation services through its inpatient and outpatient care facilities. PH New England grants credit without collateral to clients, however, it routinely obtains assignment of (or is otherwise entitled to receive) clients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicaid and commercial insurance providers).

Amounts due from government agencies and other receivables by financial class as a percentage of total accounts receivable at June 30, 2014 and 2013, are as follows:

	2014	2013
Medicaid	18 %	14 %
Commercial insurance	29	24
Other third-party payors	50	59
Self-pay	3	3
	100 %	100 %

Income Taxes

Guidance in the area of "*Accounting for Uncertainty in Income Taxes,*" under the Financial Accounting Standards Board (FASB) Accounting Standard Codification, clarifies the accounting for uncertainty in tax positions taken or expected to be taken in a tax return, including issues relating to financial statement recognition and measurement. This standard provides that the tax effects from an uncertain tax position can be recognized in the financial statements only if the position is "more-likely-than-not" to be sustained if the position were to be challenged by a taxing authority. The standard also provides guidance on measurement, classification, interest and penalties, and disclosure. The adoption of this standard by PH New England has not had an impact on the accompanying financial statements. The tax years ended 2011, 2012, 2013 and 2014 are still open to audit for both federal and state purposes. PH New England has processes presently in place to ensure the maintenance of its tax-exempt status; to identify and report unrelated income; to determine its filing and tax obligations in jurisdictions for which it has nexus; and, to identify and evaluate other matters that may be considered tax positions.

Subsequent Events

PH New England evaluated its subsequent events through November 12, 2014, the date these financial statements were available to be issued.

3. RELATED PARTY TRANSACTIONS

PH New England is charged for administrative services provided by its Parent based upon a cost allocation plan. The administrative expenses charged by the Parent approximate the federally approved indirect cost rate for the Parent and its affiliates on a consolidated basis, adjusted to reflect PH New England's own administrative expenses. During the years ended June 30, 2014 and 2013, such allocated charges totaled $519,000 and $512,000, respectively, and are included as part of the administrative charges from Parent expense on the accompanying statements of operations and changes in net assets.

Amounts reflected as due to Parent on the accompanying statements of financial position of approximately $2,318,000 and $2,181,000 as of June 30, 2014 and 2013, respectively, relate to costs incurred by PH New England but paid for by the Parent.

4. CONTRIBUTIONS RECEIVABLE

At June 30, 2014 and 2013, PH New England's contributions receivable, net, consists of the following:

	2014	2013
Amounts expected to be collected:		
In less than one year	$ 81,931	$ 107,751
In one to three years	25,000	-
	106,931	107,751
Less: Discount to present value (at a rate of 4.01%)	(1,396)	-
	$ 105,535	$ 107,751

Multi-year pledges received are recorded at the present value of their expected future cash flows using a credit adjusted discount rate which articulates with the collection period of the respective pledge. Discount rates assigned to multi-year pledges in the year of origination are not subsequently adjusted.

5. NOTES RECEIVABLE

During May 2012, PH New England entered into a lease and promissory agreement with Central Vermont Community Land Trust ("CVCLT"), a non-profit corporation existing under the laws of the State of Vermont. In conjunction with a new program, PH New England agreed to lease a facility from CVCLT for twenty years. As part of the lease agreement, PH New England entered into a non-interest bearing note of $100,000 payable by CVCLT and secured by a mortgage of and security interest in the property in Barre, Vermont. The principal of this note does not bear interest nor will any principal be due at any time during which the lease between PH New England and CVCLT is in effect and for a period beginning on the date of termination of the lease and ending on the last day of the twelfth calendar month after such date. The principal due shall be reduced by $5,000 each year for the initial twenty year term of the lease, beginning with the commencement of the new program, beginning July 1, 2013. In the event the lease is in effect throughout the entire initial 20 year term, the note shall be deemed paid in full upon the conclusion of such term. In the event the lease terminates prior to the conclusion of the initial lease term, then the remaining principal shall be due and payable on the last day of the twelfth full calendar month following termination

of the lease. Interest shall begin to accrue on such remaining principal balance beginning on the first day of the first month following the due date at a rate equal to the U.S. Department of the Treasury One Year Treasury Bill Rate in effect on the due date. At June 30, 2014 and 2013, the balance of this note receivable was $95,000 and $100,000, respectively.

During July 2010, PH New England entered into a lease and promissory agreement with Burlington Housing Authority ("BHA"), a housing authority existing under the laws of the State of Vermont and the City of Burlington. In conjunction with a new program, PH New England agreed to lease a facility from BHA for twenty-five years. As part of the lease agreement, PH New England entered into a non-interest bearing note of $75,000 due and payable by BHA on the last day of the twelfth full calendar month immediately following the termination of the lease. Interest accrues on the principal balance of this note, beginning on the first day of the first month following the Due Date, at a rate equal to the One Year Treasury Bill rate in effect on that date. At June 30, 2014 and 2013, the balance of this note receivable was $75,000.

6. PROPERTY AND EQUIPMENT, NET

At June 30, 2014 and 2013, property and equipment, net, consists approximately of the following:

	2014	2013
Land	$ 77,000	$ 69,000
Buildings and improvements	9,485,000	8,923,000
Furniture, fixtures and equipment	1,163,000	1,043,000
Computer equipment	801,000	801,000
Vehicles	45,000	45,000
Construction-in-progress	10,000	7,000
	11,581,000	10,888,000
Less: Accumulated depreciation and amortization	(6,854,000)	(6,332,000)
	$ 4,727,000	$ 4,556,000

Included in property and equipment are assets acquired under a capital lease arrangement. At June 30, 2014 and 2013, furniture acquired under capital lease arrangements had a cost, each year, of approximately $170,000, and accumulated amortization of approximately $160,000 and $142,000, respectively. Principal payments related to these capital leases totaled approximately $11,000 and $23,000, respectively, for the years ended June 30, 2014 and 2013. The capital lease bears interest at a rate of 8.2% with monthly payments through August 2015. Amounts outstanding under these capital leases as of June 30, 2014 and 2013 totaled approximately $14,000 and $25,000, respectively.

Approximate annual principal payments due on capital leases are as follows for the years ended June 30:

2015	$ 12,000
2016	1,000
	$ 13,000

7. LONG-TERM DEBT

At June 30, 2014 and 2013, long-term debt consists of the following:

- On May 1, 2007, PH New England entered into a loan agreement with Citizens Bank of Rhode Island in the amount of $146,000 due in 120 monthly installments with a final balloon payment at the end of the term. The interest rate resets in the fifth year of the loan at a rate equal to the then 5-Year Treasury Constant Maturity rate plus an additional one hundred and seventy-five basis points (175) which resulted in a rate of 2.59% effective June 2012 through the term of the loan agreement in April 2017. The proceeds of the loan were used to purchase and renovate a building. Amounts due under the mortgage are secured by the property purchased. At June 30, 2014 and 2013, the balance of this mortgage payable was approximately $93,000 and $102,000, respectively.

- On July 18, 2008, PH New England entered into a loan agreement with Citizens Bank of Rhode Island in the amount of $200,000 due in 120 monthly installments with a final balloon payment, including interest amortized over fifteen years at a rate of 6.465%, through July 2018. The proceeds of the loan were used to purchase and renovate a building in Holyoke, MA. Amounts due under the mortgage are secured by property in Springfield, MA. At June 30, 2014 and 2013, the balance of this mortgage payable was approximately $143,000 and $155,000, respectively.

Approximate annual principal payments due on all debt are as follows for the years ended June 30:

2015	$ 23,000
2016	24,000
2017	85,000
2018	14,000
2019	90,000
	$ 236,000

8. REVOLVING LOAN FUND

In relation to the acquisition of RICAODD, PH New England assumed an agreement, the Rhode Island Revolving Loan Fund Project- R House, with the State of Rhode Island's Department of Mental Health - Retardation and Hospitals. The revolving loan fund program is a federally mandated program established to provide financial assistance loans to residents of group homes for recovering substance abusers. The State of Rhode Island has provided PH New England with $100,000 to fund these interest-free loans. The revolving loan fund account increases with interest earned on funds on deposit and decreases as a result of uncollectible loans. The loan fund assets are recorded within cash and cash equivalents and other receivables on the accompanying statements of financial position. The loan is due to the State of Rhode Island upon dissolution of the program. Outstanding loans receivable as of June 30, 2014 and 2013 were approximately $6,500 and $26,000, respectively.

9. CLIENT AND THIRD-PARTY REVENUE

For the years ended June 30, 2014 and 2013, client and third-party revenue consists approximately of the following:

	2014	2013
Healthcare services	$ 2,811,000	$ 2,075,000
Food stamps	174,000	269,000
Private insurance and client payments	3,789,000	3,068,000
Client fees	1,055,000	1,077,000
School lunch program	75,000	85,000
Education, tutoring, and other	201,000	198,000
	$ 8,105,000	$ 6,772,000

10. TEMPORARILY RESTRICTED NET ASSETS

At June 30, 2014 and 2013, temporarily restricted net assets are available for the following purposes:

	2014	2013
Capital initiatives	$ 13,000	$ 63,000
Program initiatives	96,000	76,000
	$ 109,000	$ 139,000

For the years ended June 30, 2014 and 2013, net assets totaling approximately $191,000 and $17,000, respectively, were released in satisfaction of donor-imposed restrictions for program and capital initiatives.

11. TAX-DEFERRED ANNUITY PLAN

PH New England has a tax-deferred annuity plan, which is sponsored by the Parent, for all eligible employees under Section 403(b) of the Code. PH New England makes contributions equal to 3% to 10% of each active participant's compensation, based on years of service, as defined in the plan agreement. Total contributions to this plan by PH New England for fiscal 2014 and 2013, totaled approximately $500,000 and $420,000, respectively, and is recorded as part of employee benefits and payroll taxes on the accompanying statements of operations and changes in net assets.

12. FUNCTIONAL EXPENSES

PH New England provides drug and alcohol rehabilitative healthcare services to clients and related support activities as described in Note 1. Expenses related to providing these services, included in the statements of operations and changes in net assets for the years ended June 30, 2014 and 2013, are as follows:

	2014	2013
Residential treatment services	$ 13,795,221	$ 12,533,583
Ambulatory treatment services	3,270,394	3,873,810
Healthcare services	2,523,228	2,309,259
Prevention and education services	-	32,622
Adminstration and general	3,109,688	2,939,191
Fundraising	125,303	144,775
Total expenses	$ 22,823,834	$ 21,833,240

13. COMMITMENTS AND CONTINGENCIES

Lease Commitments

PH New England leases facilities, vehicles and other equipment under various non-cancelable operating leases expiring at various dates through fiscal 2019. Total expense under these leases was approximately $927,000 and $738,000 for the years ended June 30, 2014 and 2013, respectively.

Future minimum rental payments due are approximately as follows for the years ended June 30:

2015	$ 769,000
2016	484,000
2017	395,000
2018	232,000
2019	94,000
	$ 1,974,000

In addition, PH New England rents certain facilities under operating leases on a month-to-month basis. Rent expense relating to these month-to-month leases totaled approximately $312,000 and $417,000 for the years ended June 30, 2014 and 2013, respectively.

Litigation

PH New England is contingently liable under various claims which have arisen in the ordinary course of its business. In the opinion of management, the claims will be defended as appropriate and, in certain cases, are adequately covered by insurance. PH New England believes that the resolution of these matters will not have a material effect on its financial position, changes in net assets or cash flows.

Other

PH New England's title to the facility located in Exeter, RI, is subject to a right of reversion held by the State of Rhode Island if PH New England, or its designee, fails at any time within 25 years from the date of execution of the deed to comply with all the terms and conditions set forth in the deed and related attachments. The deed was executed on November 20, 1990. The terms of the deed include, among other pertinent provisions, that the property be used to provide long-term residential drug dependency treatment, provide for the increase of current drug dependency treatment slots, conduct research into efficient treatment methods and length of stay, and provide individual and group counseling and training.
PH New England believes that it has and will continue to operate this facility consistent with these stated purposes and has included this facility within property and equipment on the accompanying statements of financial position.

SUPPLEMENTARY INFORMATION

PHOENIX HOUSES OF NEW ENGLAND, INC.
Supplemental Information – Schedule of Functional Expenses
For the year ended June 30, 2014

	Program Services				Supporting Services			
	Residential Treatment Services	Ambulatory Treatment Services	Healthcare Services	Total	Administration and General	Fund-raising	Total	Total
Salaries	$ 6,682,582	$ 2,008,935	$ 1,295,805	$ 9,987,322	$ 1,388,751	$ 69,769	$ 1,458,520	$ 11,445,842
Employee benefits and payroll taxes	1,966,771	594,111	379,656	2,940,538	439,098	19,833	458,931	3,399,469
Consulting and contractual services	643,061	91,395	89,304	823,760	284,765	-	284,765	1,108,525
Resident sustenance	814,652	-	151,475	966,127	-	-	-	966,127
Occupancy costs	1,430,202	263,787	110,521	1,804,510	188,418	10,027	198,445	2,002,955
Vehicle costs	185,225	12,963	4,365	202,553	72,657	-	72,657	275,210
Communications	429,819	79,291	44,306	553,416	51,860	4,448	56,308	609,724
Office and program supplies	372,738	60,586	157,960	591,284	63,446	9,705	73,151	664,435
Insurance	177,315	31,332	33,810	242,457	9,649	782	10,431	252,888
Travel	106,897	63,490	57,823	228,210	42,463	4,229	46,692	274,902
Interest	13,808	-	-	13,808	-	-	-	13,808
Miscellaneous	158,427	13,906	7,326	179,659	33,176	5,647	38,823	218,482
Repairs and maintenance	452,492	25,873	94,245	572,610	11,706	494	12,200	584,810
Depreciation and amortization	361,232	24,725	96,632	482,589	4,499	369	4,868	487,457
Administrative charges from Parent	-	-	-	-	519,200	-	519,200	519,200
Total expenses reported by function	$ 13,795,221	$ 3,270,394	$ 2,523,228	$ 19,588,843	$ 3,109,688	$ 125,303	$ 3,234,991	$ 22,823,834

This schedule should be read in conjunction with the accompanying report of independent certified public accountants and the financial statements and notes thereto.

PHOENIX HOUSES OF NEW ENGLAND, INC.
Supplemental Information – Schedule of Functional Expenses
For the year ended June 30, 2013

	Program Services					Supporting Services				
	Residential Treatment Services	Ambulatory Treatment Services	Healthcare Services	Prevention and Education Services	Total	Administration and General	Fund-raising	Costs of Direct Benefits to Donors	Total	Total
Salaries	$ 6,315,014	$ 2,386,264	$ 1,157,038	$ 25,410	$ 9,883,726	$ 1,333,685	$ 76,738	$ -	$ 1,410,423	$ 11,294,149
Employee benefits and payroll taxes	1,608,309	613,103	307,393	6,812	2,535,617	323,019	18,942	-	341,961	2,877,578
Consulting and contractual services	489,144	230,956	110,950	-	831,050	292,656	-	-	292,656	1,123,706
Resident sustenance	747,765	346	118,866	-	866,977	-	395	14,032	14,427	881,404
Occupancy costs	1,254,505	260,006	100,735	-	1,615,246	141,094	12,637	-	153,731	1,768,977
Vehicle costs	213,693	11,988	10,070	-	235,751	79,489	-	-	79,489	315,240
Communications	422,728	95,094	58,573	-	576,395	60,656	5,183	-	65,839	642,234
Office and program supplies	385,520	65,617	131,913	-	583,050	50,802	12,887	-	63,689	646,739
Insurance	166,215	35,109	30,462	400	232,186	30,421	500	-	30,921	263,107
Travel	78,546	99,037	61,265	-	238,848	38,245	6,387	1,225	45,857	284,705
Interest	16,383	-	-	-	16,383	3,399	-	-	3,399	19,782
Miscellaneous	153,260	25,752	7,520	-	186,532	60,974	9,073	479	70,526	257,058
Repairs and maintenance	296,867	25,344	105,467	-	427,678	4,655	1,262	-	5,917	433,595
Depreciation and amortization	385,634	25,194	109,007	-	519,835	8,096	771	-	8,867	528,702
Administrative charges from Parent	-	-	-	-	-	512,000	-	-	512,000	512,000
Total functional expenses	12,533,583	3,873,810	2,309,259	32,622	18,749,274	2,939,191	144,775	15,736	3,099,702	21,848,976
Less: Costs of direct benefits to donors for special event	-	-	-	-	-	-	-	(15,736)	(15,736)	(15,736)
Total expenses reported by function	$ 12,533,583	$ 3,873,810	$ 2,309,259	$ 32,622	$ 18,749,274	$ 2,939,191	$ 144,775	$ -	$ 3,083,966	$ 21,833,240

This schedule should be read in conjunction with the accompanying report of independent certified public accountants and the financial statements and notes thereto.

PHOENIX HOUSES OF NEW ENGLAND
Board of Directors

Phoenix Houses of New England is a not-for-profit. No officers or directors have a percentage of ownership.

SHERI L. SWEITZER
[redacted]

SCOTT BICKFORD
Chief Executive Officer
Air Planning, LLC
[redacted]

RACHEL KAPLAN CALDWELL
Associate Legal Counsel
Health Care & Regulatory
CVS Caremark
[redacted]

SEAN T. COTTRELL
Vice President
Starkweather & Shepley Insurance Brokerage, Inc.
[redacted]

ALAN ELAND
Teacher
Moses Brown School
[redacted]

WILLIAM T. FISHER, JR., Ed.D, M.S.W.
Director of Field Education
Professor of Social Work
Springfield College
[redacted]

THE HONORABLE MAUREEN McKENNA GOLDBERG
Associate Justice
Rhode Island Supreme Court
[redacted]

PETER H. HURLEY
Peter H. Hurley Real Estate
[redacted]

DANIEL J. JAEHNIG
News Anchor
NBC 10
[redacted]

RANDY R. MARTINEZ
Director, Diversity Strategy and Management
CVS Caremark
[redacted]

DONALD C. McQUEEN
Senior Vice President
Bank of America Merrill Lynch
[redacted]

HOWARD P. MEITINER
President & Chief Executive Officer
Phoenix House Foundation
[redacted]

PETER H. OTTMAR
Chairman
TWOBOLT
[redacted]

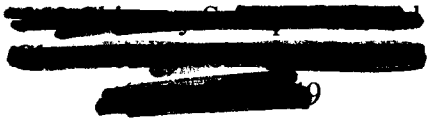
DONALD P. WOLFE
Executive Director
McAuley Corporation
[redacted]

PHOENIX HOUSES OF NEW ENGLAND

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Patrick McEneaney	Executive Director	235,000	0%	0
Susan Shubitowski	Finance Director	155,000	0%	0
Neil Gaer	Senior Program Director	140,000	0%	0
Peter DalPra	Program Director	62,000	80%	49,600
Amelie Gooding	Program Director	78,000	0%	0

Patrick B. McEneaney



Work Experience

2008 – Present: Phoenix Houses of Florida
1999 - Present: Phoenix Houses of New England
Senior Vice President, Regional Director

Responsible for the fiscal, clinical and administrative operation of two organizations that encompasses fifty programs in forty-seven sites located in seven states.

- Develops short and long range goals and objectives for the organizations.
- Establishes policy that reflects the agency's mission and Board directives.
- Oversees the fiscal integrity of the agencies.
- Supervises senior staff.
- Interacts with state and community officials to affect the delivery of quality behavioral healthcare services.
- Has grown the New England region from $7.1 million in revenue in 1999 to approximately $19 million in Fiscal Year 2009 with surpluses during each of the past five fiscal years.
- Has stabilized the Florida regional budget and is securing additional revenue streams.

1998-1999 Consultant Glastonbury, CT
Private Consultant

Provided services related to human resources to the health care industry.

1986-1998 Catholic Medical Center Jamaica, NY
Vice President, Human Resources

Responsible for human resources administration in a 1300 bed, multi facility health care delivery system with over 6700 employees.

- Supervised forty-five corporate and facility based staff
- Assisted in the development and administration of a $350 million dollar compensation budget.
- Acted as chief labor negotiator and maintained productive relationships with eight unions.
- Developed deferred compensation programs and acted as Management Trustee for pension funds in excess of $4 billion in assets.

- Played a leadership role in ensuring compliance with regulatory mandates.

1979-1986 St. John's Queen's Hospital Division Elmhurst, NY
Director of Personnel

Catholic Medical Center Jamaica, NY
Associate Director, Personnel and Labor Relations

Positions held concurrently. Responsible for human resources and labor relations.

- Revised HR policies and introduced new orientation and staff development programs.
- Developed an innovative information system.
- Developed and administered annual operating budget.
- Established and maintained excellent working relationships with union representation and improved procedures for conflict resolution.

1976-1979 Catholic Medical Center Jamaica, NY
Various Human Resource positions

Positions held included Affirmative Action Coordinator, Director of Labor Relations and Assistant Personnel Director.

1993-1999 St. John's University Jamaica, NY

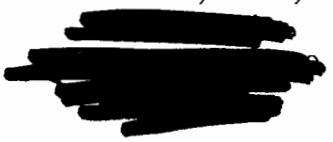
Education

1990 Baruch College, City University of New York
Executive MBA

1984 Cornell University, Ithaca, NY
Labor Relations Certificate Program

1975 Queens College, City University of New York

NEIL S. GAER, MPA, CADC



PROFILE

- Directed client care from consultation to supervision; expertise lies in the field of alcohol and other drug rehabilitation.
- Conducted Substance Abuse Program Development and Implementation
- Empathetic leader, with solid ethics and boundaries, high aspirations and skilled in oral/written communication.
- Contributed to the success and growth of a national alcohol and drug rehabilitation business.
- Effectively able to interact with diverse populations.

AREAS OF EXPERTISE

Program Development

- Established residential and ambulatory adult, adolescent and criminal justice drug rehabilitation programs from inception.
- Developed management programs that meet national accreditation standards.
- Initiated progressive program development including internal program evaluation.

Management

- Recognized for effectively supervising the daily activities of a regional alcohol and drug rehabilitation agency; overseeing the management of twelve programs in four states.
- Manage regional operations including budget administration, fiscal management, compliance with local, state and federal contractual agreements and regulations, personnel issues and evaluations, inventory control and building maintenance.
- Conducted weekly staff meetings to develop professional growth and improve overall skill levels.

Communication

- Organized countless public relations activities; adept at describing the importance of alcohol and drug rehabilitation to diverse groups such as civic and community-based organizations.
- Assembled Community Advisory Boards designed to ensure quality care and substance abuse education and prevention.
- Worked collaboratively with human and social service agencies to identify and defined the needs of the community.

WORK HISTORY

01 –Present	Phoenix House of New England, Providence Rhode Island Vice President, Director Clinical Affairs/ Senior Program Director, Massachusetts and New Hampshire
00 – 01	Phoenix House Foundation, New York, New York Deputy Director National Training
99 – 00	MARATHON, Inc/Phoenix Houses of New England Program Director, Phoenix House Springfield Center
8/97-99	Alcohol Drug Recovery Center, Hartford, Connecticut *Detoxification Counselor/Out Patient Assessment Counselor*
4/97-7/97	Community Prevention & Addiction Services, Willimantic, Connecticut *State Administered General Assistance Case Manager*
1990 - 1997	MARATHON, INC., Providence, Rhode Island Marathon House, Dublin, New Hampshire *Case Coordinator; 1990 - 1995* Marathon of Keene, Keene, New Hampshire *Program Supervisor; 1995 - 1997*

EDUCATION

UNIVERSITY NEW HAVEN, New Haven, Connecticut
Masters of Public Administration

SPRINGFIELD COLLEGE, Springfield, Massachusetts
Bachelor of Science, Human Services

SUMMARY OF QUALIFICATIONS

Certified Alcohol and Drug Counselor, Massachusetts #1014AD
Licensed Alcohol and Drug Counselors - 1, Massachusetts # 201
NIDA Resource Specialist Addiction Severity Index
Conducted Substance Abuse Program Development and Implementation

Susan Shubitowski
[redacted]

Job Title **Vice President and Regional Director of Finance**

Professional Experience

Phoenix Houses of NE, Inc., Providence, RI 2000-present
Regional Director of Finance

Responsible for all financial functions within the New England region, including management of contract and third party billing, direct over sight of financial statement preparation, presentation of financial statements to the board of directors, preparation of budgets for contract proposals, and completion of other documentation as requested by various government agencies within five states of operation. Oversee accounting staff and work with program directors to manage budget variances, and monitor program financial performance. Use Lawson Accounting System, CATS, Microsoft Office Suite and various tax programs.

LogoAthletic, Inc., Mattapoisett, MA 1991-2000
Accounting Manager

Responsibilities include preparation of monthly financial statements with related schedules and analyses, reconciliation of inter-company transactions, preparation and maintenance of budgets, and supervision of accounts payable processing, royalty reporting, commission payments, and international banking. Worked directly with auditors, both internal and external. Used Peachtree Accounting Complete for Windows, Microsoft Office, ClarisWorks, SAMMS, Millennium, JBA, and SAP.

Omega Electric Co., Inc., Providence, RI 1989-1990
Controller

Supervised all aspects of accounting function. Responsible for preparation of all financial reports and reconciliation to general ledger, including the preparation of monthly financial statements, tracking of jobs in progress, and oversight of payroll, accounts receivable and account payable functions. Assisted outside auditor in preparation of quarterly and yearly financial statements. Active in A/R collections. Also responsible for other small companies owned by the president of Omega, and intercompany reconciliations. Used Xerox PC with Contrak II, Lotus 123, Word and Formdesigner.

Reliable Truss Co., Inc., New Bedford, MA 1985-1989
General Accountant

Responsibilities included month-end and year-end closing, financial statements, account analyses, bank reconciliations, insurance schedule, payroll and payroll taxes. Also responsible for other small companies owned by the president of Reliable Truss, and reconciliation of inter-company accounts. Used IBM PC with One-Write, System 2.

Education

MBA – Business Administration
University of Massachusetts Dartmouth, 2002 – Beta Gamma Sigma
Bachelor of Science - Accounting
Southeastern Massachusetts University, 1988

References available upon request

AMELIE GOODING MA
[redacted]
603-352-7825
603-361-1702
[redacted]

SKILLS:
Twenty-five years of management and clinical experience in Substance Abuse and Mental Health services
Expertise in staff hiring, training, and supervision
Responsible for developing a continuum of care and related quality assurance and outcome measures
Experience in contract negotiation and management with government agencies and third party payers
Psychiatric and substance abuse assessment and interviewing skills
Individual, group and family psychotherapy skills
Team building and Motivational Enhancement expertise
Grant writing and fiscal management experience
Public relations and community development experience

PROFESSIONAL EXPERIENCE:

5/1999-present: PROGRAM DIRECTOR
Phoenix House-Keene Center, Keene NH
Create and manage a continuum of care ranging from Detoxification services and residential treatment to Intensive Outpatient and Adolescent Outpatient Services. Develop new payment streams and referral sources; submit grants and work with various agencies; prepare for and obtain CARF accreditation,.

9/2000-present: CLINICAL CONSULTANT
Vermont Academy, Saxtons River VT & Proctor Academy, Andover NH
Conduct alcohol and drug assessments on students caught using chemical substances. Interview student and parents and submit report to student, family and school.

6/1997-4/1999: CLINICAL DIRECTOR
Marathon Behavioral Treatment Services, Keene NH
Develop, implement and direct residential substance abuse and dual diagnosis treatment; oversee Crisis/Detox services, Outpatient services, including a prison diversion program, and Transitional Living program. Hire, train, and supervise a clinical staff of 10. Implement and oversee Quality Assurance

10/91-11/92: CLINICAL DIRECTOR OF DUAL DIAGNOSIS SERVICE
Spofford Hall, Spofford NH
Manage a 15-bed inpatient rehabilitation unit and supervise a 12 -member clinical staff; develop and implement dual diagnosis program; conduct individual and group therapy; conduct treatment planning, quality assurance and clinical supervision.

10/85-9/91: PROGRAM DIRECTOR, MENTAL HEALTH UNIT
The Cheshire Medical Center, Keene NH
Hire and supervise a seven-member clinical staff; implement and oversee inpatient programming for 10 adults and 10 adolescents; ER triage and assessment and crisis management; initiate and co-sponsor quarterly educational symposia for professional community

9/83-8/85: COORDINATOR OF PSYCHIATRIC SERVICES /STAFF THERAPIST
C.B. Wilson Center, Faribault, MN
Clinically manage a ten-bed adolescent unit and carry a case load of five clients for individual therapy (5 times weekly) and case management; co-lead four groups weekly; facilitate team meeting and write up weekly treatment plans.

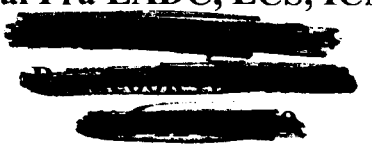
EDUCATION:

2007-2008	NEW ENGLAND LEADERSHIP INSTITUTE State Sponsored 6 day training at Antioch New England Year-long mentorship project on leadership style
1983	ANTIOCH UNIVERSITY **MASTERS OF ARTS IN COUNSELING** Adolescent specialization
1975	VASSAR COLLEGE **BACHELOR OF ARTS** double major: French and Psychology

LICENSURE:
1999: Licensed as a Clinical Mental Health Counselor in New Hampshire with Addiction Specialization #326
2006: Licensed as a Drug and Alcohol Counselor in New Hampshire #0592
2008: Licensed as Master's Prepared Drug and Alcohol Counselor in NH #0592

BOARD MEMBERSHIP:2004: New Hampshire Alcohol & Other Drug Services Providers Association
Vice-President for Treatment. Re-elected in 2008
2009: Re-Appointed for a second term to Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Of Alcohol and Drug policy
2008: Co-Chair of the Governor's Commission Treatment Task Force

Peter A. Dal Pra LADC, LCS, ICADC, ICCS



EDUCATION

New Hampshire Technical Institute
Concord, New Hampshire
Associate in Science Degree in Human Services with a Major in Alcohol and Drug Abuse Counseling.
Received May 20, 1994 with Honors.

PROFESSIONAL EXPERIENCE

March 2, 2009 To Present	Phoenix House, Franklin Center Franklin, NH Program Director
July 2000 to Present	DalPra Counseling Services Subcontracting with: LTG Counseling-Manchester, NH
Jan. 2002 to Nov. 2008	Serenity Place, Manchester NH Interim Executive Director Clinical Director/Supervisor
Apr. 2001 to Jan. 2002	Community Alliance for Teen Safety-Teen Resource Exchange, Derry NH Alcohol & Drug Counselor
Oct. 1997 to May 2001	NH Division of Alcohol and Drug Abuse Prevention & Recovery Chemical Dependency/ HIV AIDS/Prevention Case Manager
Sept. 1997 to June 2000	Southeastern NH Services, Dover NH NH State Certified IDIP Instructor
Sept. 1994 to Oct. 1997	Nashua Public Health Department, Nashua, New Hampshire HIV/AIDS Street Outreach Worker.
July 1994 to Feb. 1995	Seaborne Hospital, Dover, New Hampshire Adult/Adolescent Units Counselor I
Feb. 1993 to Nov. 2008	Serenity Place-REAP, Manchester, New Hampshire NH State Certified IDIP Instructor

PROFESSIONAL SOCIETIES

May 1998	NAADAC National Association of Addiction Professionals
May 1998	NHADACA NH Association of Alcoholism and Drug Abuse Counselors

PERSONAL

Adjunct Faculty NH Technical Institute, Concord NH
Licensed Alcohol and Drug Abuse Counselor, March 1998 Lic. # 0439
Licensed Clinical Supervisor, August 2006 Lic # 029
Internationally Certified Alcohol & Drug Counselor ICADC # 19095
Internationally Certified Clinical Supervisor ICCS # 01965
Nationally Certified Trainer:
"Preventing HIV Disease Among Substance Abusers".
"Reaching Adolescents with Risk Free Messages".
Faculty New England Institute of Addiction Studies (NEIAS) 2007, 2008, 2009
Past President Board of Directors-Manchester NH East Little League
Past Member Board of Director-Manchester East Little League
Past President– NH Alcohol and Drug Abuse Counselors Association
Retired Board Member- NH Alcohol and Drug Abuse Counselors Association
Co-Chair Legislative Policy Committee- NH Alcohol and Drug Abuse Counselors Association
Member NH Board of Alcohol & Other Drug Abuse Professional Practice-Peer Review Committee
Former Member Board of Directors- Southern NH AIDS Task Force
Former Member Health & Safety Committee Greater Nashua Red Cross
Senior Staff-NH Teen Institute Summer Program
Co-Director NH Teen Institute Summer Program 2006, 2009
Certified "Challenge Course Instructor"
Advisory Board Member Southern NH Integrated Health Care Program
Member Demand Treatment Coalition
Member Northern Hillsborough County Coalition
Certified Instructor PRIME for LIFE
2003 Jefferson Award Recipient
Former Board of Director-NH Alcohol and Other Drug Service Providers Association
Member Governor's Commission on Alcohol Prevention, Intervention and Treatment-Treatment Task Force
Former Member Mobile Community Health Team Project-Homeless Healthcare Advisory Board
Governor Lynch Appointee to the Commission to Examine Driving While Impaired (DWI) Education and Intervention Programs
2007 Legislative Advocate Award Recipient from NHADACA
2009 Lifetime Advocacy Award Recipient from NHADACA

REFERENCES

Available upon request

99

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF COMMUNITY BASED CARE SERVICES

Bureau of Drug and Alcohol Services

Nicholas A. Toumpas
Commissioner

Diane Langley, Director
Sheri Rockburn, Director

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6738 1-800-804-0909
Fax: 603-271-6105 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

May 30, 2014

Sole Source

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug and Alcohol Services, to enter into **sole source** amendments with multiple vendors increasing the price limitations by $7,444,467 in the aggregate from $14,888,937 to an amount not to exceed $22,333,404 in the aggregate for a continuum of substance abuse treatment services state-wide and extending the completion date from June 30, 2014 to June 30, 2015, effective July 1, 2014 or date of Governor and Executive Council approval, whichever is later.

52.9% Federal / 47.1 General

Summary of contracted amounts by vendor:

Contractor	Current Budget	Increase/Decrease Amount	Revised Modified Budget
Child & Family Services	$ 173,606	$ 86,803	$ 260,409
Concord Hospital	$ 148,812	$ 74,406	$ 223,218
Families First of the Greater Seacoast	$ 57,844	$ 28,922	$ 86,766
Families in Transition	$ 665,060	$ 332,530	$ 997,590
Grafton County	$ 138,822	$ 69,411	$ 208,233
Greater Nashua Council on Alcoholism	$ 2,713,890	$ 1,356,945	$ 4,070,835
Headrest, Inc.	$ 502,900	$ 251,450	$ 754,350
Horizons Counseling Center, Inc.	$ 379,152	$ 189,576	$ 568,728
Manchester Alcoholism Rehabilitation Center	$ 2,241,198	$ 1,120,599	$ 3,361,797
The Mental Health Center of Greater Manchester, Inc.	$ 54,228	$ 27,114	$ 81,342
Phoenix Houses of New England, Inc.	$ 2,914,980	$ 1,457,490	$ 4,372,470
National Council on Alcoholism and Drug Dependence of Greater Manchester	$ 864,936	$ 432,468	$ 1,297,404
Southeastern New Hampshire Alcohol and Drug Abuse Services	$ 2,659,672	$ 1,329,836	$ 3,989,508
Tri-County Community Action Program	$ 1,223,811	$ 611,904	$ 1,835,715
The Youth Council	$ 150,026	$ 75,013	$ 225,039
Totals	$ 14,888,937	$ 7,444,467	$22,333,404

Funds to support this request are anticipated to be available in the following accounts in SFY 2015 upon the availability and continued appropriation of funds in the future operating budgets, with

authority to adjust amounts within the price limitation and amend the related terms of the contracts without further approval from Governor and Executive Council.

05-95-49-491510-2989 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, GOVERNOR COMMISSION FUNDS (100% General Funds)

05-95-49-491510-2990 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, CLINICAL SERVICES (34.4% General 65.6% Federal)

Please see Attachment A for financial details

EXPLANATION

These **sole source** actions are requested to provide a continuum of substance abuse treatment services for SFY 2015 as the healthcare landscape in New Hampshire rapidly changes with the implementation of the New Hampshire Health Protection Program (NHHPP). Under the New Hampshire Health Protection Program a substance use disorders benefit will be made available in New Hampshire on a limited Medicaid basis for the first time. As a result of these changes and the immediacy with which the New Hampshire Health Protection Program is being implemented, the Department determined it was necessary to put forth a sole source amendment for this transition year. This Requested Action to approve 15 of 15 amendments totaling $7,444,467 is anticipated to be spent state-wide for services that include community based outpatient, intensive outpatient, residential, transitional living, and recovery support services, including specialized treatment services for pregnant and parenting women and their children. Funds are used to support services for individuals who are not eligible for Medicaid or the New Hampshire Health Protection Program and for services not covered by these programs. See Matrix of Services (Attachment B).

Client eligibility for treatment services is targeted at those either unable to pay for services or able to pay only part of the cost of services, and who has or is suspected of having an alcohol or other drug abuse problem, and who is a resident of the State of New Hampshire or is homeless in NH. Previously, the contractors have established rates and sliding fee scales independently; however, for SFY15, Bureau of Drug and Alcohol Services established a universal sliding fee scale for all contracted providers. The required universal sliding fee scale along with standardized service rates will ensure that clients bear the same degree of financial responsibility regardless of which Bureau of Drug and Alcohol Services contracted provider they access services with.

These contracts will continue to allow the State to improve the quality and array of services available to clients. Quality improvement efforts include the exchange of data and information that will support "data driven" prevention and treatment programming to better address the needs of clients within particular regions of the state. Furthermore, the payment structure built into these contracts incentivizes practices that lead to positive client outcomes such as: abstinence, involvement in employment and/or education, and lack of involvement with the criminal justice system.

The following data illustrate the critical need for substance abuse treatment in New Hampshire. The National Survey on Drug Use and Health commissioned by the Substance Abuse and Mental Health Services Administration provides incidence rates for the 12 and over population in New Hampshire. Data collected in 2011/2012 provided the following rates:

- Alcohol Dependence or Abuse: 86,548 (6.79% of population)
- Illicit Drug Dependence or Abuse: 32,160 (2.76% of population)

- Needing but not receiving treatment for alcohol abuse: 73,949 (6.55% of population)
- Needing but not receiving treatment for illicit drug use: 28,563 (2.53% of population)

Recently, heroin and prescription drug use and the consequences of that use have reached epidemic proportion in New Hampshire:

- According to the 2011-2012 National Survey on Drug Use and Health, the rate of New Hampshire's young adults (ages 18 to 25) who reported non-medical use of pain relievers was the 11TH highest of all states, with 11.6% reporting abuse in the past year
- In the last ten years, the number of people admitted to state funded treatment programs rose by 90% for heroin use and by 500% for prescription opiate abuse. The sharpest increase was between 2012 and 2013.
- According to the New Hampshire State Police Forensic Laboratory, of traffic stops and arrests leading to a blood or urine test in 2012, 13%, or 704 arrests, involved heroin
- In 2011, drug-related deaths peaked at 200, more than ever before and four times as many deaths as in 2000, with 80% of drug deaths involving prescription medication, primarily opioid pain relievers

Should the Governor and Executive Council determine to not authorize this Request, agencies would not have sufficient resources to promote, implement and provide the array of services necessary to provide individuals with substance use disorders the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment services could result in the loss of Federal Block Grant funds made available for these services.

The vendors were originally selected for these agreements through a competitive bid process. The original contracts for SFY 2013 were approved by Governor and Counsel on June 20, 2012, (Items 96, 97, 99 – 110, 112). Amendments for SFY 2014 were approved on June 5, 2013 (Item # 102A), except Grafton County approved on July 10, 2013 (Item # 50) and The Youth Council on June 19, 2013 (Item # 134), with this request providing services for the period July 1, 2014 to June 30, 2015. These amendments represent level funding of all vendors.

This Governor and Executive Council package includes the amendment #2 and a copy of the Governor and Council Letters for amendment #1 and for the original contract for each contractor. An electronic copy of amendment #1 for each contractor can viewed on line at http://sos.nh.gov/GC2.aspx.

The following performance measures will be used to assess the effectiveness of the agreements:

- The timeliness with which providers respond to calls requesting services within 5 business days to conduct initial eligibility screening.
- A $75.00 payment will be paid to the treatment contractor for each client who either completes or transfers to another treatment provider for continuing services.
- A $50.00 client follow-up fee will be paid to the treatment contractor at 3 months and again at 6 months post-discharge for each client who is contacted for follow-up and who meets at least 3 of the outcome criteria below:
    - Abstinence: The client reports reduced or no substance use in the past 30 days.
    - Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school.
    - Crime and Criminal Justice: The client reports no arrests in the past 30 days.
    - Stability in Housing: The client reports being in stable housing.
    - Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

Area served: State-wide

Source of Funds: 52.9% Federal Funds from Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant and 47.1% General Funds.

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Diane Langley
Director

Approved by:
Nicholas A. Toumpas
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #2 to the Substance Use Disorder Treatment and Recovery Support Services Contract

This 2nd Amendment to the Substance Use Disorder Treatment and Recovery Support Services contract (hereinafter referred to as "Amendment 2") dated this 15th day of May 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Phoenix Houses of New England, Inc. (hereinafter referred to as "the Contractor"), a non-profit corporation with a place of business at 99 Wayland Avenue, Suite 100, Providence, RI 02906.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, (item # 108) and amended by an agreement (Amendment #1 to the Contract) approved on June 5, 2013, (Item # 102A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 of the Agreement, the State may amend the Contract by written agreement of the parties; and;

WHEREAS, the parties agree to extend the current contract by one year.

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

1) Amend Form P-37, Block 1.6 to read:
   a) 05-95-49-491510-29890000-102-500734
   b) 05-95-49-491510-29900000-102-500734
2) Amend Form P-37, Block 1.7 to read June 30, 2015.
3) Amend Form P-37, Block 1.8 to read $4,372,470
4) Delete Exhibit A and replace with Exhibit A Amendment #2
5) Delete Exhibit B and replace with Exhibit B Amendment #2

Contractor Initials: BM
Date: 5/22/14

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

5/25/14
Date

NAME
TITLE Director

Phoenix Houses of New England, Inc.

5/22/14
Date

NAME PATRICK B. McENEANEY
TITLE SR VP, REGIONAL DIRECTOR

Acknowledgement:
State of RHODE ISLAND, County of PROVIDENCE on MAY 22, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Ena E. Paradysz
Name and Title of Notary or Justice of the Peace

ENA E. PARADYSZ
Notary Public-State of Rhode Island
My Commission Expires
May 31, 2017

Contractor Initials:
Date: 5/22/14

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

6-2-14
Date

Name: Rosemary Wiault
Title: Assistant Attorney General

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Contractor Initials: MH
Date: 5/22/14

Exhibit A Amendment #2

Scope of Services

A. Population Served

Services are available to New Hampshire residents who meet diagnostic, financial, and other eligibility criteria for Department of Health and Human Services supported substance use disorder services as defined in Section C, Clients Eligible for Treatment Services.

B. The Contractor shall provide treatment services as identified below:

Service Table - An "X" denotes that the Contractor shall provide that service(s) to eligible individuals in accordance with all applicable laws, rules, and regulations and terms and conditions of this Agreement.

Required Services	*Treatment Services*
	Outpatient Treatment (ASAM Level 1) - Substance abuse treatment services provided in individual and group counseling sessions in a non-residential setting. Clients may be enrolled in outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
	Outpatient Treatment (ASAM Level 1) – Pregnant & Parenting Women – Outpatient Treatment as identified above provided to pregnant & parenting women.
	Intensive Outpatient Treatment (ASAM Level 2.1) – A combination of individual and group substance abuse treatment services conducted in an outpatient setting for a minimum of 3 hours of direct client treatment services per day for a minimum of three days per week. Clients receiving less than this level of service should be enrolled in an outpatient program. Clients may be enrolled in intensive outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
	Intensive Outpatient Treatment (ASAM Level 2.1) – Pregnant & Parenting Women - Intensive Outpatient Treatment as identified above provided to pregnant & parenting women.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living)*** – Residential substance abuse treatment services are designed to support individuals in the early stages of recovery that need this residential level of care and/or are homeless. The goal of these programs is to prepare clients to become self-sufficient in the community. Clients may be enrolled in low-intensity residential treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days. Residents typically work in the community and may pay a portion of their room and board.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living) – Pregnant Women*** - Low-Intensity Residential Treatment as identified above provided to

Contractor Initials: _____
Date: 5/22/19

	pregnant & parenting women.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent)*** - Short-term residential substance abuse treatment designed to assist individuals who require a more intensive level of service in a structured setting and/or individuals that may be homeless. Admission is on a voluntary basis. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent) - Pregnant Women*** - High-Intensity Residential – Adult and Medium Intensity Residential – Adolescent as identified above provided to pregnant women.
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5) - Residential treatment services for pregnant and parenting women and their children. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Recovery Support Services:*** Group or individual services that are consistent with an individual's recovery plan that prevent relapse and enhance or remove barriers to recovery. Examples of recovery support services include, but are not limited to: assisting clients with enrollment in Medicaid, the New Hampshire Health Protection Program (NHHPP), or private insurance, anger management, financial management, communication skills, spiritual support, parenting skills, health management, case management, organization and time management, recovery coaching, recovery mentoring, stress management, and vocational services. Programs may focus on a single recovery support service or provide a curriculum that includes an array of recovery support services. Types of Recovery Support Services are listed below:
X	• Continuous recovery monitoring services are regular follow-ups with clients to assess the status of the client's recovery, identify any needs the client may have and help the client to address those needs, and provide early intervention for client's who have relapsed or who's recovery is otherwise at risk.
	• Enhanced Services are specialized services that remove barriers to a client's participation in treatment. Examples of these services are child care while a parent is participating in treatment or transportation to and/or from the treatment site.
X	***Recovery Support Services*** as identified above provided to pregnant & parenting women.

C. *Required Services*

Priority Admission:

1) The Contractor shall give admission preference to pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour time frame.
2) Individuals with a history of injection drug use including the provision of interim services within 14 days.
3) Individuals with a primary diagnosis of a substance use disorder, which may also include a co-occurring mental health disorder.
4) Individuals on medication-assisted treatment for co-occurring substance abuse and mental health disorders or various opiate replacement therapies, including, but not limited to, methadone, buprenorphine and naltrexone.

Required Outreach:

New Hampshire Department of Health & Human Services (DHHS) programs receiving federal treatment Block Grant funds requires that Contractors must publicize services available to pregnant or parenting women and injection drug users in need of substance abuse treatment and that these individuals receive preference for admission to treatment. This may be done as follows, but is not limited to, street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers and social service agencies. The Contractor will submit their outreach plans to DHHS through the Bureau of Drug and Alcohol Services (BDAS) within 60 days of contract effective date.

Health Facilities Administration Licensing Requirements:

Housing programs with substance abuse treatment services at the same location will need to secure necessary licensing as a Residential Rehabilitation Facility by the DHHS Bureau of Health Facilities Administration, as appropriate, see He-P 807 at the following link: (http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html). Any contractor with an American Society of Addiction Medicine (ASAM) (October 2013) Level 3.3 or higher level program must secure this licensing for all Level 3 programs housed within the same facility as the Level 3.3 program. In the case of residential treatment and housing at the same site, residential programs should plan to treat no more than 16 pregnant or parenting women at any given time to comply with federal Medicaid restrictions on Institute for Mental Diseases (IMD) exclusion criteria. This restriction would not apply to programs in which the client's residence is in a separate location from the treatment program.

Capacity Reporting:

The Contractor must contact BDAS, as agent for DHHS, when their capacity has reached 90% within 5 business days. The Contractor must refer pregnant women to the State when the Contractor has insufficient capacity to provide services to any such pregnant women who seek the services of the program. Sending e-mail to the BDAS Clinical Services Unit Administrator may complete this notification process.

Access to Services:
The Contractor shall respond to calls requesting treatment and/or transitional living program services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within 2 business days following the day the call was received.

The Contractor is required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.

Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client should be referred to a DHHS funded provider where they are able to access interim services.

Contractors receiving grant funds from DHHS will not discriminate against clients who are using legitimate medications to assist their recovery and will not have policies that allow them to refuse admission to treatment or to discharge clients from treatment based on the use of appropriately prescribed medications and various opiate replacement therapies, including, but not limited to, methadone and buprenorphine, as well as other forms of medication-assisted treatment for co-occurring substance abuse and mental health disorders.

Clients Eligible for Treatment Services:
In order to be eligible for DHHS supported services, a client must meet all eligibility criteria described below. Eligibility determination shall be conducted as follows:

1. Substance Use Disorder, Financial Eligibility & Residency Screening: The contractor shall complete the eligibility screening module in the Web Information Technology System (WITS) to determine if the client meets residency, financial, and substance use disorder potential eligibility requirements:
    a. Residency: The client must be a resident of New Hampshire or homeless in New Hampshire to be eligible for DHHS supported services; and
    b. Financial Eligibility: The client's income must be below 400% of Federal Poverty Level (FPL) to be eligible for DHHS supported services based on the sliding fee scale described below. Once the screening has been completed, the contractor shall print the associated attestation and have the client sign this document. A copy of the signed attestation shall be maintained in the client file. The client's financial eligibility shall be reassessed no less than every 120 days.; and
    c. Potential for a Substance Use Disorder: The client must screen positive for a potential substance use disorder to be eligible for DHHS funded services.
2. Evaluation: The contractor shall conduct a full substance abuse evaluation, which includes administration of either the Addiction Severity Index (ASI) in WITS or Global Appraisal of Individual Needs (GAIN).
    a. Substance Use Disorder: This evaluation shall be used to determine if the client meets Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) criteria for a substance use disorder. Clients who meet DSM5 criteria for a substance use disorder are eligible for DHHS funded services. Client who do not meet these criteria are not eligible for DHHS funded services.

b. Level of Care: For clients who have met all other eligibility requirements, this evaluation shall be used to determine the appropriate level of care for the client based on ASAM (October 2013) criteria. The client is eligible for DHHS funded services at the assessed level of care unless such a level of care is unavailable or the client chooses to enter a lower level of care. If the assessed level of care in unavailable, the client may choose to enter the next higher level of care.

3. Medicaid/NHHPP Eligibility: The contractor shall determine whether or not the client is eligible for Medicaid/NHHPP coverage for the identified level of care. If the client is not eligible for Medicaid/NHHPP coverage for the identified level of care, the client may be eligible for DHHS funded services. If the client is eligible for Medicaid/NHHPP coverage for the identified level of care, the client is not eligible for DHHS funded services.
4. Insurance Coverage: The contractor shall determine whether or not the client has insurance that will cover services at the identified level of care. If the client does not have insurance that will reimburse for these services at a rate equal to or greater than the DHHS rate, the client is eligible for DHHS funded services. If the client has insurance that will reimburse for these services at an amount equal or greater to the DHHS reimbursement rate, the client is not eligible for DHHS funded services. The contractor may not charge the combination of the client, any 3rd party payor, and DHHS more than the maximum charge allowed. These parties shall be charged in the following order:
    a. The maximum allowed charge will be billed to the client's insurer, if applicable.
    b. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
    c. The balance of the maximum allowed charge after deducting the client's portion and the insurance payment, if applicable, shall be charged to DHHS.

Sliding Fee Scale:

The contractor shall not charge the combination of the client, any 3rd party payor and BDAS an amount greater than the maximum rate allowed for each service. All reasonable efforts shall be made to collect payment of bills. A client's inability to pay shall not preclude admission to the program and treatment.

- Client Income is 0% - 138% of FPL: 100% of the allowed charge less any amount paid for by insurance.
- Client Income is 139% - 149% of FPL: 92% of the allowed charge less any amount paid for by insurance.
- Client Income is 150% - 199% of FPL: 88% of the allowed charge less any amount paid for by insurance.
- Client Income is 200% - 249% of FPL: 75% of the allowed charge less any amount paid for by insurance.
- Client Income is 250% - 299% of FPL: 60% of the allowed charge less any amount paid for by insurance.
- Client Income is 300% - 349% of FPL: 43% of the allowed charge less any amount paid for by insurance.
- Client Income is 350% - 399% of FPL: 33% of the allowed charge less any amount paid for by insurance.

With respect to minority age individuals, a minor child shall not be denied services as a result of the parent's unwillingness to pay the fee or the minor child's decision to receive confidential services pursuant to RSA 318-B:12-a.

Waiting List Management:
When a person who is pregnant or an injection substance abuser seeks treatment and there are no appropriate treatment services available within the required time frame as outlined below, interim services **must** be made available. The Contractor agrees to maintain the wait list management system in WITS that includes a unique patient identifier and include information on dates of requests for admission to treatment, provision of interim services and source for those services, referrals made for treatment or interim services, and disposition of clients on the waiting list.

- The waiting list must contain a mechanism that identifies and counts the number of applicants who present and are determined to be appropriate for substance abuse treatment but are unable to be placed as there is no capacity;
- Maintain contact with individuals awaiting admission; and,
- Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area.

The Contractor shall remove a client awaiting treatment from the waiting list only when one of the following conditions exists:

- Such persons cannot be located for admission into treatment *or*
- Such persons refuse treatment.

Specific Interim Services for Pregnant Women, Women with Dependent Children and Injection Drug Users:
The Contractor agrees to contact the BDAS Clinical Services Unit if a pregnant women and women with dependent children or individuals with a history of injection drug use, cannot be accepted into treatment within specific time frames, and agrees that interim services will be provided or facilitated by the Contractor. Interim services for pregnant women must include counseling on the effects of alcohol and drug use on the fetus, referrals for prenatal care, and counseling and education about HIV and tuberculosis. Interim services for injection drug users must also include counseling and education in the risks of needle sharing, about the risks of transmission to sexual partners and infants, and referral for HIV, Hepatitis C and tuberculosis screening/testing. All interim services shall be documented in the client's clinical record in the WITS system.

Interim Services for other Clients:
The Contractor shall provide, or refer the client to, interim services until level of service identified in the level of care assessment is available and/or the client is willing and assessed as being sufficiently motivated to take advantage of the proposed level of service or interim services. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client shall be referred to a DHHS funded provider where they are able to access interim services.

Services to pregnant and parenting women:
The Contractor further agrees that childcare will be made available to women who are in treatment with their dependent children, either through on-site care or through arrangements with an off-site legal childcare provider. Other services required are as follows:

- The family is treated as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
- The Contractor shall provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care.
- The Contractor shall provide or arrange for childcare while the women are receiving services even if the children are not in their custody, as long as parental rights have not been terminated.
- The Contractor shall provide or arrange for primary pediatric care for the women's children, including immunizations.
- The Contractor shall provide or arrange for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting, and childcare while the women are receiving these services.
- The Contractor shall provide or arrange for therapeutic interventions for children in custody of women in treatment, which may, among other things, address the children's developmental needs, their issues of sexual and physical abuse, and neglect.
- The Contractor shall provide or arrange for sufficient case management and transportation services to ensure that the women and their children have access to the services provided for above.
- If a pregnant, pregnant injection drug using or Injection Drug Using person refuses treatment or says (s)he is not interested in treatment, the wait list report shall be completed with the engagement activities attempted.
- If a pregnant, pregnant injection drug using or Injection Drug Using person no shows or cancels treatment, interim services must be provided, as stipulated above and the wait list report shall be completed that demonstrates the activities of follow up, engagement and substance abuse treatment services offered.

Relationship(s) with Primary Health Care:
The Contractor shall arrange and coordinate services and exchange of information with other health care providers and agencies which:

- Identifies the client's current Primary Care Provider (PCP) at screening and/or intake.
- If the client has no current PCP, the Contractor shall identify available provider(s) in the client's local area such as a federally qualified community health center, community health center, or other local health services.
- Obtains client/patient authorization to communicate with PCP office.
- If no authorization is completed initially, the Contractor shall educate client as to the importance of engaging the PCP in ongoing care and address the client's concerns as part of treatment, with goal of obtaining authorization before discharge.
- Sends the discharge summary to PCP and offers to discuss recovery issues with the provider.
- Arranges (or has the client arrange) a post-discharge appointment with PCP for the client/patient for follow-up of the substance use disorder.

Tobacco Cessation:
The Contractor shall have policies and procedures for both client and Contractor staff, that not only creates a tobacco-free environment as required by law, but to offer tobacco cessation tools and programming. Tobacco use, in and of itself, shall not be grounds for administrative discharge from the program. Initially, all clients shall be assessed for motivation in stopping the use of tobacco products. Providers may tap into resources such as the DPHS Tobacco Prevention & Control Program (TPCP) and

the certified tobacco cessation counselors available through the QuitLine. Other resources for providers include:

Breathe New Hampshire
145 Hollis St., Unit C
Manchester, NH 03101
603-669-2411 (phone) or 1-800-835-8647

The New Hampshire Medicaid program covers:

- Nicotine Replacement Therapy (NRT) Gum,
- NRT Patch,
- NRT Nasal Spray,
- NRT Lozenge,
- NRT Inhaler,
- Varenicline (Chantix),
- Bupropion (Zyban),
- Group Counseling and/or
- Individual Counseling. Up to 12 individual counseling sessions are covered per year through a mental health provider (Note: These sessions would NOT be in addition to other mental health counseling sessions under Medicaid). Pregnant women also have the option of group counseling. For more information, visit the website at: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm

Tuberculosis:
The Contractor shall make available tuberculosis services (defined as screening, counseling, testing, and treatment) directly, or through other providers, to each client receiving treatment. In the case of an individual denied admission due to lack of capacity, the substance abuse treatment Contractor will refer the individual to another provider of tuberculosis services if appropriate. All Contractor providing residential services shall make available, either on-site or through agreements with health care providers, tuberculosis services, including screening, testing, counseling and referral for medical treatment.

Physical location and facilities:
For the purpose of providing the services described in Section II of the Scope of Services, the Contractor shall obtain and maintain a suitable space complying with all fire, health, and safety codes to include handicapped accessibility and being wheelchair accessible.

The Contractor shall obtain written prior approval of DHHS, acting through BDAS, before entering into any agreement concerning relocation of the service site.

Culturally and Linguistically Appropriate Standards of Care:
DHHS recognizes that culture and language have considerable impact on how consumers access services. Culturally and linguistically diverse populations experience barriers in efforts to access services. To ensure equal access to quality services, DHHS expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. When feasible and appropriate, provide clients of Limited English Proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. The Contractor is responsible for reasonable accommodations in arranging for interpreter services for hearing impaired clients.
5. The Contractor offers consumers or clients a forum through which those individuals have the opportunity to provide feedback to the Contractor regarding cultural and linguistic issues that may deserve response.

Compliance with State and Federal Laws:
The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. All services provided pursuant to this Contract shall be subject to the most current proposed or formalized rules and regulations promulgated by DHHS, pursuant to RSA 541-A.
2. The Contractor shall maintain adherence to federal and state confidentiality laws specifically: 42 CFR Part 2B, N.H. RSA 318 B:12 and N.H. RSA 172:8-A and the Health Insurance Portability and Accountability Act (HIPAA): *http://www.hhs.gov/ocr/privacy/*
3. The Contractor shall meet the standards outlined in NH Administrative Rule He-A 300, Certification and Operation of Alcohol and other Drug Disorder Treatment Programs. This administrative rule is currently expired and under revision. The Contractor should plan to meet the requirements as outlined in the expired rule until the revisions are completed. He-A 300 can be viewed on the RFP link to this document *http://www.dhhs.nh.gov/business/rfp/index.htm.*
4. The Contractor shall, upon the direction of the State, provide court-ordered evaluation in their catchment area and a sliding scale fee shall apply and the inability to pay shall not interfere with the completion and submission of the court-ordered evaluation and shall, upon the direction of the State, offer treatment to those individuals pursuant to RSA 172:13.
5. Contractors considering research, including research conducted by student interns, using individuals served by this contract as subjects must adhere to the legal requirements governing human subjects' research. Contractors must inform the DHHS via contact with BDAS prior to initiating any research involving subjects or participants related to this contract. In addition, research conducted on subjects served by this contract may need to be approved by the New Hampshire Department of Health & Human Services Committee for the Protection of Human Subjects (NH DHHS CPHS) see *http://www.dhhs.nh.gov/irb/*

Client Stabilization:
The Contractor will be expected to arrange for medical clearance for all clients receiving treatment services supported by DHHS administered by BDAS to assure that they are not at risk for acute withdrawal from alcohol and certain drugs. The Contractor shall be expected to provide a range of integrated services that include withdrawal management services that follow detoxification guidelines outlined in Treatment Improvement Protocol (TIP) #45, Detoxification and Substance Abuse Treatment and ASAM guidelines.

Clinical Services:
The Contractor shall provide the following:

a. A minimum of one (1) substance abuse counselor on site each day of the week during primary treatment hours. The substance abuse counselor shall have a bachelor's degree or equivalent in social work/psychology, guidance or nursing and/or a certificate in the field of addiction studies from an approved educational institution or educational/life experience.
b. A minimum of one (1) substance abuse support staff on site each day of the week during all hours not covered by a substance abuse counselor. The substance abuse support staff must have a high school or General Equivalency Diploma (GED). Preference is given to individuals who have completed additional courses or taken training in substance use disorders or other health fields.
c. An intake/admission coordinator on site Monday through Friday of each week. The intake/admission coordinator shall have one (1) years' work experience in the field of addiction studies.
d. A full-time Executive Director, not filling any of the positions described above.

Evaluation:
The contractor shall conduct a full substance abuse evaluation, which includes administration of either the ASI or GAIN to determine eligibility for services. This evaluation must be updated every 120 days or when the client transitions to a different level of care.

Assessment of Risk for Self-Harm/Suicide: The Contractor shall have policies and practices for assessing risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and at discharge, and a process for referral when necessary to include referrals to mental health services.

The Contractor shall develop policies, programs and protocols in accordance with SAMHSA guidelines as outlined in the Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs). These publications can be downloaded from http://www.kap.samhsa.gov/products/manuals/index.htm .

Use of Best Practices: The Contractor is required to use the Addiction Severity Index (ASI) or Global Appraisal of Individual Needs (GAIN) assessment tools, the SAMHSA/NIDA MATRS treatment-planning model and the WITS electronic case management system.

Care Coordination:
The Contractor is required to assess each client's need/appropriateness for residential transitional living services and to **refer all clients for care coordination services** made available through the Access to Recovery (ATR) initiative administered by the BDAS so long as this initiative remains available on behalf of DHHS that would commence following the initial course of treatment. Contractors are required to address motivational issues with clients for them to participate effectively in the care coordination and recovery support services. Contractors are required to have clients sign the "ATR Client Participation Agreement" (made available by BDAS), indicating that they either agree or opt out of participating in these services. The contractor will facilitate all clients who agree to participate in these services to complete the Client Participation Agreement and upon obtaining a signed release of information, refer clients to an ATR Care Coordinator Program at least two weeks prior to anticipated date of discharge (dis-enrollment) from services. Assessing the need for aftercare services is expected to take place while

the client is involved within the most recent episode of care, with a referral being made and accepted by the care coordination service prior to the client being discharged.

The Contractor must provide the following for use by the care coordination program:

- Private space for interviewing/meeting with clients.
- Access to internet (either wired or wireless) in the meeting space
- Telephone in the meeting space and
- A contact person at the Contractor's site for logistics.

It is the expectation of the BDAS at DHHS that, upon completion of appropriate signed releases, the Contractor will provide the care coordination program with necessary information from the clinical record (evaluation, treatment plan, progress notes, etc.) for the care coordination program to develop a service plan with the client.

All alcohol and other drug treatment providers under contract with the BDAS on behalf of DHHS are required to address with all clients, the need for continuing services. This includes clinically managed low-intensity treatment programs under contract with the BDAS on behalf of DHHS as well as care coordination and recovery support services made available through DHHS contracted providers; the ATR initiative administered by BDAS, so long as this initiative remains available; and/or any other resources that become available to pay for these services that would commence following the initial course of treatment. The referral for these services should take place prior to discharge from the initial course of treatment.

Relevant Policies and Guidelines:
The services provided for in this agreement shall be in addition to the services provided for in any other agreement between the State of New Hampshire, any of its agencies, or any of its officers, and the Contractor.

Without limiting the generality of any other provisions of this agreement, the Contractor shall cooperate fully with, and answer all questions of representatives of the State conducting any periodic or special review of the performance of the Contractor or any inspection of the facilities of the Contractor.

Publications Funded Under Contract:
All products produced under this contract are in the public domain. All products (written, video, audio) produced, reproduced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution, or use. The Contract shall credit DHHS on all materials produced under this contract.

Student Internships:
The Contractor shall establish policies and procedures related to student interns that address minimum coursework, experience and core competencies for those interns having direct contact with individuals served by this contract. Student interns shall complete an approved ethics course prior to beginning the internship.

Exhibit A Amendment #2

Staff Licensing Requirements:
The ratio of licensed to non-licensed service providers shall be as follows:
Agencies must have at least one Licensed, or Masters Licensed, Alcohol and Drug Counselor (LADC/MLADC) for each two unlicensed counselors providing substance abuse treatment services and a sufficient number of MLADCs or LADCs with the Licensed Clinical Supervision (LCS) credential to adequately provide for clinical supervision of all clinical staff. This requirement shall be met by the Contractor no later than six (6) months after the date of the Contract effective date.

Updated resumes, which clearly indicate the staff member is employed by the Contractor, including current positions of staff supported by funds provided through this Contract, shall be forwarded to the BDAS as agent for DHHS. The documentation shall include a copy of the New Hampshire Alcohol and Drug Counselor License.

Staff Certification Requirements:
In addition to the requirements for LADCs, all Contractor milieu staff in residential settings and transitional living programs and staff providing recovery support aftercare group services shall be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification under RSA 330-C (http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-330-C.htm). Certification must be completed within six (6) months of the contract's approval date.

Staff providing recovery support services are expected to be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification. Peer recovery support services made available through Recovery Community Organizations (RCOs), under agreement with BDAS on behalf of DHHS, shall be provided by individuals certified by those organizations (CRSW not required for peer recovery support services).

Supervision:
Ongoing clinical supervision will include weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress. When enough candidates are under supervision, group supervision may be included to help optimize the learning experience.

The content of supervision must include knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee, including the core functions as described in the Twelve Core Functions of Alcohol and Drug Counseling.

The content of supervision must also include the standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.

Staffing Changes:
BDAS as agent for DHHS shall be notified of changes in key personnel with updated resumes that clearly indicate the staff member is employed by the Contractor submitted within five (5) working days. Key personnel are those staff for whom at least 10% of their work time is spent providing alcohol or other drug abuse treatment services.

Contractor Initials: BM
Date: 5/22/14

1. New Hires: The Contractor shall notify BDAS on behalf of DHHS in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. A resume of the employee, which clearly indicates the staff member is employed by the Contractor, shall accompany this notification.

2. Vacancies: The Contractor shall notify BDAS on behalf of DHHS in writing within 14 calendar days, if at any time, any site funded under this agreement does not have adequate staffing to perform all required services for more than one month.

Other Requirements:
The Contractor shall attend trainings and/or meetings as requested by DHHS.

ATR and Recovery Support Services:
All DHHS funded treatment and recovery support service providers must also be approved Access to Recovery (ATR) providers, so long as the ATR initiative remains available, as this will be the source of funding for these recovery support services through the Voucher Management System (VMS). Information on becoming an ATR provider can be found on the DHHS website: http://www.dhhs.nh.gov/dcbcs/bdas/atr/becomingprovider.htm

Regional Network Participation:
The Contractor will designate administrative level staff to regularly participate in the Regional Network and contribute to overall regional network strategic planning, monitoring, evaluation, and cross systems communication efforts. The Contractor is highly encouraged to serve on one of the work groups and contribute to data collection, regional strategic planning and evaluation. Participation will be measured by the annual Partner Survey (http://www.partnertool.net/) administered by NH Center for Excellence under contract with BDAS as agent for DHHS.

Performance Measures:
All treatment programs under contract with BDAS on behalf of DHHS are required to report on the National Outcome Measures (NOMs) established by the SAMHSA, as required in the Federal Substance Abuse Prevention and Treatment Block Grant, via the WITS (electronic case management) system. The Department of Health and Human Services reserves the right to consider Contractor performance across all of the domains in future funding decisions.

Data and Reporting Requirements:
1. Without limiting the generality of any other provisions of this agreement, the Contractor shall provide any periodic or special reports required by the DHHS.
2. The Contractor shall notify BDAS, as an authorized agent of DHHS, whenever the Contractor has reached ninety percent capacity to admit new clients. In addition the Contractor shall have a waiting list management policy in accordance with the SAPT Block Grant requirements. This 90% notification process will become automatic when this operation is fully functional in WITS.
3. The Contractor shall notify DHHS through BDAS, within one working day, if sufficient capacity is not available to provide treatment services to a pregnant woman, parenting woman or injection drug user within the required time frames and a referral elsewhere is not successful and interim services cannot be provided.

4. The Contractor shall comply with all research and/or information systems development activities for the electronic case management/Web Information Technology System (CM/WITS) conducted by, or authorized by, DHHS.
5. The Contractor shall administer any client surveys, client evaluations including the addiction Severity Index (ASI) or the Global Appraisal of Individual Needs (GAIN), client treatment outcome instruments, the M.A.T.R.S. Treatment Planning Tool, as required by DHHS.
6. The Contractor must have the ability to communicate and submit required reports via the Web-based submission system and/or e-mail, for treatment s and recovery support services and interim services. All required clinical and documentation activities shall be entered in WITS unless specifically granted an exception by BDAS on behalf of DHHS.

Critical Incident/Sentinel Event Reporting:
The Department's Sentinel Event policy is contained in the following link: http://www.dhhs.nh.gov/dcbcs/sentinel.htm

Division of Community Based Care Services (DCBCS) Sentinel Event Notification:
The preceding events require the immediate verbal notification to the BDAS Assistant Administrator or Clinical Services Unit Administrator upon the discovery of a sentinel event involving an individual(s) receiving services through a DHHS substance use disorder treatment Contractor.

Since the initial and immediate verbal notification of a sentinel event is likely to include protected health information (PHI) as identified below, the Contractor of services to individuals receiving services funded by the DHHS shall disclose PHI in a private and secure manner. Contractors and vendors should not leave voice-mail messages, but instead make direct telephone contact with the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee. If direct telephone contact is not possible, a voice mail message may be left without protected health information, such as medications and relevant medical and psychiatric diagnoses. As soon as possible after the initial verbal notification, the Contractor will mail or fax a completed *Sentinel Event Reporting Form* as directed in this protocol.

Notification shall include the following:
1. Name and phone number of the individual reporting.
2. Name, date of birth (DOB), medications and all relevant medical and psychiatric diagnoses of individual(s) involved;
3. Location, date, and time of event;
4. Description of the event including what, when, where, how, and other relevant information and identification of any other individuals involved;
5. Legal status of the individual involved with regard to guardianship and power of attorney;
6. Community, guardian, family and/or families' knowledge of the event; and
7. Contractor contact person and contact information.

It shall be the responsibility of the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee to notify the DCBCS Quality Improvement Director by e-mail as soon as the BDAS Clinical Administrator or designee becomes aware a Sentinel Event has occurred. The DCBCS Quality Improvement Director shall make immediate notification to the Commissioner. Internal e-mails within the Department may contain PHI and all Department employees will utilize safeguards to ensure the privacy

of the PHI as stated in the DHHS General Manual Health Insurance Portability and Accountability Act (HIPAA) policy #504.

Each DCBCS contractor recognizes its responsibility to report evidence of neglect, abuse or exploitation to the appropriate regulatory agencies as required by RSA 161-F: 42-57 and RSA 169-C:29. In any case of known or suspected neglect, abuse or exploitation, the Contractor aware of the situation shall follow all applicable rules relative to individual rights protection procedures.

Written follow up information is to be forwarded by the reporting Contractor to the appropriate BDAS Administrator listed below within 72 hours by completing the *Sentinel Event Reporting Form.* To protect clients' confidential information, reporting Contractors should submit the *Sentinel Event Reporting Form* either by fax to the BDAS Assistant Administrator or the BDAS Clinical Services Unit Administrator by a mail service that provides delivery confirmation.

Bureau of Drug and Alcohol Services
Assistant Administrator
105 Pleasant Street
Concord, NH 03301
Or by fax to the BDAS Administrator's Office at 271-6105;

Follow-up information is the responsibility of the Contractor and should be submitted in a way as to protect clients' confidential information such as by mail with delivery confirmation and should include:

1. The *Sentinel Event Reporting Form(www.dhhs.nh.gov/dcbcs/documents/sentinelform.pdf)*;
2. Additional details as they are learned or if the status of the situation changes; and,
3. Copies of newspaper articles.

Additionally, DHHS requires critical incident reporting. The Contractor shall report all critical incidents/sentinel events to the BDAS Clinical Services Unit Administrator immediately via telephone. Every effort shall be made to reach the BDAS administrator directly. If a voice message is necessary, sufficient provider contact information shall be provided so that DHHS is able to reach the reporter, or other responsible staff, immediately.

A critical incident includes, but is not limited to, any child or adult protective services report to the Division of Children, Youth and Families (DCYF), or the Bureau of Elderly and Adult Services (BEAS), respectively, regarding any incident involving 1) a staff/employee to youth or client, 2) youth to youth, or 3) client to client. This includes incidents that occur while a client is on leave, or on a pass, from the Contractor and may be off site at the time the incident occurred.

A sentinel event is an unexpected occurrence involving the death or serious physical or psychological injury, or risk thereof, signaling the need for immediate investigation and response.

Death or any serious injury or medical emergency regarding staff or clients that requires emergency medical attention (EMT or other emergency personnel at the Contractor's site, or a hospital emergency room visit), or any crime reportable to law enforcement, or any other serious incident must also be reported to DHHS as described below.

Reportable sentinel events include, but are not limited to, any occurrence that meets any of the following criteria:

1. An unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition.
2. Homicide or suicide of any individual receiving DHHS funded care, treatment or services, that had been discharged from a Department funded program or facility within 30 days of the event, or has been evaluated by a service Contractor within the preceding 30 days;
3. Sexual assault or rape of any individual receiving DHHS funded care, treatment or services by another client or employee of any Department funded program or facility where there is an act that was witnessed or there is sufficient clinical evidence obtained by the Contractor to support allegation of nonconsensual sexual contact.
4. Unauthorized departure of an individual receiving DHHS funded services, from a facility providing care, resulting in death or permanent loss of function.
5. Medication error that results in death, paralysis, coma, or other permanent loss of function.
6. Delay or failure to provide DHHS funded Contractor services that result in death or permanent loss of function.
7. Abuse as a result of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one individual by another.
8. Neglect as a result of the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness.
9. Assault of or by a client of the Contractor that results in the injury of the person or another person of such severity that medical attention is required.
10. Arson resulting in property loss.
11. High profile events, which may include media coverage and/or police involvement.

On-Site Reviews:

1. The Contractor shall allow a team or person authorized by DHHS to periodically review the Contractor's systems of governance, administration, data collection and submission, clinical, and financial management in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include, but not be limited to, client record reviews to measure compliance with this exhibit.
3. The Contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. DHHS staff shall contact the Contractor in advance of the site visit, so that the Contractor shall have sufficient time to prepare any guidance/reporting systems or logs that will be reviewed at the site visit.

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Method and Conditions Precedent to Payment

The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services, and in accordance with Exhibit B.

Funding for this Agreement is funded by various sources as a percentage of the total amount of $1,457,490 as follows:

- 46 % Federal Funds from the Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959);
- 22 % General Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Funds; and
- 32 % General funds.

I. Payment Methodology

The Contractor shall be reimbursed for providing and delivering the services listed in Exhibit A, paragraph B. The following terms and conditions detailed in this Exhibit B shall apply to all services unless expressly stated otherwise.

The Contractor shall agree to use and apply all contract funds from the State for costs and expenses as detailed in the Service Reimbursement Table below. Allowable costs and expenses shall be determined by the State in accordance with applicable state and federal laws and regulations. Starting in State Fiscal Year 2015 (effective July 1, 2014) the contractor will receive a payment for each service at the rates and within the limits described below. For clients receiving DHHS supported services, the contractor may not charge the client, any 3rd party payor, and DHHS a combined rate that is more than the rate established by BDAS for that level of service or any other fees. These parties shall be charged in the following order:

1. The maximum allowed charge will be billed to the client's insurer, if applicable.
2. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
3. The balance of the maximum allowed charge, after deducting the client's portion and insurance payment, if applicable, shall be charged to DHHS.

Service Reimbursement Table - A check mark indicates the services and corresponding rates the Contractor will be reimbursed for.

Check mark indicates applicable service	Service	DHHS Established Rate	Service Limit
X	Evaluation	$225	1 every 90 days
	Outpatient – Individual	$18.75/unit***	$190 of combined individual & group/week
	Outpatient – Group	$5.00/unit	
	Intensive Outpatient*	$80.00/day	$320 (4 days)/week
X	Low-Intensity Residential – Adult	$100.00/day	$700 (7 days) /week

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X	Low-Intensity Residential – Adolescent	$128.00/day	$896 (7 days) /week
X	High-Intensity Residential – Adult	$130.00/day	$910 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Room & Board Only	$66.00/day	$462 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Clinical Services	$162.60/day	$1138.20 (7 days) /week
X	Medium Intensity Residential – Adolescent	$170.00/day	$1190 (7 days) /week
	Recovery Support Services		
X	Individual	$15.00/unit	$160 of combined individual & group/week
X	Group	$5.00/unit	
X	Continuous Recovery Monitoring – Attempted**	$15.00/contact	$60 of combined attempted and completed/month for the first 6 months post discharge
X	Continuous Recovery Monitoring – Completed	$15.00/contact	
	Enhanced Services	Varied	

* Providers may bill the per diem rate for Intensive Outpatient Treatment services only on those days when the client attends individual and/or group counseling associated with the program. It is expected that each day of attendance includes a minimum of 3 hours of group and/or individual counseling services.

**Attempted Contact is at least 3 attempts to contact a client over the course of at least one week.

*** A unit is equal to 15 minutes of service
It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period. Utilization and array will also be monitored by the Department via WITS. Failure to meet this requirement may result in amendment to or termination of the contract. At a minimum, contractors must provide the array of services they contracted to provide for in SFY14.

1. **Performance Incentives:**

   A. Access to Services:

Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received and shall conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact. For each client who screens eligible for

services and starts receiving services, whether for the identified level of care or interim services, within 10 business days following the eligibility screening, the treatment contractor will receive an incentive payment of $75.00. Access incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

B. Completion:

For each client who is discharged from the program because they have completed treatment or transferred to another treatment provider as recorded in the Discharge Type field of the WITS Discharge Module, the treatment contractor will receive an incentive payment of $75.00. Completion incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

C. Client Outcomes:

If a client who was discharged from the program meets at least 3 of the Outcome criteria below in the 3rd and/or 6th month post-discharge, as evidenced by the WITS Follow-Up module, the treatment contractor will receive an incentive payment in the amount of $50. The 3rd month post discharge is considered to be 60 – 120 days post discharge. The 6th month post discharge is considered to be 150 – 210 days post discharge. Outcomes incentives will be calculated and paid on a monthly basis for clients meeting criteria in the previous calendar month. It is expected that at least 50% of discharged clients will be contacted for 3 and/or 6 month follow-up over the contract year.

i. Abstinence: The client reports reduced or no substance use in the past 30 days.
ii. Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school.
iii. Crime and Criminal Justice: The client reports no arrests in the past 30 days.
iv. Stability in Housing: The client reports being in stable housing.
v. Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

D. Performance Incentive Payout Limits:

Performance incentives are limited to no more than 6% of the total contract amount annually. The total amount paid out during the contract year will never exceed the total contract amount. DHHS is not obligated to make payment for any incentives that occur outside of the current contract year; however, incentives may be carried over to future contract years at the discretion of DHHS.

2. Failure to Meet Deliverables:

The Contractor shall comply with all contract requirements as detailed in Exhibit A section B, Required Services. Upon determination that Contractor may not be meeting the required deliverables, within two (2) weeks BDAS will provide a written correction action plan. Within two (2) weeks of notification of the corrective action plan, Contractor will provide a written remedial plan. BDAS will monitor the corrective actions for 60 days. Failure to meet requirements of the corrective action plan within 60 days may result in withholding of any or all payments or termination of the contract.

3. Invoicing & Billing:

All billing shall be completed via the WITS system according to protocols established by BDAS.

The Contractor shall have written authorization from the State prior to using contract funds to purchase or lease any equipment with a cost in excess of two thousand five hundred dollars ($2500) and with a useful life beyond one year.

II. Allocation of Funding:

It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period. Utilization and array will also be monitored by the Department via WITS. The contractor is prohibited from spending down more than the sum of the total contract amount that includes the cost of the client services and related incentives.

III. Availability of Alternative Funding:

The New Hampshire Department of Health and Human Services may terminate or amend the contract should alternate third party payors, including Medicaid, the New Hampshire Health Protection Program and/or insurance available on the New Hampshire Insurance Exchange cover any of the services included in this contract.

IV. Limitations and restrictions of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds:

The Contractor agrees to use the SAPT funds as the payment of last resort.

Restrictions on SAPT Block Grant on State and Contractor expenditures include:
The State may not:

- Provide inpatient hospital services except under those conditions outlined in the regulations.
- Make cash payments to intended recipients of substance abuse services.
- Purchase or improve land.
- Purchase, construct, or permanently improve buildings or other facilities.
- Purchase major medical equipment.
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds. (in-kind)
- Provide financial assistance to any entity other than a public or non-profit private entity.
- Provide individuals with hypodermic needles or syringes.
- Expend more than the amount of Block Grant funds expended in FFY91 for treatment services provided in penal or correctional institutions of the State.

The Contractor shall not:

- Use any federal funds provided under this contract for the purpose of conducting testing for the etiologic agent for Human Immunodeficiency Virus (HIV) unless such testing is accompanied by appropriate pre and post-test counseling.
- Use any federal funds provided under this contract for the purpose of conducting any form of needle exchange, free needle programs or the distribution of bleach for the cleaning of needles for intravenous drug abusers.

V. Charitable Choice:

Federal Charitable Choice statutory provisions ensure that religious organizations are able to equally compete for Federal substance abuse funding administered by SAMHSA, without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries (see 42 USC 300x-65 and 42 CFR Part 54 and Part 54a, 45 CFR Part 96, Charitable Choice Provisions and Regulations). Charitable Choice statutory provisions of the Public Health Service Act enacted by Congress in 2000 are applicable to the SAPT Block Grant program. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

VI. Notwithstanding paragraph 18 of the General Provisions of this Agreement P-37, an amendment limited to adjusting amounts within the budgets and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of Governor and Executive Council.

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF DRUG AND ALCOHOL SERVICES

Nicholas A. Toumpas
Commissioner

Nancy L. Rollins
Associate
Commissioner

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6100 1-800-804-0909
FAX: 603-271-6105 TDD Access: 1-800-735-2964

G&C Approved
Date 6/5/13
Item # 102A

50.6% Federal
47.4% General

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug and Alcohol Services, to exercise renewal options with vendors by increasing the price limitations by $7,596,887 in aggregate from $7,596,890 in aggregate to $15,193,777 in aggregate for a continuum of substance abuse treatment services state-wide and extending the completion date from June 30, 2013 to June 30, 2014, effective July 1, 2013 or date of Governor and Council approval, whichever is later.

Summary of contracted amounts by vendor:

Vendor	Amount
Child and Family Services of New Hampshire	$86,803
Concord Hospital, Inc.	$74,406
Families First of the Greater Seacoast	$28,922
Families in Transition	$332,530
Greater Nashua Council on Alcoholism	$1,356,945
Headrest, Inc.	$251,450
Horizons Counseling Center, Inc.	$189,576
Manchester Alcoholism Rehabilitation Center	$1,120,599
The Mental Health Center of Greater Manchester, Inc.	$27,114
Monadnock Family Services	$97,819
Northern Human Services	$199,025
Phoenix Houses of New England, Inc.	$1,457,490
National Council on Alcoholism and Drug Dependence of Greater Manchester	$432,468
Southeastern New Hampshire Alcohol and Drug Abuse Services	$1,329,836
Tri-County Community Action Programs, Inc.	$611,904
TOTAL	$7,596,887

Funds to support this request are anticipated to be available in the following accounts in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts within the price limitation and amend the related terms of the contracts without further approval from Governor and Executive Council.

05-95-49-491510-2989 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, GOVERNOR COMMISSION FUNDS (100% General Funds)

05-95-49-491510-2990 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, CLINICAL SERVICES (34.4% General 65.6% Federal)

Please see attachment for financial details

EXPLANATION

The requested action seeks approval of 15 of 17 agreements that represent $7,596,887 of the $7,741,314 total anticipated to be spent state-wide to provide a continuum of substance abuse treatment services via the accounting codes listed. These services include community based outpatient, intensive outpatient, residential, transitional living, and recovery support services, including specialized treatment services for pregnant and parenting women and their children. This request seeks to exercise the renewal option that exists within each of the vendor contracts. The Department anticipates that the remaining two agreements will be presented to Governor and Executive Council on June 19, 2013.

Client eligibility for treatment services is targeted at those either unable to pay for services or able to pay only part of the cost of services, and who has or is suspected of having an alcohol or other drug abuse problem, and who is a resident of the State of New Hampshire or is homeless in NH. All clients discharged from treatment services supported by this contract will be referred to care coordination and recovery-support aftercare services as clinically appropriate, supported separately by the Federal Access to Recovery Grant.

The State is migrating toward a Resiliency and Recovery Oriented Systems of Care. Recovery-oriented systems of care are networks of organizations, agencies and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. In addition, these contracts will continue to allow the State to improve the quality and array of services available to clients. Quality improvement efforts include the exchange of data and information that will support "data driven" prevention and treatment programming to better address the needs to the region.

The New Hampshire Office of Energy and Planning reported the 2009 Population Estimates of New Hampshire Cities and Towns as 1,324,575. The National Survey on Drug Use and Health commissioned by the Substance Abuse and Mental Health Services Administration in 2008/2009 reported the following demographic data for New Hampshire:

- Alcohol Abuse: 97,630 (7% of population)
- Alcohol dependence: 44,850 (3% of population)
- Illicit Drug Abuse: 43,810 (3% of population)
- Illicit Drug Dependence: 32,240 (2% of population)
- Substance Abuse: 126,630 (10% of population)
- Needing but not receiving treatment for alcohol abuse: 93,990 (7% of population)
- Needing but not receiving treatment for illicit drug use: 39,390 (3% of population)

In addition, the New Hampshire Medical Examiner office reported 172 drug related overdose deaths in NH during 2010. The New Hampshire Administrative Office of the Courts reported 9,500 arrests and 5,000 convictions for Driving While Impaired in 2009. Approximately 90% of individuals arrested for Driving While Impaired have an underlying substance abuse disorder according to the National Institute on Alcohol Abuse and Alcoholism.

Should the Governor and Executive Council determine to not authorize this Request, agencies would not have sufficient resources to promote, implement and provide the array of services necessary to provide individuals with substance use disorders the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment service would place that Block Grant in jeopardy.

The vendors were originally selected for this agreement through a competitive bid process. This request covers services for the period July 1, 2013 to June 30, 2014, and anticipates exercising the option to renew for one additional year as provided all of the previous vendor contracts, pending availability of funding, the agreement of the parties and approval of Governor and Council. These services were contracted previously with the listed vendors in State Fiscal Year 2013 in the amount of $7,741,314 in the aggregate. This agreement represents level funding of all vendors.

The following performance measures will be used to measure the effectiveness of the agreements:

- Utilization criteria will be applied exclusively on a month-by-month basis according to the criteria below.

i. Contracts running at 90% to 100% of utilization in a given month will be reimbursed at 100% of the contracted rate for that month.
ii. Contracts running at 80% to 89% of utilization in a given month will be reimbursed at rate of 95% of the contracted rate for that month.
iii. Contracts running below 80% of utilization in a given month will be reimbursed at the rate of utilization for that month (for example for a given month in which utilization was 59% the contractor would be reimbursed at 59% of the contracted rate for that month).

- Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received. The following Access Criteria must be met for a minimum of 80% of prospective clients (from clients or referring agencies) for the month in which billing is being submitted:

i. Treatment contractors are required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.
ii. Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening.

- A minimum of 70% of clients, which have completed or otherwise are no longer receiving services, will have met the minimum retention standards for the modality of services received as noted below:

i. Have completed a minimum of 6 sessions of outpatient treatment services
ii. Have completed a minimum of 8 days of intensive outpatient treatment services – only those days in which a client has participated in minimum of 10 units (2.5 hours) of service per day (12 units per day is the standard for I intensive outpatient treatment services) may be counted.
iii. Have completed a minimum of 14 days of residential treatment service
iv. Has completed a minimum of 28 days in a transitional living/halfway house residential program.

Contractors, with the exception of those agencies that only offer outpatient services, are required to develop the capacity for group recovery support aftercare services for a minimum of 25% of the number treatment clients (including outpatient and transitional living program clients) they are under contract to serve. Group recovery support aftercare services are services that are consistent with an individual's recovery plan that prevent relapse and enhance or remove barriers to recovery. Recovery Support Services include, but are not limited to, guidance in financial management, parenting, vocational training, life management and spiritual counseling as well as transportation and child-care. These group recovery support services are for clients discharged from substance use disorder treatment services provided under contract with the Bureau of Drug and Alcohol Services on behalf of the Department, which may include clients that had received SUD treatment from the Contractor or a different agency. Contractors are only allowed to access these services for their clients or clients that had received substance use disorder treatment from a different agency through the statewide care coordination program under agreement with the Bureau of Drug and Alcohol Services on behalf of the Department.

All treatment programs under contract with the Bureau of Drug and Alcohol Services on behalf of the Department are required to report on the National Outcome Measures (see attached) established by the Substance Abuse and Mental Health Services Administration, as required in the Federal Substance Abuse Prevention and Treatment Block Grant, via the Electronic Health Record/Web Infrastructure Treatment System. The Department of Health and Human Services reserves the right to consider Contractor performance across all of the domains in future funding decisions. The Contractor is expected to meet or exceed these percentages as measured by the Electronic Health Record/Web Infrastructure Treatment System.

Area served: State-wide

Source of Funds: 52.6% Federal Funds from Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant and 47.4% General.

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Nancy L. Rollins
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF DRUG AND ALCOHOL SERVICES

Nicholas A. Toumpas
Commissioner

Nancy L. Rollins
Associate
Commissioner

105 PLEASANT STREET, CONCORD, NH 03301
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FAX: 603-271-6105 TDD Access: 1-800-735-2964

May 24, 2012

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

Approved by: G+C
Date: 6/20/12
Item No.: 108
Contract No.: 1024152

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug & Alcohol Services, to enter into an agreement with Phoenix Houses of New England, Inc. (Vendor # 177589), 99 Wayland Ave., Suite 100, Providence, RI 02906, to provide for a continuum of substance abuse treatment services, in an amount not to exceed $1,457,490.00 to be effective July 1, 2012 or date of Governor and Council approval, whichever is later, through June 30, 2013. Funds are available in the following accounts for State Fiscal Year 2013:

05-95-95-958410-5365 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: COMMISSIONER, DCBCS TREATMENT & PREVENTION, ALCOHOL AND OTHER TREATMENT

Fiscal Year	Class/Object	Class Title	Job Number	Amount
SFY 2013	102-500734	Contracts for Prog Svc	95846501	$670,372.00
			Subtotal	$670,372.00

05-95-95-958410-1388 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: COMMISSIONER, DCBCS TREATMENT AND PREVENTION, GOVERNOR

Fiscal Year	Class/Object	Class Title	Job Number	Amount
SFY 2013	102-500734	Contracts for Prog Svc	95848501	$326,988.00
			Subtotal	$326,988.00

05-95-95-958410-1387 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: COMMISSIONER, DCBCS TREATMENT & PREVENTION, TREATMENT-PREVENTION-STATE

Fiscal Year	Class/Object	Class Title	Job Number	Amount
SFY 2013	102-500734	Contracts for Prog Svc	95841387	$460,130.00
			Subtotal	$460,130.00
			Total	$1,457,490.00

EXPLANATION

The purpose of this agreement is to provide a continuum of substance abuse treatment services such as community based outpatient, intensive outpatient, residential, transitional living, and recovery support services, including specialized treatment services for pregnant and parenting women and their children, in the Statewide.

Client eligibility for treatment services is targeted at those either unable to pay for services or able to pay only part of the cost of services, and who has or is suspected of having an alcohol or other drug abuse problem, and who is a resident of the State of New Hampshire or is homeless in NH. All clients discharged from treatment services supported by this contract will be referred to care coordination and recovery-support aftercare services as clinically appropriate, supported separately by the Federal Access to Recovery Grant.

The State is migrating toward a Resiliency and Recovery Oriented Systems of Care. Recovery-oriented systems of care are networks of organizations, agencies and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. In addition, this contract will allow the State to improve the quality and array of services available to clients. Quality improvement efforts include the exchange of data and information that will support "data driven" prevention and treatment programming to better address the needs to the region.

The New Hampshire Office of Energy and Planning reported the 2009 Population Estimates of New Hampshire Cities and Towns as 1,324,575. The National Survey on Drug Use and Health commissioned by the Substance Abuse and Mental Health Services Administration in 2008/2009 reported the following demographic data for New Hampshire:

- Alcohol Abuse: 97,630 (7% of population)
- Alcohol dependence: 44,850 (3% of population)
- Illicit Drug Abuse: 43,810 (3% of population)
- Illicit Drug Dependence: 32,240 (2% of population)
- Substance Abuse: 126,630 (10% of population)
- Needing but not receiving treatment for alcohol abuse: 93,990 (7% of population)
- Needing but not receiving treatment for illicit drug use: 39,390 (3% of population)

In addition, the New Hampshire Medical Examiner office reported 172 drug related overdose deaths in NH during 2010. The New Hampshire Administrative Office of the Courts reported 9,500 arrests and 5,000 convictions for Driving While Impaired in 2009. Approximately 90% of individuals arrested for Driving While Impaired have an underlying substance abuse disorder according to the National Institute on Alcohol Abuse and Alcoholism.

Should the Governor and Executive Council determine to not authorize this Request, agencies would not have sufficient resources to promote, implement and provide the array of services necessary to provide individuals with substance use disorders the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment service would place that Block Grant in jeopardy.

Phoenix Houses of New England, Inc. was selected for this agreement through a competitive bid process. A Request for Proposals was posted on the Department's web site on March 6, 2012 through April 2, 2012. In addition, a bidder's conference was held on March 12, 2012.

A total of 19 proposals were received. A review committee of three professionals reviewed each proposal. All reviewers have between three to twenty years experience managing agreements with vendors for various public health programs. Areas of specific expertise include: maternal and child health; substance abuse prevention and treatment; chronic and communicable diseases; and public health infrastructure. Eighteen of the proposals were selected for funding based on review criteria that included availability of funds, consistency with stated funding priorities, technical score, and equitable geographic distribution. The agency that was not selected did not meet the minimum scoring criteria established for funding. The Bid Summary is attached.

This request covers services for the period July 1, 2012 to June 30, 2013, with an option to renew for one additional year, pending availability of funding, the agreement of the parties and approval of Governor and Council. These services were contracted previously with this agency in State Fiscal Year 2012 in the amount of $1,457,490.00. This agreement represents level funding.

The following performance measures will be used to measure the effectiveness of the agreement:

- Utilization criteria will be applied exclusively on a month-by-month basis according to the criteria below.

i. Contracts running at 90% to 100% of utilization in a given month will be reimbursed at 100% of the contracted rate for that month.
ii. Contracts running at 80% to 89% of utilization in a given month will be reimbursed at rate of 95% of the contracted rate for that month.
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- Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received. The following Access Criteria must be met for a minimum of 80% of prospective clients (from clients or referring agencies) for the month in which billing is being submitted:

i. Treatment contractors are required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.
ii. Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening.

- A minimum of 70% of clients, which have completed or otherwise are no longer receiving services, will have met the minimum retention standards for the modality of services received as noted below:

i. Have completed a minimum of 6 sessions of outpatient treatment services (OP)
ii. Have completed a minimum of 8 days of intensive outpatient treatment services (IOP) – only those days in which a client has participated in minimum of 10 units (2.5 hours) of service per day (12 units per day is the standard for IOP services) may be counted.
iii. Have completed a minimum of 14 days of residential treatment service
iv. Has completed a minimum of 28 days in a transitional living/halfway house residential program.

Area served: Statewide.

Source of Funds: 45.99% Federal Funds from Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant, 50.85% General Funds and 3.16% Other (Highway) Funds.

In the event that the Federal or Other Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Nancy L. Rollins
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

NLR/df

Program Name		CFS	Con. Hosp.	Fam. 1st	FIT	Easter Seals	FOR-NH	GC HOC	GNCA	Headrest	Horizons	MHCGM	MFS	NHS	Phoenix	NCADD	SENHS	TYC	Tri-CAP	NESCT
Contract Purpose	TX&RSS																			
RFP Score Summary																				
RFA/RFP CRITERIA	Max Pts																			
Experience and Capacity	15	14.00	13.00	13.00	15.00	13.00	13.00	11.00	12.00	12.00	14.00	15.00	13.00	15.00	13.00	12.00	15.00	12.00	13.00	10.00
Approach	50	42.00	46.00	48.00	48.00	47.00	39.00	41.00	47.00	42.00	46.00	40.00	43.00	48.00	45.00	42.00	48.00	36.00	42.00	27.00
Budget	25	24.00	25.00	25.00	24.00	23.00	18.00	23.00	20.00	22.00	18.00	25.00	19.00	24.00	16.00	22.00	22.00	23.00	23.00	15.00
Financial Sustainability	10	7.50	8.30	9.00	10.00	7.00	0.00	7.50	6.90	8.30	9.50	9.00	6.50	9.50	7.20	6.50	7.50	7.20	8.30	5.60
Total	100	88.00	92.00	97.00	97.00	90.00	70.00	82.00	86.00	84.00	88.00	89.00	82.00	97.00	81.00	83.00	93.00	81.00	87.00	58.00
BUDGET REQUEST		$120,256	$85,000	$27,207	$406,796	$2,221,666	$47,050	$116,428	$1,750,112	$288,000	$245,963	$30,000	$153,454	$244,501	$2,615,553	$513,951	$1,329,836	$87,567	$747,691	$930,630
BUDGET AWARDED		$36,303	$74,406	$28,912	$322,536	$1,120,599	$39,238	$69,211	$1,546,045	$251,500	$189,576	$17,119	$97,119	$199,025	$1,457,490	$432,468	$1,329,836	$75,013	$611,907	$0

RFP Reviewers

	Name	Job Title	Dept/Agency	Qualifications
1	Tym Rourke	Sub. Use Disorders	Grantmaking/GC	All reviewers have between 3-20 years experience managing agreements with vendors for various DHHS and DOC programs. Arens of specific expertise include Maternal and Child Health; Substance Abuse
2	Pamela Sullivan	Youth Counselor	SYDC	
3	Heidi Young	Program Specialist	DCYF	
4	Bernie Bluhm	Prog. Planner/Rev. Spec.	Family Services	
5	Alan West,Ph.D.	Psychologist/VA	TX/Co-occurring	
6	Mary Miller	Prog. Spec. IV	OCPH	
7	Michelle Ricco	Prog. Spec. IV	DPHS	
8	Kathleen Hessefort	Internal Auditor I	BDAS/FBO	
9	Lindy Keller	Administrator I	BDAS-RAD	
10	Michael Lawless	Prog. Spec. IV	BDAS/CSU	
11	Bruce Blaney	Regional Coordinator	BDAS-CSU	
12	Jim Shanelaris	Administrator I	BDAS-FBOU	
13	Linda Parker	Prog. Spec. IV	BDAS-CSU	
14	Rosemary Shannon	Administrator I	BDAS-CSU	
15	Rob O'Hannon	ATR Prog. Spec.	BDAS/ATR	
16	Jaime Powers	Tx&Rec. Serv. Coord.	BDAS/ATR	
17	John Sweeney	Systems Dev.	BDAS/IT	
18	Michael Rodgers	Assistant Administrator	BDAS	
19	Jeffrey Metzger	Sr. Mngt. Analyst	BDAS/PSU	
20	Ann Crawford	Regional Coordinator	BDAS/PSU	
21	Valerie Morgan	Administrator I	BDAS/PSU	

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Substance Use Disorder Treatment and Recovery Support Services Contract

This 3rd Amendment to the Substance Use Disorder Treatment and Recovery Support Services contract (hereinafter referred to as "Amendment 3") dated this 12th day of November, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Tri-County Community Action Program, Inc. (hereinafter referred to as "the Contractor"), a non-profit corporation with a place of business at 30 Exchange Street, Berlin, NH 03570.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, (Item # 102), and amended by an agreement (Amendment #1 to the Contract) approved on June 5, 2013, (Item # 102A), and further amended by an agreement (Amendment #2 to the Contract) approved on June 18, 2014, (Item #99), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 of the Agreement, the State may amend the Contract by written agreement of the parties;

WHEREAS, the State and the Contractor have agreed to add new services to the Agreement;

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

1) Amend Form P-37, Block 1.8 to read $2,034,740
2) Delete Exhibit A Amendment #2 and replace with Exhibit A Amendment #3
3) Delete Exhibit B Amendment #2 and replace with Exhibit B Amendment #3
4) Delete Exhibit C and replace with Exhibit C Amendment #1
5) Add Exhibit C-1
6) Delete Exhibit G and replace with Exhibit G Amendment #1

Contractor Initials: MC
Date: 11-20-14

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12-4-14
Date

Diane Langley
Director

Tri-County Community Action Program, Inc.

11-20-14
Date

NAME Michael Coughlin
TITLE Chief Executive Officer

Acknowledgement:
State of NH, County of Coos on 11-20-2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Suzanne French, Notary
Name and Title of Notary or Justice of the Peace

SUZANNE C. FRENCH
Notary Public - New Hampshire
My Commission Expires June 19, 2018

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/10/14
Date

Name: Megan A. Yorke
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Exhibit A Amendment #3

Scope of Services

A. Population Served

Services are available to New Hampshire residents who meet diagnostic, financial, and other eligibility criteria for Department of Health and Human Services supported substance use disorder services as defined in Section C, Clients Eligible for Treatment Services.

B. The Contractor shall provide treatment services as identified below:

Service Table - An "X" denotes that the Contractor shall provide that service(s) to eligible individuals in accordance with all applicable laws, rules, and regulations and terms and conditions of this Agreement.

Required Services	*Treatment Services*
X	***Outpatient Treatment (ASAM Level 1)*** - Substance abuse treatment services provided in individual and group counseling sessions in a non-residential setting. Clients may be enrolled in outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Outpatient Treatment (ASAM Level 1) – Pregnant & Parenting Women*** – Outpatient Treatment as identified above provided to pregnant & parenting women.
X	***Intensive Outpatient Treatment (ASAM Level 2.1)*** – A combination of individual and group substance abuse treatment services conducted in an outpatient setting for a minimum of 3 hours of direct client treatment services per day for a minimum of three days per week. Clients receiving less than this level of service should be enrolled in an outpatient program. Clients may be enrolled in intensive outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Intensive Outpatient Treatment (ASAM Level 2.1) – Pregnant & Parenting Women*** - Intensive Outpatient Treatment as identified above provided to pregnant & parenting women.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living)*** – Residential substance abuse treatment services are designed to support individuals in the early stages of recovery that need this residential level of care and/or are homeless. The goal of these programs is to prepare clients to become self-sufficient in the community. Clients may be enrolled in low-intensity residential treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days. Residents typically work in the community and may pay a portion of their room and board.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living) – Pregnant Women*** - Low-Intensity Residential Treatment as identified above provided to

	pregnant & parenting women.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent)*** - Short-term residential substance abuse treatment designed to assist individuals who require a more intensive level of service in a structured setting and/or individuals that may be homeless. Admission is on a voluntary basis. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent) - Pregnant Women*** - High-Intensity Residential – Adult and Medium Intensity Residential – Adolescent as identified above provided to pregnant women.
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5) - Residential treatment services for pregnant and parenting women and their children. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Recovery Support Services:*** Group or individual services that are consistent with an individual's recovery plan that prevent relapse and enhance or remove barriers to recovery. Examples of recovery support services include, but are not limited to: assisting clients with enrollment in Medicaid, the New Hampshire Health Protection Program (NHHPP), or private insurance, anger management, financial management, communication skills, spiritual support, parenting skills, health management, case management, organization and time management, recovery coaching, recovery mentoring, stress management, and vocational services. Programs may focus on a single recovery support service or provide a curriculum that includes an array of recovery support services. Types of Recovery Support Services are listed below:
X	• Continuous recovery monitoring services are regular follow-ups with clients to assess the status of the client's recovery, identify any needs the client may have and help the client to address those needs, and provide early intervention for client's who have relapsed or who's recovery is otherwise at risk.
	• Enhanced Services are specialized services that remove barriers to a client's participation in treatment. Examples of these services are child care while a parent is participating in treatment or transportation to and/or from the treatment site.
X	***Recovery Support Services*** as identified above provided to pregnant & parenting women.

C. ***Required Services***

Priority Admission:

1) The Contractor shall give admission preference to pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour time frame.
2) Individuals with a history of injection drug use including the provision of interim services within 14 days.
3) Individuals with a primary diagnosis of a substance use disorder, which may also include a co-occurring mental health disorder.
4) Individuals on medication-assisted treatment for co-occurring substance abuse and mental health disorders or various opiate replacement therapies, including, but not limited to, methadone, buprenorphine and naltrexone.

Required Outreach:

~~New Hampshire Department of Health & Human Services (DHHS) programs receiving federal treatment~~ Block Grant funds requires that Contractors must publicize services available to pregnant or parenting women and injection drug users in need of substance abuse treatment and that these individuals receive preference for admission to treatment. This may be done as follows, but is not limited to, street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of ~~such treatment distributed to the network of community based organizations, health care providers and~~ social service agencies. The Contractor will submit their outreach plans to DHHS through the Bureau of Drug and Alcohol Services (BDAS) within 60 days of contract effective date.

Health Facilities Administration Licensing Requirements:

Housing programs with substance abuse treatment services at the same location will need to secure ~~necessary licensing as a Residential Rehabilitation Facility by the DHHS Bureau of Health Facilities~~ Administration, as appropriate, see He-P 807 at the following link: (http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html). Any contractor with an American Society of Addiction Medicine (ASAM) (October 2013) Level 3.3 or higher level program must secure this licensing for all Level 3 programs housed within the same facility as the Level 3.3 program. In the case of residential treatment and housing at the same site, residential programs should plan to treat no ~~more than 16 pregnant or parenting women at any given time to comply with federal Medicaid restrictions~~ on Institute for Mental Diseases (IMD) exclusion criteria. This restriction would not apply to programs in which the client's residence is in a separate location from the treatment program.

Capacity Reporting:

The Contractor must contact BDAS, as agent for DHHS, when their capacity has reached 90% within 5 ~~business days. The Contractor must refer pregnant women to the State when the Contractor has~~ insufficient capacity to provide services to any such pregnant women who seek the services of the program. Sending e-mail to the BDAS Clinical Services Unit Administrator may complete this notification process.

Access to Services:
The Contractor shall respond to calls requesting treatment and/or transitional living program services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within 2 business days following the day the call was received.

The Contractor is required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.

Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client should be referred to a DHHS funded provider where they are able to access interim services.

Contractors receiving grant funds from DHHS will not discriminate against clients who are using legitimate medications to assist their recovery and will not have policies that allow them to refuse admission to treatment or to discharge clients from treatment based on the use of appropriately prescribed medications and various opiate replacement therapies, including, but not limited to, methadone and buprenorphine, as well as other forms of medication-assisted treatment for co-occurring substance abuse and mental health disorders.

Clients Eligible for Treatment Services:
In order to be eligible for DHHS supported services, a client must meet all eligibility criteria described below. Eligibility determination shall be conducted as follows:

1. Substance Use Disorder, Financial Eligibility & Residency Screening: The contractor shall complete the eligibility screening module in the Web Information Technology System (WITS) to determine if the client meets residency, financial, and substance use disorder potential eligibility ~~requirements~~:
    a. Residency: The client must be a resident of New Hampshire or homeless in New Hampshire to be eligible for DHHS supported services; and
    b. Financial Eligibility: The client's income must be below 400% of Federal Poverty Level (FPL) to be eligible for DHHS supported services based on the sliding fee scale described below. Once the screening has been completed, the contractor shall print the associated ~~attestation and have the client sign this document. A copy of the signed attestation shall~~ be maintained in the client file. The client's financial eligibility shall be reassessed no less than every 120 days.; and
    c. Potential for a Substance Use Disorder: The client must screen positive for a potential substance use disorder to be eligible for DHHS funded services.
2. Evaluation: The contractor shall conduct a full substance abuse evaluation, which includes ~~administration of either the Addiction Severity Index (ASI) in WITS or Global Appraisal of~~ Individual Needs (GAIN).
    a. Substance Use Disorder: This evaluation shall be used to determine if the client meets Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) criteria for a substance use disorder. Clients who meet DSM5 criteria for a substance use disorder are eligible for DHHS funded services. Client who do not meet these criteria are not ~~eligible for DHHS funded services~~.

b. Level of Care: For clients who have met all other eligibility requirements, this evaluation shall be used to determine the appropriate level of care for the client based on ASAM (October 2013) criteria. The client is eligible for DHHS funded services at the assessed level of care unless such a level of care is unavailable or the client chooses to enter a lower level of care. If the assessed level of care in unavailable, the client may choose to enter the next higher level of care.

3. Medicaid/NHHPP Eligibility: The contractor shall determine whether or not the client is eligible for Medicaid/NHHPP coverage for the identified level of care. If the client is not eligible for Medicaid/NHHPP coverage for the identified level of care, the client may be eligible for DHHS funded services. If the client is eligible for Medicaid/NHHPP coverage for the identified level of care, the client is not eligible for DHHS funded services.
4. Insurance Coverage: The contractor shall determine whether or not the client has insurance that will cover services at the identified level of care. If the client does not have insurance that will reimburse for these services at a rate equal to or greater than the DHHS rate, the client is eligible for DHHS funded services. If the client has insurance that will reimburse for these services at an ~~amount equal or greater to the DHHS reimbursement rate, the client is not eligible for DHHS~~ funded services. The contractor may not charge the combination of the client, any 3rd party payor, and DHHS more than the maximum charge allowed. These parties shall be charged in the following order:
    a. The maximum allowed charge will be billed to the client's insurer, if applicable.
    b. The client will be charged their portion of the maximum allowed charge based on the BDAS ~~published sliding fee scale~~.
    c. The balance of the maximum allowed charge after deducting the client's portion and the insurance payment, if applicable, shall be charged to DHHS.

Sliding Fee Scale:

The contractor shall not charge the combination of the client, any 3rd party payor and BDAS an amount ~~greater than the maximum rate allowed for each service. All reasonable efforts shall be made to collect~~ payment of bills. A client's inability to pay shall not preclude admission to the program and treatment.

- Client Income is 0% - 138% of FPL: 100% of the allowed charge less any amount paid for by insurance.
- Client Income is 139% - 149% of FPL: 92% of the allowed charge less any amount paid for by insurance.
- Client Income is 150% - 199% of FPL: 88% of the allowed charge less any amount paid for by insurance.
- Client Income is 200% - 249% of FPL: 75% of the allowed charge less any amount paid for by insurance.
- Client Income is 250% - 299% of FPL: 60% of the allowed charge less any amount paid for by insurance.
- Client Income is 300% - 349% of FPL: 43% of the allowed charge less any amount paid for by insurance.
- Client Income is 350% - 399% of FPL: 33% of the allowed charge less any amount paid for by insurance.

With respect to minority age individuals, a minor child shall not be denied services as a result of the parent's unwillingness to pay the fee or the minor child's decision to receive confidential services pursuant to RSA 318-B:12-a.

Waiting List Management:
When a person who is pregnant or an injection substance abuser seeks treatment and there are no appropriate treatment services available within the required time frame as outlined below, interim services **must** be made available. The Contractor agrees to maintain the wait list management system in WITS that includes a unique patient identifier and include information on dates of requests for admission to treatment, provision of interim services and source for those services, referrals made for treatment or interim services, and disposition of clients on the waiting list.

- The waiting list must contain a mechanism that identifies and counts the number of applicants who present and are determined to be appropriate for substance abuse treatment but are unable to be placed as there is no capacity;
- Maintain contact with individuals awaiting admission; and,
- Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area.

The Contractor shall remove a client awaiting treatment from the waiting list only when one of the following conditions exists:

- Such persons cannot be located for admission into treatment *or*
- Such persons refuse treatment.

Specific Interim Services for Pregnant Women, Women with Dependent Children and Injection Drug Users:
The Contractor agrees to contact the BDAS Clinical Services Unit if a pregnant women and women with dependent children or individuals with a history of injection drug use, cannot be accepted into treatment within specific time frames, and agrees that interim services will be provided or facilitated by the Contractor. Interim services for pregnant women must include counseling on the effects of alcohol and drug use on the fetus, referrals for prenatal care, and counseling and education about HIV and tuberculosis. Interim services for injection drug users must also include counseling and education in the risks of needle sharing, about the risks of transmission to sexual partners and infants, and referral for HIV, Hepatitis C and tuberculosis screening/testing. All interim services shall be documented in the client's clinical record in the WITS system.

Interim Services for other Clients:
The Contractor shall provide, or refer the client to, interim services until level of service identified in the level of care assessment is available and/or the client is willing and assessed as being sufficiently motivated to take advantage of the proposed level of service or interim services. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client shall be referred to a DHHS funded provider where they are able to access interim services.

Services to pregnant and parenting women:
The Contractor further agrees that childcare will be made available to women who are in treatment with their dependent children, either through on-site care or through arrangements with an off-site legal childcare provider. Other services required are as follows:

- The family is treated as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
- The Contractor shall provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care.
- The Contractor shall provide or arrange for childcare while the women are receiving services even if the children are not in their custody, as long as parental rights have not been terminated.
- The Contractor shall provide or arrange for primary pediatric care for the women's children, including immunizations.
- The Contractor shall provide or arrange for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting, and childcare while the women are receiving these services.
- The Contractor shall provide or arrange for therapeutic interventions for children in custody of women in treatment, which may, among other things, address the children's developmental needs, their issues of sexual and physical abuse, and neglect.
- The Contractor shall provide or arrange for sufficient case management and transportation services to ensure that the women and their children have access to the services provided for above.
- If a pregnant, pregnant injection drug using or Injection Drug Using person refuses treatment or says (s)he is not interested in treatment, the wait list report shall be completed with the engagement activities attempted.
- If a pregnant, pregnant injection drug using or Injection Drug Using person no shows or cancels treatment, interim services must be provided, as stipulated above and the wait list report shall be completed that demonstrates the activities of follow up, engagement and substance abuse treatment services offered.

Relationship(s) with Primary Health Care:
The Contractor shall arrange and coordinate services and exchange of information with other health care providers and agencies which:

- Identifies the client's current Primary Care Provider (PCP) at screening and/or intake.
- If the client has no current PCP, the Contractor shall identify available provider(s) in the client's local area such as a federally qualified community health center, community health center, or other local health services.
- Obtains client/patient authorization to communicate with PCP office.
- If no authorization is completed initially, the Contractor shall educate client as to the importance of engaging the PCP in ongoing care and address the client's concerns as part of treatment, with goal of obtaining authorization before discharge.
- Sends the discharge summary to PCP and offers to discuss recovery issues with the provider.
- Arranges (or has the client arrange) a post-discharge appointment with PCP for the client/patient for follow-up of the substance use disorder.

Tobacco Cessation:
The Contractor shall have policies and procedures for both client and Contractor staff, that not only creates a tobacco-free environment as required by law, but to offer tobacco cessation tools and programming. Tobacco use, in and of itself, shall not be grounds for administrative discharge from the program. Initially, all clients shall be assessed for motivation in stopping the use of tobacco products. Providers may tap into resources such as the DPHS Tobacco Prevention & Control Program (TPCP) and

the certified tobacco cessation counselors available through the QuitLine. Other resources for providers include:

Breathe New Hampshire
145 Hollis St., Unit C
Manchester, NH 03101
603-669-2411 (phone) or 1-800-835-8647

The New Hampshire Medicaid program covers:

- Nicotine Replacement Therapy (NRT) Gum,
- NRT Patch,
- NRT Nasal Spray,
- NRT Lozenge,
- NRT Inhaler,
- Varenicline (Chantix),
- Bupropion (Zyban),
- Group Counseling and/or
- Individual Counseling. Up to 12 individual counseling sessions are covered per year through a mental health provider (Note: These sessions would NOT be in addition to other mental health counseling sessions under Medicaid). Pregnant women also have the option of group counseling. For more information, visit the website at: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm

Tuberculosis:
The Contractor shall make available tuberculosis services (defined as screening, counseling, testing, and treatment) directly, or through other providers, to each client receiving treatment. In the case of an individual denied admission due to lack of capacity, the substance abuse treatment Contractor will refer the individual to another provider of tuberculosis services if appropriate. All Contractor providing residential services shall make available, either on-site or through agreements with health care providers, tuberculosis services, including screening, testing, counseling and referral for medical treatment.

Physical location and facilities:
For the purpose of providing the services described in Section II of the Scope of Services, the Contractor shall obtain and maintain a suitable space complying with all fire, health, and safety codes to include handicapped accessibility and being wheelchair accessible.

The Contractor shall obtain written prior approval of DHHS, acting through BDAS, before entering into any agreement concerning relocation of the service site.

Culturally and Linguistically Appropriate Standards of Care:
DHHS recognizes that culture and language have considerable impact on how consumers access services. Culturally and linguistically diverse populations experience barriers in efforts to access services. To ensure equal access to quality services, DHHS expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. When feasible and appropriate, provide clients of Limited English Proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. The Contractor is responsible for reasonable accommodations in arranging for interpreter services for hearing impaired clients.
5. The Contractor offers consumers or clients a forum through which those individuals have the opportunity to provide feedback to the Contractor regarding cultural and linguistic issues that may deserve response.

The Contractor will submit a detailed description of the language assistance services they will provide to persons with Limited English Proficiency to ensure meaningful access to their programs and/or services, within ten (10) days of the contract effective date.

Compliance with State and Federal Laws:

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. All services provided pursuant to this Contract shall be subject to the most current proposed or formalized rules and regulations promulgated by DHHS, pursuant to RSA 541-A.
2. The Contractor shall maintain adherence to federal and state confidentiality laws specifically: 42 CFR Part 2B, N.H. RSA 318 B:12 and N.H. RSA 172:8-A and the Health Insurance Portability and Accountability Act (HIPAA): *http://www.hhs.gov/ocr/privacy/*
3. The Contractor shall meet the standards outlined in NH Administrative Rule He-A 300, Certification and Operation of Alcohol and other Drug Disorder Treatment Programs. This administrative rule is currently expired and under revision. The Contractor should plan to meet the requirements as outlined in the expired rule until the revisions are completed. He-A 300 can be viewed on the RFP link to this document *http://www.dhhs.nh.gov/business/rfp/index.htm*.
4. The Contractor shall, upon the direction of the State, provide court-ordered evaluation in their catchment area and a sliding scale fee shall apply and the inability to pay shall not interfere with the completion and submission of the court-ordered evaluation and shall, upon the direction of the State, offer treatment to those individuals pursuant to RSA 172:13.
5. Contractors considering research, including research conducted by student interns, using individuals served by this contract as subjects must adhere to the legal requirements governing human subjects' research. Contractors must inform the DHHS via contact with BDAS prior to initiating any research involving subjects or participants related to this contract. In addition, research conducted on subjects served by this contract may need to be approved by the New Hampshire Department of Health & Human Services Committee for the Protection of Human Subjects (NH DHHS CPHS) see *http://www.dhhs.nh.gov/irb/*

Client Stabilization:

The Contractor will be expected to arrange for medical clearance for all clients receiving treatment services supported by DHHS administered by BDAS to assure that they are not at risk for acute withdrawal from alcohol and certain drugs. The Contractor shall be expected to provide a range of integrated services that include withdrawal management services that follow detoxification guidelines outlined in Treatment Improvement Protocol (TIP) #45, Detoxification and Substance Abuse Treatment and ASAM guidelines.

Clinical Services:
The Contractor shall provide the following:

a. A minimum of one (1) substance abuse counselor on site each day of the week during primary treatment hours. The substance abuse counselor shall have a bachelor's degree or equivalent in social work/psychology, guidance or nursing and/or a certificate in the field of addiction studies from an approved educational institution or educational/life experience.
b. A minimum of one (1) substance abuse support staff on site each day of the week during all hours not covered by a substance abuse counselor. The substance abuse support staff must have a high school or General Equivalency Diploma (GED). Preference is given to individuals who have completed additional courses or taken training in substance use disorders or other health fields.
c. An intake/admission coordinator on site Monday through Friday of each week. The intake/admission coordinator shall have one (1) years' work experience in the field of addiction studies.
d. A full-time Executive Director, not filling any of the positions described above.

Evaluation:
The contractor shall conduct a full substance abuse evaluation, which includes administration of either the ASI or GAIN to determine eligibility for services. This evaluation must be updated every 120 days or when the client transitions to a different level of care.

Assessment of Risk for Self-Harm/Suicide: The Contractor shall have policies and practices for assessing risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and at discharge, and a process for referral when necessary to include referrals to mental health services.

The Contractor shall develop policies, programs and protocols in accordance with SAMHSA guidelines as outlined in the Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs). These publications can be downloaded from http://www.kap.samhsa.gov/products/manuals/index.htm .

Use of Best Practices: The Contractor is required to use the Addiction Severity Index (ASI) or Global Appraisal of Individual Needs (GAIN) assessment tools, the SAMHSA/NIDA MATRS treatment-planning model and the WITS electronic case management system.

Care Coordination:
The Contractor is required to assess each client's need/appropriateness for residential transitional living services and to **refer all clients for care coordination services** made available through the Access to Recovery (ATR) initiative administered by the BDAS so long as this initiative remains available on behalf of DHHS that would commence following the initial course of treatment. Contractors are required to address motivational issues with clients for them to participate effectively in the care coordination and recovery support services. Contractors are required to have clients sign the "ATR Client Participation Agreement" (made available by BDAS), indicating that they either agree or opt out of participating in these services. The contractor will facilitate all clients who agree to participate in these services to complete the Client Participation Agreement and upon obtaining a signed release of information, refer

clients to an ATR Care Coordinator Program at least two weeks prior to anticipated date of discharge (dis-enrollment) from services. Assessing the need for aftercare services is expected to take place while the client is involved within the most recent episode of care, with a referral being made and accepted by the care coordination service prior to the client being discharged.

The Contractor must provide the following for use by the care coordination program:

- Private space for interviewing/meeting with clients.
- Access to internet (either wired or wireless) in the meeting space
- Telephone in the meeting space and
- A contact person at the Contractor's site for logistics.

It is the expectation of the BDAS at DHHS that, upon completion of appropriate signed releases, the Contractor will provide the care coordination program with necessary information from the clinical record (evaluation, treatment plan, progress notes, etc.) for the care coordination program to develop a service plan with the client.

All alcohol and other drug treatment providers under contract with the BDAS on behalf of DHHS are required to address with all clients, the need for continuing services. This includes clinically managed low-intensity treatment programs under contract with the BDAS on behalf of DHHS as well as care coordination and recovery support services made available through DHHS contracted providers; the ATR initiative administered by BDAS, so long as this initiative remains available; and/or any other resources that become available to pay for these services that would commence following the initial course of treatment. The referral for these services should take place prior to discharge from the initial course of treatment.

Relevant Policies and Guidelines:
The services provided for in this agreement shall be in addition to the services provided for in any other agreement between the State of New Hampshire, any of its agencies, or any of its officers, and the Contractor.

Without limiting the generality of any other provisions of this agreement, the Contractor shall cooperate fully with, and answer all questions of representatives of the State conducting any periodic or special review of the performance of the Contractor or any inspection of the facilities of the Contractor.

Publications Funded Under Contract:
All products produced under this contract are in the public domain. All products (written, video, audio) produced, reproduced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution, or use. The Contract shall credit DHHS on all materials produced under this contract.

Student Internships:
The Contractor shall establish policies and procedures related to student interns that address minimum coursework, experience and core competencies for those interns having direct contact with individuals served by this contract. Student interns shall complete an approved ethics course prior to beginning the internship.

Staff Licensing Requirements:
The ratio of licensed to non-licensed service providers shall be as follows:
Agencies must have at least one Licensed, or Masters Licensed, Alcohol and Drug Counselor (LADC/MLADC) for each two unlicensed counselors providing substance abuse treatment services and a sufficient number of MLADCs or LADCs with the Licensed Clinical Supervision (LCS) credential to adequately provide for clinical supervision of all clinical staff. This requirement shall be met by the Contractor no later than six (6) months after the date of the Contract effective date.

Updated resumes, which clearly indicate the staff member is employed by the Contractor, including current positions of staff supported by funds provided through this Contract, shall be forwarded to the BDAS as agent for DHHS. The documentation shall include a copy of the New Hampshire Alcohol and Drug Counselor License.

Staff Certification Requirements:
In addition to the requirements for LADCs, all Contractor milieu staff in residential settings and transitional living programs and staff providing recovery support aftercare group services shall be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification under RSA 330-C (http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-330-C.htm). Certification must be completed within six (6) months of the contract's approval date.

Staff providing recovery support services are expected to be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification. Peer recovery support services made available through Recovery Community Organizations (RCOs), under agreement with BDAS on behalf of DHHS, shall be provided by individuals certified by those organizations (CRSW not required for peer recovery support services).

Supervision:
Ongoing clinical supervision will include weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress. When enough candidates are under supervision, group supervision may be included to help optimize the learning experience.

The content of supervision must include knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee, including the core functions as described in the Twelve Core Functions of Alcohol and Drug Counseling.

The content of supervision must also include the standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.

Staffing Changes:
BDAS as agent for DHHS shall be notified of changes in key personnel with updated resumes that clearly indicate the staff member is employed by the Contractor submitted within five (5) working days. Key personnel are those staff for whom at least 10% of their work time is spent providing alcohol or other drug abuse treatment services.

1. New Hires: The Contractor shall notify BDAS on behalf of DHHS in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. A resume of the employee, which clearly indicates the staff member is employed by the Contractor, shall accompany this notification.

2. Vacancies: The Contractor shall notify BDAS on behalf of DHHS in writing within 14 calendar days, if at any time, any site funded under this agreement does not have adequate staffing to perform all required services for more than one month.

Other Requirements:
The Contractor shall attend trainings and/or meetings as requested by DHHS.

ATR and Recovery Support Services:
All DHHS funded treatment and recovery support service providers must also be approved Access to Recovery (ATR) providers, so long as the ATR initiative remains available, as this will be the source of funding for these recovery support services through the Voucher Management System (VMS). Information on becoming an ATR provider can be found on the DHHS website: http://www.dhhs.nh.gov/dcbcs/bdas/atr/becomingprovider.htm

Regional Network Participation:
The Contractor will designate administrative level staff to regularly participate in the Regional Network and contribute to overall regional network strategic planning, monitoring, evaluation, and cross systems communication efforts. The Contractor is highly encouraged to serve on one of the work groups and contribute to data collection, regional strategic planning and evaluation. Participation will be measured by the annual Partner Survey (http://www.partnertool.net/) administered by NH Center for Excellence under contract with BDAS as agent for DHHS.

Performance Measures:
All treatment programs under contract with BDAS on behalf of DHHS are required to report on the National Outcome Measures (NOMs) established by the SAMHSA, as required in the Federal Substance Abuse Prevention and Treatment Block Grant, via the WITS (electronic case management) system. The Department of Health and Human Services reserves the right to consider Contractor performance across all of the domains in future funding decisions.

Data and Reporting Requirements:
1. Without limiting the generality of any other provisions of this agreement, the Contractor shall provide any periodic or special reports required by the DHHS.
2. The Contractor shall notify BDAS, as an authorized agent of DHHS, whenever the Contractor has reached ninety percent capacity to admit new clients. In addition the Contractor shall have a waiting list management policy in accordance with the SAPT Block Grant requirements. This 90% notification process will become automatic when this operation is fully functional in WITS.
3. The Contractor shall notify DHHS through BDAS, within one working day, if sufficient capacity is not available to provide treatment services to a pregnant woman, parenting woman or injection drug user within the required time frames and a referral elsewhere is not successful and interim services cannot be provided.

4. The Contractor shall comply with all research and/or information systems development activities for the electronic case management/Web Information Technology System (CM/WITS) conducted by, or authorized by, DHHS.
5. The Contractor shall administer any client surveys, client evaluations including the addiction Severity Index (ASI) or the Global Appraisal of Individual Needs (GAIN), client treatment outcome instruments, the M.A.T.R.S. Treatment Planning Tool, as required by DHHS.
6. The Contractor must have the ability to communicate and submit required reports via the Web-based submission system and/or e-mail, for treatment s and recovery support services and interim services. All required clinical and documentation activities shall be entered in WITS unless specifically granted an exception by BDAS on behalf of DHHS.

Critical Incident/Sentinel Event Reporting:
The Department's Sentinel Event policy is contained in the following link: http://www.dhhs.nh.gov/dcbcs/sentinel.htm

Division of Community Based Care Services (DCBCS) Sentinel Event Notification:
The preceding events require the immediate verbal notification to the BDAS Assistant Administrator or Clinical Services Unit Administrator upon the discovery of a sentinel event involving an individual(s) receiving services through a DHHS substance use disorder treatment Contractor.

Since the initial and immediate verbal notification of a sentinel event is likely to include protected health information (PHI) as identified below, the Contractor of services to individuals receiving services funded by the DHHS shall disclose PHI in a private and secure manner. Contractors and vendors should not leave voice-mail messages, but instead make direct telephone contact with the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee. If direct telephone contact is not possible, a voice mail message may be left without protected health information, such as medications and relevant medical and psychiatric diagnoses. As soon as possible after the initial verbal notification, the Contractor will mail or fax a completed *Sentinel Event Reporting Form* as directed in this protocol.

Notification shall include the following:
1. Name and phone number of the individual reporting.
2. Name, date of birth (DOB), medications and all relevant medical and psychiatric diagnoses of individual(s) involved;
3. Location, date, and time of event;
4. Description of the event including what, when, where, how, and other relevant information and identification of any other individuals involved;
5. Legal status of the individual involved with regard to guardianship and power of attorney;
6. Community, guardian, family and/or families' knowledge of the event; and
7. Contractor contact person and contact information.

It shall be the responsibility of the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee to notify the DCBCS Quality Improvement Director by e-mail as soon as the BDAS Clinical Administrator or designee becomes aware a Sentinel Event has occurred. The DCBCS Quality Improvement Director shall make immediate notification to the Commissioner. Internal e-mails within the Department may contain PHI and all Department employees will utilize safeguards to ensure the privacy

of the PHI as stated in the DHHS General Manual Health Insurance Portability and Accountability Act (HIPAA) policy #504.

Each DCBCS contractor recognizes its responsibility to report evidence of neglect, abuse or exploitation to the appropriate regulatory agencies as required by RSA 161-F: 42-57 and RSA 169-C:29. In any case of known or suspected neglect, abuse or exploitation, the Contractor aware of the situation shall follow all applicable rules relative to individual rights protection procedures.

Written follow up information is to be forwarded by the reporting Contractor to the appropriate BDAS Administrator listed below within 72 hours by completing the *Sentinel Event Reporting Form.* To protect clients' confidential information, reporting Contractors should submit the *Sentinel Event Reporting Form* either by fax to the BDAS Assistant Administrator or the BDAS Clinical Services Unit Administrator by a mail service that provides delivery confirmation.

Bureau of Drug and Alcohol Services
Assistant Administrator
105 Pleasant Street
Concord, NH 03301
Or by fax to the BDAS Administrator's Office at 271-6105;

Follow-up information is the responsibility of the Contractor and should be submitted in a way as to protect clients' confidential information such as by mail with delivery confirmation and should include:

1. The *Sentinel Event Reporting Form(www.dhhs.nh.gov/dcbcs/documents/sentinelform.pdf)*;
2. Additional details as they are learned or if the status of the situation changes; and,
3. Copies of newspaper articles.

Additionally, DHHS requires critical incident reporting. The Contractor shall report all critical incidents/sentinel events to the BDAS Clinical Services Unit Administrator immediately via telephone. Every effort shall be made to reach the BDAS administrator directly. If a voice message is necessary, sufficient provider contact information shall be provided so that DHHS is able to reach the reporter, or other responsible staff, immediately.

A critical incident includes, but is not limited to, any child or adult protective services report to the Division of Children, Youth and Families (DCYF), or the Bureau of Elderly and Adult Services (BEAS), respectively, regarding any incident involving 1) a staff/employee to youth or client, 2) youth to youth, or 3) client to client. This includes incidents that occur while a client is on leave, or on a pass, from the Contractor and may be off site at the time the incident occurred.

A sentinel event is an unexpected occurrence involving the death or serious physical or psychological injury, or risk thereof, signaling the need for immediate investigation and response.

Death or any serious injury or medical emergency regarding staff or clients that requires emergency medical attention (EMT or other emergency personnel at the Contractor's site, or a hospital emergency room visit), or any crime reportable to law enforcement, or any other serious incident must also be reported to DHHS as described below.

Reportable sentinel events include, but are not limited to, any occurrence that meets any of the following criteria:

1. An unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition.
2. Homicide or suicide of any individual receiving DHHS funded care, treatment or services, that had been discharged from a Department funded program or facility within 30 days of the event, or has been evaluated by a service Contractor within the preceding 30 days;
3. Sexual assault or rape of any individual receiving DHHS funded care, treatment or services by another client or employee of any Department funded program or facility where there is an act that was witnessed or there is sufficient clinical evidence obtained by the Contractor to support allegation of nonconsensual sexual contact.
4. Unauthorized departure of an individual receiving DHHS funded services, from a facility providing care, resulting in death or permanent loss of function.
5. Medication error that results in death, paralysis, coma, or other permanent loss of function.
6. Delay or failure to provide DHHS funded Contractor services that result in death or permanent loss of function.
7. Abuse as a result of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one individual by another.
8. Neglect as a result of the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness.
9. Assault of or by a client of the Contractor that results in the injury of the person or another person of such severity that medical attention is required.
10. Arson resulting in property loss.
11. High profile events, which may include media coverage and/or police involvement.

On-Site Reviews:

1. The Contractor shall allow a team or person authorized by DHHS to periodically review the Contractor's systems of governance, administration, data collection and submission, clinical, and financial management in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include, but not be limited to, client record reviews to measure compliance with this exhibit.
3. The Contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. DHHS staff shall contact the Contractor in advance of the site visit, so that the Contractor shall have sufficient time to prepare any guidance/reporting systems or logs that will be reviewed at the site visit.

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Method and Conditions Precedent to Payment

The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A Amendment #3, Scope of Services, and in accordance with Exhibit B Amendment #3.

For the period of July 1, 2014 to June 30, 2015, funding for this Agreement is funded by various sources as a percentage of the total amount of $810,929 as follows:

- 46 % Federal Funds from the Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959);
- 22 % General Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Funds; and
- 32 % General funds.

I. Payment Methodology

The Contractor shall be reimbursed for providing and delivering the services listed in Exhibit A Amendment #3, paragraph B. The following terms and conditions detailed in this Exhibit B Amendment #3 shall apply to all services unless expressly stated otherwise.

The Contractor shall agree to use and apply all contract funds from the State for costs and expenses as detailed in the Service Reimbursement Table below. Allowable costs and expenses shall be determined by the State in accordance with applicable state and federal laws and regulations. Starting in State Fiscal Year 2015 (effective July 1, 2014) the contractor will receive a payment for each service at the rates and within the limits described below. For clients receiving DHHS supported services, the contractor may not charge the client, any 3rd party payor, and DHHS a combined rate that is more than the rate established by BDAS for that level of service or any other fees. These parties shall be charged in the following order:

1. The maximum allowed charge will be billed to the client's insurer, if applicable.
2. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
3. The balance of the maximum allowed charge after deducting the client's portion and the insurance payment, if applicable, shall be charged to DHHS.

Service Reimbursement Table - A check mark indicates the services and corresponding rates the Contractor will be reimbursed for.

Check mark indicates applicable service	Service	DHHS Established Rate	Service Limit
X	Evaluation	$225	1 every 90 days
X	Outpatient – Individual	$18.75/unit***	$190 of combined individual & group/week
X	Outpatient – Group	$5.00/unit	
X	Intensive Outpatient*	$80.00/day	$320 (4 days)/week
X	Low-Intensity Residential – Adult	$100.00/day	$700 (7 days) /week

X	Low-Intensity Residential – Adolescent	$128.00/day	$896 (7 days) /week
X	High-Intensity Residential – Adult	$130.00/day	$910 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Room & Board Only	$66.00/day	$462 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Clinical Services	$162.60/day	$1138.20 (7 days) /week
X	Medium Intensity Residential – Adolescent	$170.00/day	$1190 (7 days) /week
	Recovery Support Services		
X	Individual	$15.00/unit	$160 of combined individual & group/week
X	Group	$5.00/unit	
X	Continuous Recovery Monitoring – Attempted**	$15.00/contact	$60 of combined attempted and completed/month for the first 6 months post discharge
X	Continuous Recovery Monitoring – Completed	$15.00/contact	
	Enhanced Services	Varied	

* Providers may bill the per diem rate for Intensive Outpatient Treatment services only on those days when the client attends individual and/or group counseling associated with the program. It is expected that each day of attendance includes a minimum of 3 hours of group and/or individual counseling services.

**Attempted Contact is at least 3 attempts to contact a client over the course of at least one week.

*** A unit is equal to 15 minutes of service

It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period. Utilization and array will also be monitored by the Department via WITS. Failure to meet this requirement may result in amendment to or termination of the contract. At a minimum, contractors must provide the array of services they contracted to provide for in SFY14; at least twenty-five percent (25%) of the funding for the period of July 1, 2014 to June 30, 2015 must be utilized for Outpatient and/or Intensive Outpatient services.

1. **Performance Incentives:**

A. Access to Services:

Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received and shall conduct initial eligibility screening as soon as possible, ideally at the

time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact. For each client who screens eligible for services and starts receiving services, whether for the identified level of care or interim services, within 10 business days following the eligibility screening, the treatment contractor will receive an incentive payment of $75.00. Access incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

B. Completion:

For each client who is discharged from the program because they have completed treatment or transferred to another treatment provider as recorded in the Discharge Type field of the WITS Discharge Module, the treatment contractor will receive an incentive payment of $75.00. Completion incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

C. Client Outcomes:

If a client who was discharged from the program meets at least 3 of the Outcome criteria below in the 3rd and/or 6th month post-discharge, as evidenced by the WITS Follow-Up module, the treatment contractor will receive an incentive payment in the amount of $50. The 3rd month post discharge is considered to be 60 – 120 days post discharge. The 6th month post discharge is considered to be 150 – 210 days post discharge. Outcomes incentives will be calculated and paid on a monthly basis for clients meeting criteria in the previous calendar month. It is expected that at least 50% of discharged clients will be contacted for 3 and/or 6 month follow-up over the contract year.

i. Abstinence: The client reports reduced or no substance use in the past 30 days.
ii. Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school.
iii. Crime and Criminal Justice: The client reports no arrests in the past 30 days.
iv. Stability in Housing: The client reports being in stable housing.
v. Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

D. Performance Incentive Payout Limits:

Performance incentives are limited to no more than 6% of the total contract amount annually. The total amount paid out during the contract year will never exceed the total contract amount. DHHS is not obligated to make payment for any incentives that occur outside of the current contract year; however, incentives may be carried over to future contract years at the discretion of DHHS.

2. Failure to Meet Deliverables:

The Contractor shall comply with all contract requirements as detailed in Exhibit A Amendment #3 section B, Required Services. Upon determination that Contractor may not be meeting the required deliverables, within two (2) weeks BDAS will provide a written correction action plan. Within two (2) weeks of notification of the corrective action plan, Contractor will provide a written remedial plan. BDAS will monitor the corrective actions for 60 days. Failure to meet requirements of the corrective action plan within 60 days may result in withholding of any or all payments or termination of the contract.

3. Invoicing & Billing:

All billing shall be completed via the WITS system according to protocols established by BDAS.

The Contractor shall have written authorization from the State prior to using contract funds to purchase or lease any equipment with a cost in excess of two thousand five hundred dollars ($2500) and with a useful life beyond one year.

II. Allocation of Funding:

It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period and at least 25% of the funding for the period of July 1, 2014 to June 30, 2015 must be utilized for Outpatient and/or Intensive Outpatient services. Utilization and array will also be monitored by the Department via WITS. The contractor is prohibited from spending down more than the sum of the total contract amount that includes the cost of the client services and related incentives.

III. Availability of Alternative Funding:

The New Hampshire Department of Health and Human Services may terminate or amend the contract should alternate third party payors, including Medicaid, the New Hampshire Health Protection Program and/or insurance available on the New Hampshire Insurance Exchange cover any of the services included in this contract.

IV. Limitations and restrictions of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds:

The Contractor agrees to use the SAPT funds as the payment of last resort.

Restrictions on SAPT Block Grant on State and Contractor expenditures include:
The State may not:

- Provide inpatient hospital services except under those conditions outlined in the regulations.
- Make cash payments to intended recipients of substance abuse services.
- Purchase or improve land.
- Purchase, construct, or permanently improve buildings or other facilities.
- Purchase major medical equipment.
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds. (in-kind)
- Provide financial assistance to any entity other than a public or non-profit private entity.
- Provide individuals with hypodermic needles or syringes.
- Expend more than the amount of Block Grant funds expended in FFY91 for treatment services provided in penal or correctional institutions of the State.

The Contractor shall not:

- Use any federal funds provided under this contract for the purpose of conducting testing for the etiologic agent for Human Immunodeficiency Virus (HIV) unless such testing is accompanied by appropriate pre and post-test counseling.
- Use any federal funds provided under this contract for the purpose of conducting any form of needle exchange, free needle programs or the distribution of bleach for the cleaning of needles for intravenous drug abusers.

V. Charitable Choice:

Federal Charitable Choice statutory provisions ensure that religious organizations are able to equally compete for Federal substance abuse funding administered by SAMHSA, without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries (see 42 USC 300x-65 and 42 CFR Part 54 and Part 54a, 45 CFR Part 96, Charitable Choice Provisions and Regulations). Charitable Choice statutory provisions of the Public Health Service Act enacted by Congress in 2000 are applicable to the SAPT Block Grant program. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

VI. Notwithstanding paragraph 18 of the General Provisions of this Agreement P-37, an amendment limited to adjusting amounts within the budgets and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of Governor and Executive Council.

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SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A Amendment #3, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. Subparagraph 14.1.1 of the General Provisions of this contract, is deleted and the following subparagraph is added:

14.1.1 Comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $1,000,000 per occurrence with additional general liability umbrella coverage of not less than $2,000,000.

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:
Tri-County Community Action Program, Inc.

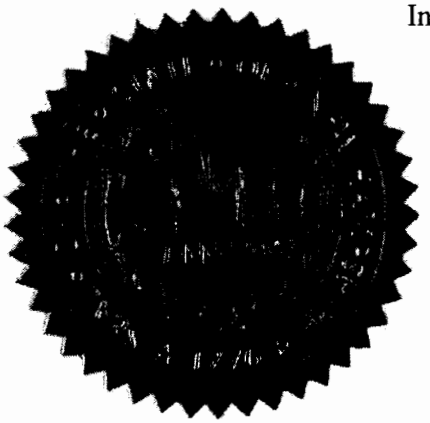
11.20.14
Date

Name: Michael Coughlin
Title: Chief Executive Officer

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that TRI-COUNTY COMMUNITY ACTION PROGRAM, INC. (TRI-COUNTY CAP) is a New Hampshire nonprofit corporation formed May 18, 1965. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 3rd day of April A.D. 2014

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Gary Coulombe, do hereby certify that:
(Name of the elected Officer of the Agency; cannot be contract signatory)

1. I am a duly elected Officer of Tri-County Community Action Program, Inc..
(Agency Name)

2. The following is a true copy of the resolution duly adopted at a meeting of the Board of Directors of

the Agency duly held on September 23, 2014:
(Date)

RESOLVED: That the Chief Executive Officer
(Title of Contract Signatory)

is hereby authorized on behalf of this Agency to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The forgoing resolutions have not been amended or revoked, and remain in full force and effect as of

the 20th day of November, 2014.
(Date Contract Signed)

4. Michael Coughlin is the duly elected Chief Executive Officer
(Name of Contract Signatory) (Title of Contract Signatory)

of the Agency.

(Signature of the Elected Officer)

STATE OF NEW HAMPSHIRE

County of Coos

The forgoing instrument was acknowledged before me this 20th day of November, 2014,

By Gary Coulombe.
(Name of Elected Officer of the Agency)

Suzanne C. French
(Notary Public/Justice of the Peace)

(NOTARY SEAL)

Commission Expires: June 19, 2018

SUZANNE C. FRENCH
Notary Public - New Hampshire
My Commission Expires June 19, 2018

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/20/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Karen Shaughnessy
FIAI/Cross Insurance 1100 Elm Street Manchester NH 03101	PHONE (A/C, No, Ext): (603) 669-3218 FAX (A/C, No): (603) 645-4331 E-MAIL ADDRESS: kshaughnessy@crossagency.com
INSURED	**INSURER(S) AFFORDING COVERAGE** / **NAIC #**
Tri-County Community Action Program, Inc 30 Exchange Street Berlin NH 03570	INSURER A: Arch Ins Co 11150 INSURER B: Maine Employers Mutual Ins Co. INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES **CERTIFICATE NUMBER:** CL1471714530 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			NCPCKG0328200	7/22/2014	7/1/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			NCAUT0328200	7/22/2014	7/1/2015	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Underinsured motorist	$ 1,000,000 $ $ $ $ 1,000,000
B	UMBRELLA LIAB X OCCUR X EXCESS LIAB CLAIMS-MADE DED RETENTION $			NCFXS0328200	7/22/2014	7/1/2015	EACH OCCURRENCE AGGREGATE	$ 2,000,000 $ 2,000,000 $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		3102801186 (3a.) NH All officers included	7/1/2014	7/1/2015	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
A	Professional Liability			NCPCKG0328200	7/22/2014	7/22/2015	Per Occurence Aggregate	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Refer to policy for exclusionary endorsements and special provisions.

CERTIFICATE HOLDER

NH-DHHS-BDAS
105 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Laura Perrin/KS5 Laura Perrin

TRI-COUNTY COMMUNITY ACTION PROGRAM, INC.

AUDITED FINANCIAL STATEMENTS

FOR THE YEARS ENDED
JUNE 30, 2013 AND 2012

INDEX TO FINANCIAL STATEMENTS

Financial Statements

Supplemental Schedules

INDEPENDENT AUDITOR'S REPORT

Todd C. Fahey, Esq.
Court-Appointed Special Trustee and
The Board of Directors of
Tri-County Community Action Program, Inc.
Berlin, New Hampshire 03570

Report on the Financial Statements
We have audited the accompanying financial statements of Tri-County Community Action Program, Inc. (a nonprofit organization) which comprise the statements of financial position as of June 30, 2013 and 2012, and the related statements of activities, functional expenses and cash flows for the years then ended and the related notes to the financial statements.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and the fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America: this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on theses financial statements based on our audits. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financials are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Basis for Qualified Opinion
As more fully described in Note B to the financial statements, Tri-County Community Action Program, Inc. had not previously classified the difference between its assets and liabilities as unrestricted net assets, temporarily restricted net assets and permanently restricted net assets based on the existence or absence of donor-imposed restrictions. The effects on the financial statements of that departure from those accounting principles are not reasonably determinable.

Qualified Opinion
In our opinion, except for the effects of the matter described in the Basis for Qualified Opinion paragraph, the financial statements referred to above present fairly, in all material respects, the financial position of Tri-County Community Action Program, Inc. as of June 30, 2013 and 2012, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Emphasis of Matter
As discussed in Note P to the financial statements, the 2012 financial statements have been restated to correct a misstatement. Our opinion is not modified with respect to this matter.

Other Matters
Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplemental schedule of functional expenses (pages 26-29) and the schedule of expenditures of federal awards on (pages 30-35), as required by Office of Management and Budget Circular A-133, Audits of States, Local Governments and Non-Profit Organizations are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards
In accordance with Government Auditing Standards, we have also issued our report dated March 31, 2014, on our consideration of Tri-County Community Action Program, Inc.'s internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering Tri-County Community Action Program, Inc.'s internal control over financial reporting and compliance.

Sincerely,

Mason + Rich, P.A.

MASON + RICH PROFESSIONAL ASSOCIATION
Certified Public Accountants
Concord, New Hampshire

March 31, 2014

TRI-COUNTY COMMUNITY ACTION PROGRAM, INC

STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2013 AND 2012

ASSETS

	2013	2012
CURRENT ASSETS		
Cash	$ 88,679	$ -
Accounts Receivable	966,287	626,033
Inventories	65,023	99,759
Due From Insurance	41,353	-
Prepaid Expenses	16,052	-
Other Assets	1,320	-
Total Current Assets	1,178,714	725,792
PROPERTY AND EQUIPMENT		
Property, Plant and Equipment	10,937,228	10,585,785
Less: Accumulated Depreciation	(3,954,459)	(3,410,650)
Net Property and Equipment	6,982,769	7,175,135
OTHER ASSETS		
Restricted Cash	631,525	442,275
Other Assets	-	46,174
Total Other Assets	631,525	488,449
TOTAL ASSETS	$ 8,793,008	$ 8,389,376

(Continued on next page)

The Accompanying Notes are an Integral Part of These Financial Statements

TRI-COUNTY COMMUNITY ACTION PROGRAM, INC

STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2013 AND 2012

LIABILITIES AND NET ASSETS

	2013	2012
CURRENT LIABILITIES		
Current Portion of Long-Term Debt	$ 313,590	$ 3,337,972
Current Portion of Lease Payable	35,874	30,067
Line of Credit	685,587	793,976
Bank Overdraft	-	8,046
Accounts Payable	1,245,898	1,001,434
Accrued Compensated Absences	260,353	406,689
Accrued Salaries	77,408	114,987
Accrued Expenses	117,657	14,753
Other Liabilities	467,840	630,759
Total Current Liabilities	3,204,207	6,338,683
LONG-TERM LIABILITIES		
Long-Term Debt, Net of Current Portion	4,602,933	930,918
Lease Payable, Net of Current Portion	5,410	39,603
Interest Rate Swap at Fair Value	82,650	114,433
Total Long-Term Liabilities	4,690,993	1,084,954
TOTAL LIABILITIES	7,895,200	7,423,637
NET ASSETS		
Unrestricted	(250,495)	(375,462)
Unrestricted - Board Designated	22,781	-
Temporarily Restricted	1,125,522	1,341,201
TOTAL NET ASSETS	897,808	965,739
TOTAL LIABILITIES AND NET ASSETS	$ 8,793,008	$ 8,389,376

The Accompanying Notes are an Integral Part of These Financial Statements

TRI-COUNTY COMMUNITY ACTION PROGRAM, INC.

STATEMENT OF ACTIVITIES

FOR THE YEAR ENDED JUNE 30, 2013

	Unrestricted	Temporarily Restricted	Total
SUPPORT AND REVENUES			
Grants and Contracts	$ 13,350,557	$ 268,289	$ 13,618,846
Program Funding	1,506,303	-	1,506,303
Utility Programs	1,590,891	-	1,590,891
In-Kind Contributions	695,449	-	695,449
Contributions	311,018	478,531	789,549
Fundraising	30,265	-	30,265
Rental Income	609,832	-	609,832
Interest Income	723	-	723
Gain (Loss) on Disposal	31,280	-	31,280
Other Revenue	142,317	-	142,317
Total Support and Revenues	18,268,635	746,820	19,015.455
NET ASSETS RELEASED FROM RESTRICTION			
Expiration of Program Restrictions	962,499	(962,499)	-
OPERATING EXPENSES			
Agency Fund	1,034,468	-	1,034,468
Headstart	2,521,533	-	2,521,533
Guardianship	757,207	-	757,207
Transportation	1,226,314	-	1,226,314
Volunteer	128,489	-	128,489
Workforce Development	459,244	-	459,244
AOD	1,361,031	-	1,361,031
Carroll County Dental	649,067	-	649,067
Carroll County Restorative Justice	189,210	-	189,210
Support Center	247,906	-	247,906
Homeless	550,703	-	550,703
Energy & Community Development	8,650,600	-	8,650,600
Elder	1,339,397	-	1,339,397
Total Operating Expenses	19,115,169	-	19,115.169
CHANGES IN NET ASSETS FROM OPERATIONS	115,965	(215.679)	(99,714)
OTHER INCOME			
Gain on Interest Rate Swap	31.783	-	31.783
TOTAL CHANGES IN NET ASSETS	147,748	(215,679)	(67,931)
Net Assets, Beginning of Year	(375,462)	1,341,201	965.739
Net Assets, End of Year	$ (227.714)	$ 1.125,522	$ 897,808

(Continued on next page)

The Accompanying Notes are an Integral Part of These Financial Statements

TRI-COUNTY COMMUNITY ACTION PROGRAM, INC.

STATEMENT OF ACTIVITIES

FOR THE YEAR ENDED JUNE 30, 2012

	Unrestricted	Temporarily Restricted	Total
SUPPORT AND REVENUES			
Grants and Contracts	$ 15,732,761	$ 686,718	$ 16,419,479
Program Funding	1,935,620	-	1,935,620
Utility Programs	671,725	-	671,725
In-Kind Contributions	411,442	-	411,442
Contributions, as restated	266,155	405,470	671,625
Fundraising	54,929	-	54,929
Rental Income	44,496	-	44,496
Interest Income	884	-	884
Gain (Loss) on Disposal	2,247	-	2,247
Other Revenue	212,551	-	212,551
Total Support and Revenues	19,332,810	1,092,188	20,424,998
NET ASSETS RELEASED FROM RESTRICTION			
Expiration of Program Restrictions	-	-	-
OPERATING EXPENSES			
Agency Fund	1,515,511	-	1,515,511
Headstart	2,522,460	-	2,522,460
Guardianship	814,151	-	814,151
Transportation	1,055,705	-	1,055,705
Volunteer	129,170	-	129,170
Workforce Development	534,984	-	534,984
AOD	1,545,026	-	1,545,026
Carroll County Dental	595,841	-	595,841
Carroll County Restorative Justice	261,197	-	261,197
Support Center	311,910	-	311,910
Homeless	908,177	-	908,177
Energy & Community Development	9,619,568	-	9,619,568
Elder	1,326,239	-	1,326,239
Total Operating Expenses	21,139,939	-	21,139,939
CHANGES IN NET ASSETS FROM OPERATIONS	(1,807,129)	1,092,188	(714,941)
OTHER EXPENSES			
Loss on Interest Rate Swap	44,620	-	44,620
CHANGES IN NET ASSETS, AS RESTATED	(1,851,749)	1,092,188	(759,561)
Net Assets, Beginning of Year as Previously Reported	2,235,260	-	2,235,260
Prior Period Adjustment, see Note P	(758,973)	249,013	(509,960)
Net Assets, Beginning of Year, as Restated	1,476,287	249,013	1,725,300
Net Assets, End of Year	$ (375,462)	$ 1,341,201	$ 965,739

The Accompanying Notes are an Integral Part of These Financial Statements

TRI-COUNTY COMMUNITY ACTION PROGRAM Inc.

Serving Coos, Carroll & Grafton Counties

30 Exchange Street, Berlin, NH 03570 • (603) 752-7001 • Toll Free: 1-800-552-4617 • Fax: (603) 752-7607
Website: http://www.tccap.org • E-mail: admin@tccap.org
Chief Executive Officer: Michael W. Coughlin

BOARD OF DIRECTORS
FY2015

COÖS COUNTY

Board Chair
Sandy Alonzo
Teacher

Treasurer
Cathy Conway
Vice President- Economic Development - NCIC

Secretary
Gary Coulombe
Firefighter

Andrew Lefebvre
Teacher

CARROLL COUNTY

Anne Barber
Attorney

Michael Dewar
Business Owner

GRAFTON COUNTY

Nancy Kitchen
Animal Trainer-
Squam Lakes Science Center

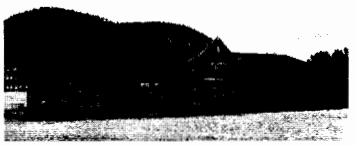
TRI-COUNTY COMMUNITY ACTION PROGRAM Inc.

Serving Coos, Carroll & Grafton Counties

30 Exchange Street, Berlin, NH 03570 • (603) 752-7001 • Toll Free: 1-800-552-4617 • Fax: (603) 752-7607
Website: www.tccap.org • E-mail: admin@tccap.org
Chief Executive Officer: Michael Coughlin

List of Key Administrative Personnel

	As of:	November, 2014	This Contract	
Title	**Name**	**Annual Salary**	**Percentage**	**Amount**
Chief Executive Officer	Michael Coughlin	$140,000	0.00%	0
Chief Financial Officer	Robert Boschen	$100,000	0.00%	0
Division Director, Alcohol & Other Drugs	Kristy Letendre	$44,100	85%	37,485
Clinical Director	Elaine Davis	$50,000	85%	42,500



MICHAEL W. COUGHLIN, M.S.

Chief Executive – Nonprofit Sector

Complex, Multi-Site Operations ❖ Revenue & Margin Growth
Strategic Partnerships
Community & Public Engagement

Motivating and results driven; recognized for:

- ✓ Strategic planning and financial management
- ✓ Mentoring & developing inspired leaders
- ✓ Innovation, marketing and branding
- ✓ Entrepreneurial spirit
- ✓ Assuring highest quality standards
- ✓ Passionate advocacy for mission

EDUCATION

Master of Science, Social Work - Columbia University, New York, New York
Bachelor of Arts - Quinnipiac University, Hamden, Connecticut

PROFESSIONAL EXPERIENCE

REHABILITATIVE RESOURCES, INC. 2012 - 2013

One of the larger agencies providing services to people with developmental disabilities in Massachusetts. Serving hundreds of clients in 44 residential facilities, employment supports and day habilitation programs all over the state. $25 million in annual revenue and over 600 full and part-time staff.

- CEO

Recruited to this position at an agency in need of change, in a time of distress. Followed a 31-year CEO, and reporting to a Board of Directors that expects transformation. Re-configured the senior leadership team, designed a five-year strategic planning process, and began agency-wide healing and cultural re-invigoration.

- **Organizational Development:** Leveraged the agency's considerable reputational and financial assets into distinct advantages in preparing for its 5-year strategic plan.
  - Met nearly every employee directly, either through individual team meeting visits, or through three regional town hall-style events, the first time this has happened.
  - Launched company-wide strategic planning process, involving stakeholders at every level and region of the organization.

- **Executive Development:** Reorganized senior management team into a streamlined, truly decision-making group. Set the conditions and expectations to become a high performing team. Secured executive coaching for leaders where necessary.

- **Community and Market Development:** Met with all major funders to understand their perceptions of the company, and to re-set a new focus on customer service excellence. Performed evaluations of the competitive environment, and began to build strategic coalitions with potential partners for new business.

ARIZONA'S CHILDREN ASSOCIATION 2011 to 2012
Arizona's oldest multi-service nonprofit, located in every county in the state, serving over 45,000 children and families every year in over 20 different programs, including behavioral health, substance abuse, foster care. $40 million in annual revenue and nearly 750 full and part-time staff.

➢ **CEO**
Recruited to this position as successor to a 20-year CEO. Executed a financial turnaround: moving a projected $750,000 deficit to break-even status within five months.

- **Organizational Development:** Stabilized financials and worked with Board and staff to create an aggressive five-year plan for growth:
  - Engaged program leaders, Finance team and fundraising to overcome previous year's losses and improve performance in turning around current year financials.
  - Re-organized senior program leaders from regional structure to lines of business, resulting in much better program consistency and communication with staff.

- **Executive Development:** Empowered Executive team to make decisions without micro-managing. Created an environment where creativity and execution exist side by side.

- **Community Relations:** Reached out to community leaders, funders, donors, competitors and potential partners. Made sure to be accessible, to offer our agency's support.

GOODWILL INDUSTRIES OF NORTHERN NEW ENGLAND 2007 to 2010
Serving Maine, New Hampshire and Vermont, with $60 million in annual revenue. Employing 1400 people and serving over 20,000 individuals per year with services including developmental disability, brain injury and behavioral health. 25 stores and 30 program locations in three states.

➢ **CEO**
Recruited to this position to create and execute a new strategic plan. Increased annual revenue by $20 million in three years to $60 million. Doubled the number of clients served during the same period. Greatly improved employee and community relations.

- **Organizational Development:** Created Goodwill's strategic plan for Board approval, carried out its plans and achieved exceptional results:

  - Grew state and federal revenue by $10 million per year through increases in grants, fees and philanthropy.
  - Maximized growth of retail business, earning $10 million in new profitable revenue annually within three years.
  - Initiated and implemented two acquisitions of other nonprofits.
  - Increased agency margins each year, exceeding $1.9 million in F.Y. 2010.
  - Championed new initiatives in quality improvement, employee relations and safety.

- **Executive Development:** Stabilized and grew a strong executive team, breaking down silos to achieve trust and true team performance. Created learning opportunities and career development for staff at all levels.

- **Community and Government Relations:** Increased Goodwill's profile through improved marketing, branding and partnerships with other organizations. Built strong relations with Departments of Health and Human Services, Attorney General's Office and Congressional delegations. Greatly expanded engagement with volunteers.

GENESIS BEHAVIORAL HEALTH, Laconia, New Hampshire 2002 to 2007
One of ten community mental health programs licensed by the Division of Behavioral Health in New Hampshire. $8 million organization provides comprehensive mental health care.

➢ **Executive Director**

Recruited to this organization to assume management responsibility and implement an aggressive turnaround. Guided management team to drive growth and service quality. Grew revenue by 35%, generating over $1 million in new margins, in a time of shrinking state funds.

- ***Organizational Development:*** Directed organizational analysis, strategic planning and company-wide initiatives. Returned organization and balance sheet to fiscal health.
- ***Executive Development:*** Led a successful management restructuring, stabilizing the executive team. Helped Board of Directors become a stronger, more cohesive group.
- ***Community & Government Relations:*** Built a bridge to community and government through marketing and education events as well as personal contacts.

WARREN SHEPELL CONSULTANTS, Toronto, Ontario 2000 to 2001
One of Canada's leading behavioral health firms, supporting 1500+ client organizations and generating $35 million annually. Ranked one of "50 best managed private companies in Canada" by Arthur Andersen and Financial Post.

➢ **Vice President, Operations**

Managed nation-wide counseling operations provided by mental health professionals and para-professionals. Managed a $19 million budget.

- ***Staffing:*** Led a national network of over 1100 Doctorate and Master's level professionals, providing service to over 70,000 clients per year
- ***Service / Network Management & Expansion:*** Directed the management of 28 offices coast to coast, to support new contracts. Played key role in 18% one-year revenue growth and 20% profit margins.
- ***Business Development & PR:*** Participated in sales efforts, resulting in winning key accounts. Represented company as a media spokesperson.

CHC- WORKING WELL, Mississauga, Ontario 1989 to 2000
One of Canada's largest behavioral health providers. Contracts with 1200+ client organizations, generating $30 million annually.

- ➢ **Vice President, Research & Development** - 1998 to 2000
- ➢ **National Director, Client Services** - 1995 to 1998
- ➢ **Regional Manager, Client Services** - 1993 to 1995
- ➢ **Area Manager, Client Services** - 1991 to 1993
- ➢ **Employee Assistance Counselor** - 1989 to 1991

Extensive Board service involvement

Robert Boschen. Jr., CMA, MBA

SUMMARY/OBJECTIVE

Professional with excellent managerial, analytical, financial and teamwork skills. Able to take the lead or supporting role on crucial projects. Accustomed to tight, rapid deadlines and innovative, proactive and reactive work environments. Can adjust to varied software systems and research situations rapidly, and able to teach a team to do so. Seek professional managerial/analytical operations position within driving distance of North Conway, New Hampshire.

SKILLS/ABILITIES

- Certified Management Accountant (CMA).
- Goal oriented manager with ability to manage assigned budget.
- Ability to supervise and manage staff to set and achieve directed goals.
- Comfortable working with all levels of staff and management.
- Ability to implement, manage and direct crucial programs – financial and operational.
- Excellent analytical abilities - including capital budgeting, cost/benefit analysis, and benchmarking analysis.
- Detailed exposure to mergers and acquisitions. Can coordinate purchasing and Requisition for Proposals.
- Manufacturing (cost accounting), construction, governmental and service industry exposure.
- Knowledge of internal and external corporate and governmental reporting needs.
- Worked on and led various projects which saved employers sizable tax and operating expense dollars.
- Can construct complete accounting/reporting system. Can implement controls related to accounting and systems.
- Excellent with mainframe and PC based software packages including Excel, PowerPoint, and Access.

WORK EXPERIENCE

Town of Falmouth — **Falmouth, Maine**

Director of Finance — **August 2011 –Present**

- Responsible for financial operations and reporting related to the $11 million budget for the Town – population 11,165 A vibrant coastal town in Maine, in 2011 Falmouth was among the "Top Cities to Live and Learn" in the United States, according to the second-annual national ranking released by Forbes Magazine.
- Finance area includes, but is not limited payroll, budgeting, accounting, purchasing, investments and financial analysis/forecasting. Report directly to Town Manager. On the Senior Management Team.
- Responsible for and prepared the Town CAFR (Comprehensive Annual Financial Report). Have received the Government Finance Officers Award for Excellence in Financial Reporting for fiscal year 2011 and 2012. Presently will outsource part of this to free up more time for strategic planning/special projects.
- Responsible for financial presentation to Standard and Poor's – Credit rating raised from AA+ to AAA.
- Decentralized/reassigned clerical finance duties such as property tax bill creation, payroll and invoice entry out to entitywide clerical workers. Finance, through a bookkeeper and accountant, now supervises/coordinates such duties.
- Decentralized budgeting and purchasing duties entitywide - creating more accountability for the departments. Finance and Administration now supervises/coordinates such duties.
- Restructured the Finance department and positions within it. Prior staff duties of the Finance Director, such as bank reconciliations and high level monthly financial reports have been moved to staff in order to allow the Finance Director to manage. Replaced the Budget & Purchasing Director with a Staff Accountant.
- Created a reporting system that allows departments to run their own financial reports and at any time.
- Created five year forecasting model. Performed Requests for Proposal that led to new banking partner.
- Manage financial staff and all their duties. Responsible for government financial reports.
- Responsible for staff that coordinates the MUNIS system. Major version upgrade occurred at the time of my arrival.
- Finance Department budget is $250K. Responsible for the accounts payable for the combined City/School budget of $42 million. Responsible for investments of $30 million.

City of Waterville — **Waterville, Maine**

Director of Finance/Treasurer — **October 2006 – August 2011**

- Responsible for financial operations and reporting related to the $16 million budget for the City – population 15,600 - a service center that expands to roughly 40,000 during the work day. Finance area includes, but is not limited to tax and fee collections, payroll, budgeting, accounting and financial analysis/forecasting, lien procedures and investments.
- Report directly to City Manager. On the Senior Management Team.
- Responsible for and prepare the City CAFR (Comprehensive Annual Financial Report).
- Manage financial staff and all their duties. Responsible for government financial reports.
- Responsible for financial presentation to Standard and Poor's – Credit rating raised from A- to A+
- Responsible for staff that coordinates the MUNIS system. Modules include but are not limited to G/L, payroll, fixed assets, billing, and accounts payable. System implementation began at the time of my arrival.
- Finance Department budget is $450K. Interact with all levels of City government.
- Responsible for the accounts payable and payroll for the combined City/School budget of $36 million

State of Maine, Department of Health and Human Services (DHHS), Augusta, Maine Nov 2003 - Oct 2006

Director of Finance for the Office of Medical Services (Medicaid) ***Aug 2005 – Oct 2006***

Director of Finance & Reimbursement for Bureau of Medical Services (Medicaid) ***Nov 2003 – Jul 2005***

- Responsible for financial operations, strategies and tactics for the over $2.3 billion budget for the MaineCare (Medicaid) and related Medicare budget. This consisted of approximately 25% to 30% of the State of Maine's budget and insures over 20% of the State of Maine's population.
- Duties became more sophisticated financial analysis, forecasting and reporting oriented as two separate units related to reimbursement were elevated to their own Division status with their own full Directorships.
- Reported directly to Deputy Commissioner of Finance for DHHS. On the Senior Management Team (SMT) of the Office/Bureau. Interacted with all levels of State government including the Governor's Office for Health Planning.
- Consistently managed and balanced sensitive political implications with financial issues.
- Dealt with numerous providers on their fiscal issues and requests for informal reviews of reimbursement.
- Bureau contained about 240 employees. Approximately 100 reported to the Director of Finance and Reimbursement position. These included financial staff responsible for ORACLE financials.
- Responsible for budget, financial analysis, rate setting, third party liability, data capture & control and AR/AP cash unit.
- Incorporated a monthly budget and detailed budgeting/forecasting model for MaineCare. Refined a cash flow model to insure sufficient State and Federal funds are available.
- The Certificate of Need Unit (CON) for hospitals was under this Division until combined with other CON areas.
- Executive Committee member on the new Maine Claims Management System (MECMS). This was a $25MM to $30MM system that became the claims processing system for MaineCare.
- Developed and maintained an interim payment system that supplemented the payments for MECMS.
- Reviewed policies and regulations for the Bureau to ensure financial issues are in compliance.

M&H Logging and Construction **Rangeley, Maine**

Controller **September 2001 – November 2003**

- Responsible for the financials, human resources, and office operations (including information technology) for a construction business and its related entities including a logging corporation and a land enterprise. Company grew from 30 to 70 employees.
- Initiated working capital updates and monthly closings. Included percentage-of-completion analyses.
- Managed two offices responsible for payroll, billing, accounts payable, job accounting and various other duties.
- Responsible for insurance audits and price proposal bids from insurance companies for all insurances.
- Coordinated worker's compensation cases. Managed land accounts.
- Prepared forms for sales taxes, unemployment taxes, W-2s, 1099s, fuel excise tax refunds, and other related forms.
- Kept W-9s and insurance certificates updated. A project to update these saved the companies tens of thousands of dollars in insurance fees. Maintained system hardware and software integrity.
- Updated an in-house project tracking system and devising a method to reconcile it to the Peachtree Accounting System.

Franklin Community Health Network **Farmington, Maine**

Controller **October 1997 – September 2001**

- Reported directly to CFO for this rural health network that had about $63 million in revenues.
- Involved in coordination of Certificate of Need to expand hospital facilities. Expansion was about $12.5 million.
- Vastly improved analysis and reporting tools used by the Finance Department and the Network.
- Involved with various special projects, many that involve heavy legal contact – one, providing Charity Care for the indigent, as the start-up and continuing project manager, the other, a community based health card, as a financial manager. Both were featured in the New England section of the Wall Street Journal. The former program received national attention in various large publications including the Chicago Tribune and Boston Globe. It was featured on the Today show as a revolutionary new program in health care.
- Presentations to all boards including parent, hospital, physician association and others.
- Analyzed and created budgets to obtain grants. Coordinated governmental grant audit.
- Created a consolidated network income statement, balance sheet, and self-standing statement of cash flows.
- Coordinated contracts with outside providers and strategic partners. One project, required support as a financial manager, involved a forward thinking managed care cardiovascular program saving thousands per patient on cardiac rehabilitation.
- Involved in various other strategic and tactical projects including purchases of buildings and medical practices.
- Involved in contract negotiation, including prices, and writing/formation of contracts. Created reports in MEDITECH.

Aetna, Inc and Aetna Life and Casualty **September 1991- July 1997**
Aetna, Inc. - Aetna/US Healthcare - Midwest Region ***Chicago, Illinois***
Director Planning and Budgeting ***September 1996 - July 1997***

- Responsible for operating plans, membership reporting and budget for the Midwest region (one of six and the largest). $52 million in operating expenses. $1.4 billion revenue. $375 million projected profit.
- Analyzed contribution margin, medical PMPM, and operating expenses on a monthly basis. Made recommendations to improve the results related to these measures.
- Built reports and data gathering methods from foundation up. Presentations to senior management.
- Corrected/prepared financials for startup HMO state filing. Managed special projects and financial planning staff.

Aetna Life & Casualty Company - Pharmacy - Finance Department ***Middletown, Connecticut***
Director/CFO - Finance ***February 1994 - September 1996***

- Complete responsibility for Finance Department. Reported to CEO. Cost center manager duties.
- Detailed exposure to mergers and acquisitions. Taught audit department to perform non-statistical sampling.
- $825 million in revenue in 1996. Exceeded $1.1 billion by 1997. Profits of $4 million in 1993 expanded to $32 million for 1996. Created 1996 to 1998 strategic plans.
- Converted billing method to be in line with industry standards. This improved our competitive marketing status.
- Responsible for financial reporting, controls, rebates, accounts payable, accounts receivable, pricing, policies and procedures, budgeting, accounting research, special projects, and other financial duties.
- Worked on projects to improve systems, automate reports, and increase data integrity. Coordinated major project to integrate Pharmacy data and systems into Aetna standard reporting systems.

Aetna Life & Casualty Company - Information Technology ***Hartford, Connecticut***
Expense Management Consultant & Account Representative ***September 1991 - February 1994***

United Technologies - Otis Elevator International/Hamilton Standard **Connecticut**
Senior Tax Specialist, Consolidations Accountant & G/L Systems Admin. **February 1988 - September 1991**

Kaiser Permanente, Accountant - Medical Group **Hartford, Connecticut, Dec 1986 - Feb. 1988**

KMG Main Hurdman, Tax Specialist **Stamford, Connecticut, March 1986 - Dec 1986**

PROFESSIONAL ORGANIZATIONS & EDUCATION

- Member of Institute of Management Accountants
- Member of Government Finance Officers Association
- Associate Member Maine Society of Certified Public Accountants
- The University of Connecticut, Storrs, Connecticut — Master of Business Administration
- The University of Connecticut, Storrs, Connecticut — Bachelor of Science in Business Administration - Finance

Kristy M. Letendre

Objective

To maintain a career in Human Services / Substance Abuse Administration while attaining skills to perform all tasks at maximum potential.

Education

PRESENT | WHITE MOUNTAINS COMMUNITY COLLEGE

- Major: Business Administration

ONGOING EDUCATION | NHADACA

- Ethics, Confidentiality, Trauma and Addiction, Seeking Safety

COSEMTOLOGY CERTIFICATE | MAY 2001 | LABARON BEAUTY ACADEMY

- Major: Cosmetology

HIGH SCHOOL DIPLOMA | JUNE 1996 | NEW BEDFORD HIGH SCHOOL

- Major: College Preparation

Skills & Abilities

PROFESSIONAL SKILLS

- Prime For Life Certified Instructor
- AED / CPR Certified

LEADERSHIP

- 2010 / Alumni Leadership North Country / White Mountains Community College
- WIPFLI 11th & 12th Annual Conference for Grant Funded Programs

Experience

- **Director | Tri-County CAP / Division of Alcohol & Drug Services | Present**

- **Associate Director | Tri-County CAP / Division of Alcohol & Drug Services | 12/08-04/14**

- **Administrative Assistant | Tri-County CAP / Division of Alcohol & Drug Services | 09/08-12/08**

- **Program Specialist | Tri-County CAP / Division of Alcohol & Drug Services | 05/04-09/08**

REFERENCES: AVAILABLE UPON REQUEST

ELAINE C. DAVIS

EDUCATION: Master of Science, Graduate Program in Community Mental Health, SNHU, Major - Co-occurring psychiatric and addictive disorders - 2005.
Master of Science in Human Services, Major in Community Psychology, Springfield College, 1994.
B.S., Human Services, Springfield College, 1991.

LICENSES: NH Licensed Clinical Mental Health Counselor – 2007-Prersent
NH Masters Licensed Alcohol Counselor and Drug Counselor – 1994-Present

AREAS OF EFFECTIVENESS:

Program Development

Developed, coordinated, and facilitated a Pre/natal substance abuse screening and early intervention program.

Revised, updated, and integrated hospital-wide discharge planning policy.

Implemented and facilitated Student Assistance Program for N.H.-SAU#7.

Initiated alternative forms of the therapeutic processes (i.e. meditative and guided imagery, relaxation techniques) for an inpatient residential substance abuse treatment facility.

Chaired, organized, and implemented a 2-year Strategic Plan for local human service agency with over 150 employees.

Management and Administration

Managed hospital social service department, to include all department head duties and supervision of hospital chaplain and utilization review RN, plus all direct service of hospital-related social work duties.

Implemented and coordinated all aspects of clinical treatment for North Country Shelter, North American Family Institute.

Managed Outpatient Clinical Substance Abuse Office for 13 months prior to administrative support hiring.

Management of private practice from 1994 - present, with numerous HMO/PPO contractual agreements, including DCYF-NH.

WORK HISTORY: Clinical Director – Friendship House, Bethlehem, NH – 6/18/12 - present
Private Practice in Psychotherapy - Gorham, NH - 7/2007 to present.
Clinical Coordinator, North American Family Institute - North Country Shelter, Jefferson, NH 3/2006 - 4/2007.
Supervision for Licensed Clinician Candidates since 2007.

Northern New Hampshire Mental Health and Disability Services, therapist and case manager, Berlin, NH - 2/2003 - 2/2006.

Addictions Counselor, Trainer, Lifestyle Consultant, Private Practice, Berlin/Gorham, NH 1/94 - 2/2003.

Director of Social Services, Androscoggin Valley Hospital, Berlin, NH 11/97 to 02/99

Founders Hall Outpatient, Substance Abuse Counselor, 2/91 to 1/94.

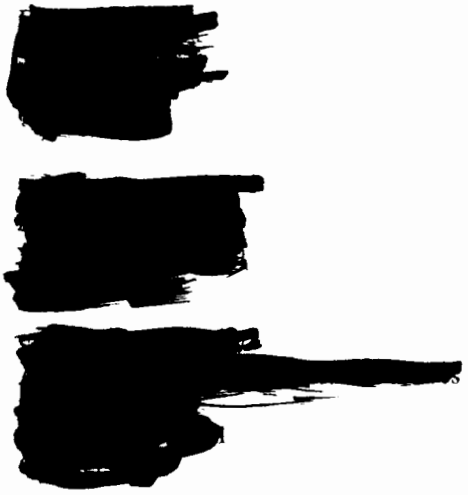
Northern N.H. Council on Alcoholism, Derby's Lodge, residential substance abuse counselor/program counselor/weekend manager (now Friendship House, Bethlehem, N.H.), 11/86 to 6/88 and 7/89 to 2/91.

Adjunct Faculty, Granite State College 2006 - Present.

Adjunct Faculty, Springfield College - 1995.

PROFESSIONAL ACTIVITIES: Member Coos County Coalition
Past member NH Coalition on Substance Abuse, Mental Health, & Aging.
Board Member of N.H. Alcohol and Drug Abuse Counselors Association.
Past Member, Androscoggin Valley Domestic Violence Council, Berlin, N.H.
Trainer for numerous community agencies, task forces, etc.
Member Berlin/Gorham Adolescent Drug Court Treatment Team
Member NH Attorney General/Office of Victim Witness Assistance Mental Health Provider Network

REFERENCES:



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
Bureau of Drug and Alcohol Services

Nicholas A. Toumpas
Commissioner

Diane Langley, Director
Sheri Rockburn, Director

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6738 1-800-804-0909
Fax: 603-271-6105 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

May 30, 2014

G&C Approved

Date 6-18-14

Item # 99

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug and Alcohol Services, to enter into **sole source** amendments with multiple vendors increasing the price limitations by $7,444,467 in the aggregate from $14,888,937 to an amount not to exceed $22,333,404 in the aggregate for a continuum of substance abuse treatment services state-wide and extending the completion date from June 30, 2014 to June 30, 2015, effective July 1, 2014 or date of Governor and Executive Council approval, whichever is later.

Summary of contracted amounts by vendor:

Contractor	Current Budget	Increase/Decrease Amount	Revised Modified Budget
Child & Family Services	$ 173,606	$ 86,803	$ 260,409
Concord Hospital	$ 148,812	$ 74,406	$ 223,218
Families First of the Greater Seacoast	$ 57,844	$ 28,922	$ 86,766
Families in Transition	$ 665,060	$ 332,530	$ 997,590
Grafton County	$ 138,822	$ 69,411	$ 208,233
Greater Nashua Council on Alcoholism	$ 2,713,890	$ 1,356,945	$ 4,070,835
Headrest, Inc.	$ 502,900	$ 251,450	$ 754,350
Horizons Counseling Center, Inc.	$ 379,152	$ 189,576	$ 568,728
Manchester Alcoholism Rehabilitation Center	$ 2,241,198	$ 1,120,599	$ 3,361,797
The Mental Health Center of Greater Manchester, Inc.	$ 54,228	$ 27,114	$ 81,342
Phoenix Houses of New England, Inc.	$ 2,914,980	$ 1,457,490	$ 4,372,470
National Council on Alcoholism and Drug Dependence of Greater Manchester	$ 864,936	$ 432,468	$ 1,297,404
Southeastern New Hampshire Alcohol and Drug Abuse Services	$ 2,659,672	$ 1,329,836	$ 3,989,508
Tri-County Community Action Program	$ 1,223,811	$ 611,904	$ 1,835,715
The Youth Council	$ 150,026	$ 75,013	$ 225,039
Totals	$ 14,888,937	$ 7,444,467	$22,333,404

Funds to support this request are anticipated to be available in the following accounts in SFY 2015 upon the availability and continued appropriation of funds in the future operating budgets, with

- Needing but not receiving treatment for alcohol abuse: 73,949 (6.55% of population)
- Needing but not receiving treatment for illicit drug use: 28,563 (2.53% of population)

Recently, heroin and prescription drug use and the consequences of that use have reached epidemic proportion in New Hampshire:

- According to the 2011-2012 National Survey on Drug Use and Health, the rate of New Hampshire's young adults (ages 18 to 25) who reported non-medical use of pain relievers was the 11TH highest of all states, with 11.6% reporting abuse in the past year
- In the last ten years, the number of people admitted to state funded treatment programs rose by 90% for heroin use and by 500% for prescription opiate abuse. The sharpest increase was between 2012 and 2013.
- According to the New Hampshire State Police Forensic Laboratory, of traffic stops and arrests leading to a blood or urine test in 2012, 13%, or 704 arrests, involved heroin
- In 2011, drug-related deaths peaked at 200, more than ever before and four times as many deaths as in 2000, with 80% of drug deaths involving prescription medication, primarily opioid pain relievers

Should the Governor and Executive Council determine to not authorize this Request, agencies would not have sufficient resources to promote, implement and provide the array of services necessary to provide individuals with substance use disorders the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment services could result in the loss of Federal Block Grant funds made available for these services.

The vendors were originally selected for these agreements through a competitive bid process. The original contracts for SFY 2013 were approved by Governor and Counsel on June 20, 2012, (Items 96, 97, 99 – 110, 112). Amendments for SFY 2014 were approved on June 5, 2013 (Item # 102A), except Grafton County approved on July 10, 2013 (Item # 50) and The Youth Council on June 19, 2013 (Item # 134), with this request providing services for the period July 1, 2014 to June 30, 2015. These amendments represent level funding of all vendors.

This Governor and Executive Council package includes the amendment #2 and a copy of the Governor and Council Letters for amendment #1 and for the original contract for each contractor. An electronic copy of amendment #1 for each contractor can viewed on line at http://sos.nh.gov/GC2.aspx.

The following performance measures will be used to assess the effectiveness of the agreements:

- The timeliness with which providers respond to calls requesting services within 5 business days to conduct initial eligibility screening.
- A $75.00 payment will be paid to the treatment contractor for each client who either completes or transfers to another treatment provider for continuing services.
- A $50.00 client follow-up fee will be paid to the treatment contractor at 3 months and again at 6 months post-discharge for each client who is contacted for follow-up and who meets at least 3 of the outcome criteria below:
    - Abstinence: The client reports reduced or no substance use in the past 30 days.
    - Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school.
    - Crime and Criminal Justice: The client reports no arrests in the past 30 days.
    - Stability in Housing: The client reports being in stable housing.
    - Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

State of New Hampshire
Department of Health and Human Services
Amendment #2 to the Substance Use Disorder Treatment and Recovery Support Services Contract

This 2nd Amendment to the Substance Use Disorder Treatment and Recovery Support Services contract (hereinafter referred to as "Amendment 2") dated this 15th day of May 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Tri-County Community Action Program, Inc. (hereinafter referred to as "the Contractor"), a non-profit corporation with a place of business at 30 Exchange Street, Berlin, NH 03570.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, (item # 102) and amended by an agreement (Amendment #1 to the Contract) approved on June 5, 2013, (Item # 102A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 of the Agreement, the State may amend the Contract by written agreement of the parties; and;

WHEREAS, the parties agree to extend the current contract by one year.

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

1) Amend Form P-37, Block 1.6 to read:
   a) 05-95-49-491510-29890000-102-500734
   b) 05-95-49-491510-29900000-102-500734
2) Amend Form P-37, Block 1.7 to read June 30, 2015.
3) Amend Form P-37, Block 1.8 to read $1,835,715
4) Delete Exhibit A and replace with Exhibit A Amendment #2
5) Delete Exhibit B and replace with Exhibit B Amendment #2

Contractor Initials: MC
Date: 5/29/14

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

5/30/14
Date

NAME
TITLE

Tri-County Community Action Program, Inc.

5-29-14
Date

NAME Michael Coughlin
TITLE Chief Executive Officer

Acknowledgement:
State of NH, County of Coos on 5-29-14, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Name and Title of Notary or Justice of the Peace
Suzanne C. French, Notary

SUZANNE C. FRENCH
Notary Public - New Hampshire
My Commission Expires June 19, 2018

Contractor Initials: MC
Date: 5/29/14

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

6-2-14
Date

Name: Rosemary Wyatt
Title: Assistant Attorney General

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

_____
Date

Name:
Title:

Contractor Initials: MC
Date: 5/29/14

Exhibit A Amendment #2

Scope of Services

A. Population Served

Services are available to New Hampshire residents who meet diagnostic, financial, and other eligibility criteria for Department of Health and Human Services supported substance use disorder services as defined in Section C, Clients Eligible for Treatment Services.

B. The Contractor shall provide treatment services as identified below:

Service Table - An "X" denotes that the Contractor shall provide that service(s) to eligible individuals in accordance with all applicable laws, rules, and regulations and terms and conditions of this Agreement.

Required Services	*Treatment Services*
	Outpatient Treatment (ASAM Level 1) - Substance abuse treatment services provided in individual and group counseling sessions in a non-residential setting. Clients may be enrolled in outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
	Outpatient Treatment (ASAM Level 1) – Pregnant & Parenting Women – Outpatient Treatment as identified above provided to pregnant & parenting women.
	Intensive Outpatient Treatment (ASAM Level 2.1) – A combination of individual and group substance abuse treatment services conducted in an outpatient setting for a minimum of 3 hours of direct client treatment services per day for a minimum of three days per week. Clients receiving less than this level of service should be enrolled in an outpatient program. Clients may be enrolled in intensive outpatient treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
	Intensive Outpatient Treatment (ASAM Level 2.1) – Pregnant & Parenting Women - Intensive Outpatient Treatment as identified above provided to pregnant & parenting women.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living)*** – Residential substance abuse treatment services are designed to support individuals in the early stages of recovery that need this residential level of care and/or are homeless. The goal of these programs is to prepare clients to become self-sufficient in the community. Clients may be enrolled in low-intensity residential treatment and recovery support services simultaneously when clinically appropriate. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days. Residents typically work in the community and may pay a portion of their room and board.
X	***Low-Intensity Residential Treatment (ASAM Level 3.1, Formerly Transitional Living) – Pregnant Women*** - Low-Intensity Residential Treatment as identified above provided to

Contractor Initials: MC
Date: 5/29/14

	pregnant & parenting women.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent)*** - Short-term residential substance abuse treatment designed to assist individuals who require a more intensive level of service in a structured setting and/or individuals that may be homeless. Admission is on a voluntary basis. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***High-Intensity Residential – Adult (ASAM Level 3.5, Formerly: Residential – Treatment Adult) and Medium Intensity Residential – Adolescent (ASAM Level 3.5, Formerly: Residential – Treatment Adolescent) - Pregnant Women*** - High-Intensity Residential – Adult and Medium Intensity Residential – Adolescent as identified above provided to pregnant women.
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5) - Residential treatment services for pregnant and parenting women and their children. Continued service and transfer/discharge decisions are based on ASAM Criteria (October 2013). Clinical staff shall conduct a redetermination of ASAM level of care in response to any changes impacting level of risk on any ASAM dimension on an on-going basis and no less than every 30 days.
X	***Recovery Support Services:*** Group or individual services that are consistent with an individual's recovery plan that prevent relapse and enhance or remove barriers to recovery. Examples of recovery support services include, but are not limited to: assisting clients with enrollment in Medicaid, the New Hampshire Health Protection Program (NHHPP), or private insurance, anger management, financial management, communication skills, spiritual support, parenting skills, health management, case management, organization and time management, recovery coaching, recovery mentoring, stress management, and vocational services. Programs may focus on a single recovery support service or provide a curriculum that includes an array of recovery support services. Types of Recovery Support Services are listed below:
X	• Continuous recovery monitoring services are regular follow-ups with clients to assess the status of the client's recovery, identify any needs the client may have and help the client to address those needs, and provide early intervention for client's who have relapsed or who's recovery is otherwise at risk.
	• Enhanced Services are specialized services that remove barriers to a client's participation in treatment. Examples of these services are child care while a parent is participating in treatment or transportation to and/or from the treatment site.
X	***Recovery Support Services*** as identified above provided to pregnant & parenting women.

C. *Required Services*

Priority Admission:

1) The Contractor shall give admission preference to pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour time frame.
2) Individuals with a history of injection drug use including the provision of interim services within 14 days.
3) Individuals with a primary diagnosis of a substance use disorder, which may also include a co-occurring mental health disorder.
4) Individuals on medication-assisted treatment for co-occurring substance abuse and mental health disorders or various opiate replacement therapies, including, but not limited to, methadone, buprenorphine and naltrexone.

Required Outreach:

New Hampshire Department of Health & Human Services (DHHS) programs receiving federal treatment Block Grant funds requires that Contractors must publicize services available to pregnant or parenting women and injection drug users in need of substance abuse treatment and that these individuals receive preference for admission to treatment. This may be done as follows, but is not limited to, street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers and social service agencies. The Contractor will submit their outreach plans to DHHS through the Bureau of Drug and Alcohol Services (BDAS) within 60 days of contract effective date.

Health Facilities Administration Licensing Requirements:

Housing programs with substance abuse treatment services at the same location will need to secure necessary licensing as a Residential Rehabilitation Facility by the DHHS Bureau of Health Facilities Administration, as appropriate, see He-P 807 at the following link: (http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html). Any contractor with an American Society of Addiction Medicine (ASAM) (October 2013) Level 3.3 or higher level program must secure this licensing for all Level 3 programs housed within the same facility as the Level 3.3 program. In the case of residential treatment and housing at the same site, residential programs should plan to treat no more than 16 pregnant or parenting women at any given time to comply with federal Medicaid restrictions on Institute for Mental Diseases (IMD) exclusion criteria. This restriction would not apply to programs in which the client's residence is in a separate location from the treatment program.

Capacity Reporting:

The Contractor must contact BDAS, as agent for DHHS, when their capacity has reached 90% within 5 business days. The Contractor must refer pregnant women to the State when the Contractor has insufficient capacity to provide services to any such pregnant women who seek the services of the program. Sending e-mail to the BDAS Clinical Services Unit Administrator may complete this notification process.

Access to Services:
The Contractor shall respond to calls requesting treatment and/or transitional living program services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within 2 business days following the day the call was received.

The Contractor is required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.

Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client should be referred to a DHHS funded provider where they are able to access interim services.

Contractors receiving grant funds from DHHS will not discriminate against clients who are using legitimate medications to assist their recovery and will not have policies that allow them to refuse admission to treatment or to discharge clients from treatment based on the use of appropriately prescribed medications and various opiate replacement therapies, including, but not limited to, methadone and buprenorphine, as well as other forms of medication-assisted treatment for co-occurring substance abuse and mental health disorders.

Clients Eligible for Treatment Services:
In order to be eligible for DHHS supported services, a client must meet all eligibility criteria described below. Eligibility determination shall be conducted as follows:

1. Substance Use Disorder, Financial Eligibility & Residency Screening: The contractor shall complete the eligibility screening module in the Web Information Technology System (WITS) to determine if the client meets residency, financial, and substance use disorder potential eligibility requirements:
    a. Residency: The client must be a resident of New Hampshire or homeless in New Hampshire to be eligible for DHHS supported services; and
    b. Financial Eligibility: The client's income must be below 400% of Federal Poverty Level (FPL) to be eligible for DHHS supported services based on the sliding fee scale described below. Once the screening has been completed, the contractor shall print the associated attestation and have the client sign this document. A copy of the signed attestation shall be maintained in the client file. The client's financial eligibility shall be reassessed no less than every 120 days.; and
    c. Potential for a Substance Use Disorder: The client must screen positive for a potential substance use disorder to be eligible for DHHS funded services.
2. Evaluation: The contractor shall conduct a full substance abuse evaluation, which includes administration of either the Addiction Severity Index (ASI) in WITS or Global Appraisal of Individual Needs (GAIN).
    a. Substance Use Disorder: This evaluation shall be used to determine if the client meets Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) criteria for a substance use disorder. Clients who meet DSM5 criteria for a substance use disorder are eligible for DHHS funded services. Client who do not meet these criteria are not eligible for DHHS funded services.

b. Level of Care: For clients who have met all other eligibility requirements, this evaluation shall be used to determine the appropriate level of care for the client based on ASAM (October 2013) criteria. The client is eligible for DHHS funded services at the assessed level of care unless such a level of care is unavailable or the client chooses to enter a lower level of care. If the assessed level of care in unavailable, the client may choose to enter the next higher level of care.

3. Medicaid/NHHPP Eligibility: The contractor shall determine whether or not the client is eligible for Medicaid/NHHPP coverage for the identified level of care. If the client is not eligible for Medicaid/NHHPP coverage for the identified level of care, the client may be eligible for DHHS funded services. If the client is eligible for Medicaid/NHHPP coverage for the identified level of care, the client is not eligible for DHHS funded services.
4. Insurance Coverage: The contractor shall determine whether or not the client has insurance that will cover services at the identified level of care. If the client does not have insurance that will reimburse for these services at a rate equal to or greater than the DHHS rate, the client is eligible for DHHS funded services. If the client has insurance that will reimburse for these services at an amount equal or greater to the DHHS reimbursement rate, the client is not eligible for DHHS funded services. The contractor may not charge the combination of the client, any 3rd party payor, and DHHS more than the maximum charge allowed. These parties shall be charged in the following order:
    a. The maximum allowed charge will be billed to the client's insurer, if applicable.
    b. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
    c. The balance of the maximum allowed charge after deducting the client's portion and the insurance payment, if applicable, shall be charged to DHHS.

Sliding Fee Scale:

The contractor shall not charge the combination of the client, any 3rd party payor and BDAS an amount greater than the maximum rate allowed for each service. All reasonable efforts shall be made to collect payment of bills. A client's inability to pay shall not preclude admission to the program and treatment.

- Client Income is 0% - 138% of FPL: 100% of the allowed charge less any amount paid for by insurance.
- Client Income is 139% - 149% of FPL: 92% of the allowed charge less any amount paid for by insurance.
- Client Income is 150% - 199% of FPL: 88% of the allowed charge less any amount paid for by insurance.
- Client Income is 200% - 249% of FPL: 75% of the allowed charge less any amount paid for by insurance.
- Client Income is 250% - 299% of FPL: 60% of the allowed charge less any amount paid for by insurance.
- Client Income is 300% - 349% of FPL: 43% of the allowed charge less any amount paid for by insurance.
- Client Income is 350% - 399% of FPL: 33% of the allowed charge less any amount paid for by insurance.

With respect to minority age individuals, a minor child shall not be denied services as a result of the parent's unwillingness to pay the fee or the minor child's decision to receive confidential services pursuant to RSA 318-B:12-a.

Waiting List Management:

When a person who is pregnant or an injection substance abuser seeks treatment and there are no appropriate treatment services available within the required time frame as outlined below, interim services **must** be made available. The Contractor agrees to maintain the wait list management system in WITS that includes a unique patient identifier and include information on dates of requests for admission to treatment, provision of interim services and source for those services, referrals made for treatment or interim services, and disposition of clients on the waiting list.

- The waiting list must contain a mechanism that identifies and counts the number of applicants who present and are determined to be appropriate for substance abuse treatment but are unable to be placed as there is no capacity;
- Maintain contact with individuals awaiting admission; and,
- Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area.

The Contractor shall remove a client awaiting treatment from the waiting list only when one of the following conditions exists:

- Such persons cannot be located for admission into treatment *or*
- Such persons refuse treatment.

Specific Interim Services for Pregnant Women, Women with Dependent Children and Injection Drug Users:

The Contractor agrees to contact the BDAS Clinical Services Unit if a pregnant women and women with dependent children or individuals with a history of injection drug use, cannot be accepted into treatment within specific time frames, and agrees that interim services will be provided or facilitated by the Contractor. Interim services for pregnant women must include counseling on the effects of alcohol and drug use on the fetus, referrals for prenatal care, and counseling and education about HIV and tuberculosis. Interim services for injection drug users must also include counseling and education in the risks of needle sharing, about the risks of transmission to sexual partners and infants, and referral for HIV, Hepatitis C and tuberculosis screening/testing. All interim services shall be documented in the client's clinical record in the WITS system.

Interim Services for other Clients:

The Contractor shall provide, or refer the client to, interim services until level of service identified in the level of care assessment is available and/or the client is willing and assessed as being sufficiently motivated to take advantage of the proposed level of service or interim services. If the client is not able to access interim services at the contractor's agency for geographic or other reasons, the client shall be referred to a DHHS funded provider where they are able to access interim services.

Services to pregnant and parenting women:

The Contractor further agrees that childcare will be made available to women who are in treatment with their dependent children, either through on-site care or through arrangements with an off-site legal childcare provider. Other services required are as follows:

- The family is treated as a unit and, therefore, admits both women and their children into treatment services, if appropriate.
- The Contractor shall provide or arrange for primary medical care for women who are receiving substance abuse services, including prenatal care.
- The Contractor shall provide or arrange for childcare while the women are receiving services even if the children are not in their custody, as long as parental rights have not been terminated.
- The Contractor shall provide or arrange for primary pediatric care for the women's children, including immunizations.
- The Contractor shall provide or arrange for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting, and childcare while the women are receiving these services.
- The Contractor shall provide or arrange for therapeutic interventions for children in custody of women in treatment, which may, among other things, address the children's developmental needs, their issues of sexual and physical abuse, and neglect.
- The Contractor shall provide or arrange for sufficient case management and transportation services to ensure that the women and their children have access to the services provided for above.
- If a pregnant, pregnant injection drug using or Injection Drug Using person refuses treatment or says (s)he is not interested in treatment, the wait list report shall be completed with the engagement activities attempted.
- If a pregnant, pregnant injection drug using or Injection Drug Using person no shows or cancels treatment, interim services must be provided, as stipulated above and the wait list report shall be completed that demonstrates the activities of follow up, engagement and substance abuse treatment services offered.

Relationship(s) with Primary Health Care:
The Contractor shall arrange and coordinate services and exchange of information with other health care providers and agencies which:

- Identifies the client's current Primary Care Provider (PCP) at screening and/or intake.
- If the client has no current PCP, the Contractor shall identify available provider(s) in the client's local area such as a federally qualified community health center, community health center, or other local health services.
- Obtains client/patient authorization to communicate with PCP office.
- If no authorization is completed initially, the Contractor shall educate client as to the importance of engaging the PCP in ongoing care and address the client's concerns as part of treatment, with goal of obtaining authorization before discharge.
- Sends the discharge summary to PCP and offers to discuss recovery issues with the provider.
- Arranges (or has the client arrange) a post-discharge appointment with PCP for the client/patient for follow-up of the substance use disorder.

Tobacco Cessation:
The Contractor shall have policies and procedures for both client and Contractor staff, that not only creates a tobacco-free environment as required by law, but to offer tobacco cessation tools and programming. Tobacco use, in and of itself, shall not be grounds for administrative discharge from the program. Initially, all clients shall be assessed for motivation in stopping the use of tobacco products. Providers may tap into resources such as the DPHS Tobacco Prevention & Control Program (TPCP) and

the certified tobacco cessation counselors available through the QuitLine. Other resources for providers include:

Breathe New Hampshire
145 Hollis St., Unit C
Manchester, NH 03101
603-669-2411 (phone) or 1-800-835-8647

The New Hampshire Medicaid program covers:

- Nicotine Replacement Therapy (NRT) Gum,
- NRT Patch,
- NRT Nasal Spray,
- NRT Lozenge,
- NRT Inhaler,
- Varenicline (Chantix),
- Bupropion (Zyban),
- Group Counseling and/or
- Individual Counseling. Up to 12 individual counseling sessions are covered per year through a mental health provider (Note: These sessions would NOT be in addition to other mental health counseling sessions under Medicaid). Pregnant women also have the option of group counseling. For more information, visit the website at: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm

Tuberculosis:
The Contractor shall make available tuberculosis services (defined as screening, counseling, testing, and treatment) directly, or through other providers, to each client receiving treatment. In the case of an individual denied admission due to lack of capacity, the substance abuse treatment Contractor will refer the individual to another provider of tuberculosis services if appropriate. All Contractor providing residential services shall make available, either on-site or through agreements with health care providers, tuberculosis services, including screening, testing, counseling and referral for medical treatment.

Physical location and facilities:
For the purpose of providing the services described in Section II of the Scope of Services, the Contractor shall obtain and maintain a suitable space complying with all fire, health, and safety codes to include handicapped accessibility and being wheelchair accessible.

The Contractor shall obtain written prior approval of DHHS, acting through BDAS, before entering into any agreement concerning relocation of the service site.

Culturally and Linguistically Appropriate Standards of Care:
DHHS recognizes that culture and language have considerable impact on how consumers access services. Culturally and linguistically diverse populations experience barriers in efforts to access services. To ensure equal access to quality services, DHHS expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. When feasible and appropriate, provide clients of Limited English Proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. The Contractor is responsible for reasonable accommodations in arranging for interpreter services for hearing impaired clients.
5. The Contractor offers consumers or clients a forum through which those individuals have the opportunity to provide feedback to the Contractor regarding cultural and linguistic issues that may deserve response.

Compliance with State and Federal Laws:

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. All services provided pursuant to this Contract shall be subject to the most current proposed or formalized rules and regulations promulgated by DHHS, pursuant to RSA 541-A.
2. The Contractor shall maintain adherence to federal and state confidentiality laws specifically: 42 CFR Part 2B, N.H. RSA 318 B:12 and N.H. RSA 172:8-A and the Health Insurance Portability and Accountability Act (HIPAA): *http://www.hhs.gov/ocr/privacy/*
3. The Contractor shall meet the standards outlined in NH Administrative Rule He-A 300, Certification and Operation of Alcohol and other Drug Disorder Treatment Programs. This administrative rule is currently expired and under revision. The Contractor should plan to meet the requirements as outlined in the expired rule until the revisions are completed. He-A 300 can be viewed on the RFP link to this document *http://www.dhhs.nh.gov/business/rfp/index.htm*.
4. The Contractor shall, upon the direction of the State, provide court-ordered evaluation in their catchment area and a sliding scale fee shall apply and the inability to pay shall not interfere with the completion and submission of the court-ordered evaluation and shall, upon the direction of the State, offer treatment to those individuals pursuant to RSA 172:13.
5. Contractors considering research, including research conducted by student interns, using individuals served by this contract as subjects must adhere to the legal requirements governing human subjects' research. Contractors must inform the DHHS via contact with BDAS prior to initiating any research involving subjects or participants related to this contract. In addition, research conducted on subjects served by this contract may need to be approved by the New Hampshire Department of Health & Human Services Committee for the Protection of Human Subjects (NH DHHS CPHS) see *http://www.dhhs.nh.gov/irb/*

Client Stabilization:

The Contractor will be expected to arrange for medical clearance for all clients receiving treatment services supported by DHHS administered by BDAS to assure that they are not at risk for acute withdrawal from alcohol and certain drugs. The Contractor shall be expected to provide a range of integrated services that include withdrawal management services that follow detoxification guidelines outlined in Treatment Improvement Protocol (TIP) #45, Detoxification and Substance Abuse Treatment and ASAM guidelines.

Clinical Services:
The Contractor shall provide the following:

a. A minimum of one (1) substance abuse counselor on site each day of the week during primary treatment hours. The substance abuse counselor shall have a bachelor's degree or equivalent in social work/psychology, guidance or nursing and/or a certificate in the field of addiction studies from an approved educational institution or educational/life experience.
b. A minimum of one (1) substance abuse support staff on site each day of the week during all hours not covered by a substance abuse counselor. The substance abuse support staff must have a high school or General Equivalency Diploma (GED). Preference is given to individuals who have completed additional courses or taken training in substance use disorders or other health fields.
c. An intake/admission coordinator on site Monday through Friday of each week. The intake/admission coordinator shall have one (1) years' work experience in the field of addiction studies.
d. A full-time Executive Director, not filling any of the positions described above.

Evaluation:
The contractor shall conduct a full substance abuse evaluation, which includes administration of either the ASI or GAIN to determine eligibility for services. This evaluation must be updated every 120 days or when the client transitions to a different level of care.

Assessment of Risk for Self-Harm/Suicide: The Contractor shall have policies and practices for assessing risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and at discharge, and a process for referral when necessary to include referrals to mental health services.

The Contractor shall develop policies, programs and protocols in accordance with SAMHSA guidelines as outlined in the Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs). These publications can be downloaded from http://www.kap.samhsa.gov/products/manuals/index.htm .

Use of Best Practices: The Contractor is required to use the Addiction Severity Index (ASI) or Global Appraisal of Individual Needs (GAIN) assessment tools, the SAMHSA/NIDA MATRS treatment-planning model and the WITS electronic case management system.

Care Coordination:
The Contractor is required to assess each client's need/appropriateness for residential transitional living services and to **refer all clients for care coordination services** made available through the Access to Recovery (ATR) initiative administered by the BDAS so long as this initiative remains available on behalf of DHHS that would commence following the initial course of treatment. Contractors are required to address motivational issues with clients for them to participate effectively in the care coordination and recovery support services. Contractors are required to have clients sign the "ATR Client Participation Agreement" (made available by BDAS), indicating that they either agree or opt out of participating in these services. The contractor will facilitate all clients who agree to participate in these services to complete the Client Participation Agreement and upon obtaining a signed release of information, refer clients to an ATR Care Coordinator Program at least two weeks prior to anticipated date of discharge (dis-enrollment) from services. Assessing the need for aftercare services is expected to take place while

the client is involved within the most recent episode of care, with a referral being made and accepted by the care coordination service prior to the client being discharged.

The Contractor must provide the following for use by the care coordination program:

- Private space for interviewing/meeting with clients.
- Access to internet (either wired or wireless) in the meeting space
- Telephone in the meeting space and
- A contact person at the Contractor's site for logistics.

It is the expectation of the BDAS at DHHS that, upon completion of appropriate signed releases, the Contractor will provide the care coordination program with necessary information from the clinical record (evaluation, treatment plan, progress notes, etc.) for the care coordination program to develop a service plan with the client.

All alcohol and other drug treatment providers under contract with the BDAS on behalf of DHHS are required to address with all clients, the need for continuing services. This includes clinically managed low-intensity treatment programs under contract with the BDAS on behalf of DHHS as well as care coordination and recovery support services made available through DHHS contracted providers; the ATR initiative administered by BDAS, so long as this initiative remains available; and/or any other resources that become available to pay for these services that would commence following the initial course of treatment. The referral for these services should take place prior to discharge from the initial course of treatment.

Relevant Policies and Guidelines:
The services provided for in this agreement shall be in addition to the services provided for in any other agreement between the State of New Hampshire, any of its agencies, or any of its officers, and the Contractor.

Without limiting the generality of any other provisions of this agreement, the Contractor shall cooperate fully with, and answer all questions of representatives of the State conducting any periodic or special review of the performance of the Contractor or any inspection of the facilities of the Contractor.

Publications Funded Under Contract:
All products produced under this contract are in the public domain. All products (written, video, audio) produced, reproduced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution, or use. The Contract shall credit DHHS on all materials produced under this contract.

Student Internships:
The Contractor shall establish policies and procedures related to student interns that address minimum coursework, experience and core competencies for those interns having direct contact with individuals served by this contract. Student interns shall complete an approved ethics course prior to beginning the internship.

Staff Licensing Requirements:
The ratio of licensed to non-licensed service providers shall be as follows:
Agencies must have at least one Licensed, or Masters Licensed, Alcohol and Drug Counselor (LADC/MLADC) for each two unlicensed counselors providing substance abuse treatment services and a sufficient number of MLADCs or LADCs with the Licensed Clinical Supervision (LCS) credential to adequately provide for clinical supervision of all clinical staff. This requirement shall be met by the Contractor no later than six (6) months after the date of the Contract effective date.

Updated resumes, which clearly indicate the staff member is employed by the Contractor, including current positions of staff supported by funds provided through this Contract, shall be forwarded to the BDAS as agent for DHHS. The documentation shall include a copy of the New Hampshire Alcohol and Drug Counselor License.

Staff Certification Requirements:
In addition to the requirements for LADCs, all Contractor milieu staff in residential settings and transitional living programs and staff providing recovery support aftercare group services shall be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification under RSA 330-C (http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-330-C.htm). Certification must be completed within six (6) months of the contract's approval date.

Staff providing recovery support services are expected to be Certified Recovery Support Workers (CRSW) under the Board of Alcohol and Drug Abuse Professional Practice, or working toward that certification. Peer recovery support services made available through Recovery Community Organizations (RCOs), under agreement with BDAS on behalf of DHHS, shall be provided by individuals certified by those organizations (CRSW not required for peer recovery support services).

Supervision:
Ongoing clinical supervision will include weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress. When enough candidates are under supervision, group supervision may be included to help optimize the learning experience.

The content of supervision must include knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee, including the core functions as described in the Twelve Core Functions of Alcohol and Drug Counseling.

The content of supervision must also include the standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.

Staffing Changes:
BDAS as agent for DHHS shall be notified of changes in key personnel with updated resumes that clearly indicate the staff member is employed by the Contractor submitted within five (5) working days. Key personnel are those staff for whom at least 10% of their work time is spent providing alcohol or other drug abuse treatment services.

1. New Hires: The Contractor shall notify BDAS on behalf of DHHS in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. A resume of the employee, which clearly indicates the staff member is employed by the Contractor, shall accompany this notification.

2. Vacancies: The Contractor shall notify BDAS on behalf of DHHS in writing within 14 calendar days, if at any time, any site funded under this agreement does not have adequate staffing to perform all required services for more than one month.

Other Requirements:
The Contractor shall attend trainings and/or meetings as requested by DHHS.

ATR and Recovery Support Services:
All DHHS funded treatment and recovery support service providers must also be approved Access to Recovery (ATR) providers, so long as the ATR initiative remains available, as this will be the source of funding for these recovery support services through the Voucher Management System (VMS). Information on becoming an ATR provider can be found on the DHHS website: http://www.dhhs.nh.gov/dcbcs/bdas/atr/becomingprovider.htm

Regional Network Participation:
The Contractor will designate administrative level staff to regularly participate in the Regional Network and contribute to overall regional network strategic planning, monitoring, evaluation, and cross systems communication efforts. The Contractor is highly encouraged to serve on one of the work groups and contribute to data collection, regional strategic planning and evaluation. Participation will be measured by the annual Partner Survey (http://www.partnertool.net/) administered by NH Center for Excellence under contract with BDAS as agent for DHHS.

Performance Measures:
All treatment programs under contract with BDAS on behalf of DHHS are required to report on the National Outcome Measures (NOMs) established by the SAMHSA, as required in the Federal Substance Abuse Prevention and Treatment Block Grant, via the WITS (electronic case management) system. The Department of Health and Human Services reserves the right to consider Contractor performance across all of the domains in future funding decisions.

Data and Reporting Requirements:
1. Without limiting the generality of any other provisions of this agreement, the Contractor shall provide any periodic or special reports required by the DHHS.
2. The Contractor shall notify BDAS, as an authorized agent of DHHS, whenever the Contractor has reached ninety percent capacity to admit new clients. In addition the Contractor shall have a waiting list management policy in accordance with the SAPT Block Grant requirements. This 90% notification process will become automatic when this operation is fully functional in WITS.
3. The Contractor shall notify DHHS through BDAS, within one working day, if sufficient capacity is not available to provide treatment services to a pregnant woman, parenting woman or injection drug user within the required time frames and a referral elsewhere is not successful and interim services cannot be provided.

4. The Contractor shall comply with all research and/or information systems development activities for the electronic case management/Web Information Technology System (CM/WITS) conducted by, or authorized by, DHHS.
5. The Contractor shall administer any client surveys, client evaluations including the addiction Severity Index (ASI) or the Global Appraisal of Individual Needs (GAIN), client treatment outcome instruments, the M.A.T.R.S. Treatment Planning Tool, as required by DHHS.
6. The Contractor must have the ability to communicate and submit required reports via the Web-based submission system and/or e-mail, for treatment s and recovery support services and interim services. All required clinical and documentation activities shall be entered in WITS unless specifically granted an exception by BDAS on behalf of DHHS.

Critical Incident/Sentinel Event Reporting:
The Department's Sentinel Event policy is contained in the following link: http://www.dhhs.nh.gov/dcbcs/sentinel.htm

Division of Community Based Care Services (DCBCS) Sentinel Event Notification:
The preceding events require the immediate verbal notification to the BDAS Assistant Administrator or Clinical Services Unit Administrator upon the discovery of a sentinel event involving an individual(s) receiving services through a DHHS substance use disorder treatment Contractor.

Since the initial and immediate verbal notification of a sentinel event is likely to include protected health information (PHI) as identified below, the Contractor of services to individuals receiving services funded by the DHHS shall disclose PHI in a private and secure manner. Contractors and vendors should not leave voice-mail messages, but instead make direct telephone contact with the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee. If direct telephone contact is not possible, a voice mail message may be left without protected health information, such as medications and relevant medical and psychiatric diagnoses. As soon as possible after the initial verbal notification, the Contractor will mail or fax a completed *Sentinel Event Reporting Form* as directed in this protocol.

Notification shall include the following:
1. Name and phone number of the individual reporting.
2. Name, date of birth (DOB), medications and all relevant medical and psychiatric diagnoses of individual(s) involved;
3. Location, date, and time of event;
4. Description of the event including what, when, where, how, and other relevant information and identification of any other individuals involved;
5. Legal status of the individual involved with regard to guardianship and power of attorney;
6. Community, guardian, family and/or families' knowledge of the event; and
7. Contractor contact person and contact information.

It shall be the responsibility of the BDAS Assistant Administrator or Clinical Services Unit Administrator or designee to notify the DCBCS Quality Improvement Director by e-mail as soon as the BDAS Clinical Administrator or designee becomes aware a Sentinel Event has occurred. The DCBCS Quality Improvement Director shall make immediate notification to the Commissioner. Internal e-mails within the Department may contain PHI and all Department employees will utilize safeguards to ensure the privacy

of the PHI as stated in the DHHS General Manual Health Insurance Portability and Accountability Act (HIPAA) policy #504.

Each DCBCS contractor recognizes its responsibility to report evidence of neglect, abuse or exploitation to the appropriate regulatory agencies as required by RSA 161-F: 42-57 and RSA 169-C:29. In any case of known or suspected neglect, abuse or exploitation, the Contractor aware of the situation shall follow all applicable rules relative to individual rights protection procedures.

Written follow up information is to be forwarded by the reporting Contractor to the appropriate BDAS Administrator listed below within 72 hours by completing the *Sentinel Event Reporting Form.* To protect clients' confidential information, reporting Contractors should submit the *Sentinel Event Reporting Form* either by fax to the BDAS Assistant Administrator or the BDAS Clinical Services Unit Administrator by a mail service that provides delivery confirmation.

Bureau of Drug and Alcohol Services
Assistant Administrator
105 Pleasant Street
Concord, NH 03301
Or by fax to the BDAS Administrator's Office at 271-6105;

Follow-up information is the responsibility of the Contractor and should be submitted in a way as to protect clients' confidential information such as by mail with delivery confirmation and should include:

1. The *Sentinel Event Reporting Form(www.dhhs.nh.gov/dcbcs/documents/sentinelform.pdf)*;
2. Additional details as they are learned or if the status of the situation changes; and,
3. Copies of newspaper articles.

Additionally, DHHS requires critical incident reporting. The Contractor shall report all critical incidents/sentinel events to the BDAS Clinical Services Unit Administrator immediately via telephone. Every effort shall be made to reach the BDAS administrator directly. If a voice message is necessary, sufficient provider contact information shall be provided so that DHHS is able to reach the reporter, or other responsible staff, immediately.

A critical incident includes, but is not limited to, any child or adult protective services report to the Division of Children, Youth and Families (DCYF), or the Bureau of Elderly and Adult Services (BEAS), respectively, regarding any incident involving 1) a staff/employee to youth or client, 2) youth to youth, or 3) client to client. This includes incidents that occur while a client is on leave, or on a pass, from the Contractor and may be off site at the time the incident occurred.

A sentinel event is an unexpected occurrence involving the death or serious physical or psychological injury, or risk thereof, signaling the need for immediate investigation and response.

Death or any serious injury or medical emergency regarding staff or clients that requires emergency medical attention (EMT or other emergency personnel at the Contractor's site, or a hospital emergency room visit), or any crime reportable to law enforcement, or any other serious incident must also be reported to DHHS as described below.

Reportable sentinel events include, but are not limited to, any occurrence that meets any of the following criteria:

1. An unanticipated death or permanent loss of function, not related to the natural course of an individual's illness or underlying condition.
2. Homicide or suicide of any individual receiving DHHS funded care, treatment or services, that had been discharged from a Department funded program or facility within 30 days of the event, or has been evaluated by a service Contractor within the preceding 30 days;
3. Sexual assault or rape of any individual receiving DHHS funded care, treatment or services by another client or employee of any Department funded program or facility where there is an act that was witnessed or there is sufficient clinical evidence obtained by the Contractor to support allegation of nonconsensual sexual contact.
4. Unauthorized departure of an individual receiving DHHS funded services, from a facility providing care, resulting in death or permanent loss of function.
5. Medication error that results in death, paralysis, coma, or other permanent loss of function.
6. Delay or failure to provide DHHS funded Contractor services that result in death or permanent loss of function.
7. Abuse as a result of the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one individual by another.
8. Neglect as a result of the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness.
9. Assault of or by a client of the Contractor that results in the injury of the person or another person of such severity that medical attention is required.
10. Arson resulting in property loss.
11. High profile events, which may include media coverage and/or police involvement.

On-Site Reviews:

1. The Contractor shall allow a team or person authorized by DHHS to periodically review the Contractor's systems of governance, administration, data collection and submission, clinical, and financial management in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include, but not be limited to, client record reviews to measure compliance with this exhibit.
3. The Contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. DHHS staff shall contact the Contractor in advance of the site visit, so that the Contractor shall have sufficient time to prepare any guidance/reporting systems or logs that will be reviewed at the site visit.

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Method and Conditions Precedent to Payment

The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services, and in accordance with Exhibit B.

Funding for this Agreement is funded by various sources as a percentage of the total amount of $611,904 as follows:

- 46 % Federal Funds from the Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959);
- 22 % General Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Funds; and
- 32 % General funds.

I. Payment Methodology

The Contractor shall be reimbursed for providing and delivering the services listed in Exhibit A, paragraph B. The following terms and conditions detailed in this Exhibit B shall apply to all services unless expressly stated otherwise.

The Contractor shall agree to use and apply all contract funds from the State for costs and expenses as detailed in the Service Reimbursement Table below. Allowable costs and expenses shall be determined by the State in accordance with applicable state and federal laws and regulations. Starting in State Fiscal Year 2015 (effective July 1, 2014) the contractor will receive a payment for each service at the rates and within the limits described below. For clients receiving DHHS supported services, the contractor may not charge the client, any 3rd party payor, and DHHS a combined rate that is more than the rate established by BDAS for that level of service or any other fees. These parties shall be charged in the following order:

1. The maximum allowed charge will be billed to the client's insurer, if applicable.
2. The client will be charged their portion of the maximum allowed charge based on the BDAS published sliding fee scale.
3. The balance of the maximum allowed charge, after deducting the client's portion and insurance payment, if applicable, shall be charged to DHHS.

Service Reimbursement Table - A check mark indicates the services and corresponding rates the Contractor will be reimbursed for.

Check mark indicates applicable service	Service	DHHS Established Rate	Service Limit
X	Evaluation	$225	1 every 90 days
	Outpatient – Individual	$18.75/unit***	$190 of combined individual & group/week
	Outpatient – Group	$5.00/unit	
	Intensive Outpatient*	$80.00/day	$320 (4 days)/week
X	Low-Intensity Residential – Adult	$100.00/day	$700 (7 days) /week

Contractor Initials: MC
Date: 5/29/14

X	Low-Intensity Residential – Adolescent	$128.00/day	$896 (7 days) /week
X	High-Intensity Residential – Adult	$130.00/day	$910 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Room & Board Only	$66.00/day	$462 (7 days) /week
	Specialty Residential Treatment for Pregnant & Parenting Women (ASAM Level 3.5): Clinical Services	$162.60/day	$1138.20 (7 days) /week
X	Medium Intensity Residential – Adolescent	$170.00/day	$1190 (7 days) /week
	Recovery Support Services		
X	Individual	$15.00/unit	$160 of combined individual & group/week
X	Group	$5.00/unit	
X	Continuous Recovery Monitoring – Attempted**	$15.00/contact	$60 of combined attempted and completed/month for the first 6 months post discharge
X	Continuous Recovery Monitoring – Completed	$15.00/contact	
	Enhanced Services	Varied	

* Providers may bill the per diem rate for Intensive Outpatient Treatment services only on those days when the client attends individual and/or group counseling associated with the program. It is expected that each day of attendance includes a minimum of 3 hours of group and/or individual counseling services.

**Attempted Contact is at least 3 attempts to contact a client over the course of at least one week.

*** A unit is equal to 15 minutes of service
It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period. Utilization and array will also be monitored by the Department via WITS. Failure to meet this requirement may result in amendment to or termination of the contract. At a minimum, contractors must provide the array of services they contracted to provide for in SFY14.

1. **Performance Incentives:**

A. Access to Services:

Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received and shall conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact. For each client who screens eligible for

services and starts receiving services, whether for the identified level of care or interim services, within 10 business days following the eligibility screening, the treatment contractor will receive an incentive payment of $75.00. Access incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

B. Completion:

For each client who is discharged from the program because they have completed treatment or transferred to another treatment provider as recorded in the Discharge Type field of the WITS Discharge Module, the treatment contractor will receive an incentive payment of $75.00. Completion incentives will be calculated and paid on a monthly basis for services in the previous calendar month.

C. Client Outcomes:

If a client who was discharged from the program meets at least 3 of the Outcome criteria below in the 3rd and/or 6th month post-discharge, as evidenced by the WITS Follow-Up module, the treatment contractor will receive an incentive payment in the amount of $50. The 3rd month post discharge is considered to be 60 – 120 days post discharge. The 6th month post discharge is considered to be 150 – 210 days post discharge. Outcomes incentives will be calculated and paid on a monthly basis for clients meeting criteria in the previous calendar month. It is expected that at least 50% of discharged clients will be contacted for 3 and/or 6 month follow-up over the contract year.

i. Abstinence: The client reports reduced or no substance use in the past 30 days.
ii. Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school.
iii. Crime and Criminal Justice: The client reports no arrests in the past 30 days.
iv. Stability in Housing: The client reports being in stable housing.
v. Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

D. Performance Incentive Payout Limits:

Performance incentives are limited to no more than 6% of the total contract amount annually. The total amount paid out during the contract year will never exceed the total contract amount. DHHS is not obligated to make payment for any incentives that occur outside of the current contract year; however, incentives may be carried over to future contract years at the discretion of DHHS.

2. Failure to Meet Deliverables:

The Contractor shall comply with all contract requirements as detailed in Exhibit A section B, Required Services. Upon determination that Contractor may not be meeting the required deliverables, within two (2) weeks BDAS will provide a written correction action plan. Within two (2) weeks of notification of the corrective action plan, Contractor will provide a written remedial plan. BDAS will monitor the corrective actions for 60 days. Failure to meet requirements of the corrective action plan within 60 days may result in withholding of any or all payments or termination of the contract.

3. Invoicing & Billing:

All billing shall be completed via the WITS system according to protocols established by BDAS.

The Contractor shall have written authorization from the State prior to using contract funds to purchase or lease any equipment with a cost in excess of two thousand five hundred dollars ($2500) and with a useful life beyond one year.

II. Allocation of Funding:

It is incumbent upon the contractor to monitor service array and utilization to ensure that a consistent level of service will be available throughout the contract period. Utilization and array will also be monitored by the Department via WITS. The contractor is prohibited from spending down more than the sum of the total contract amount that includes the cost of the client services and related incentives.

III. Availability of Alternative Funding:

The New Hampshire Department of Health and Human Services may terminate or amend the contract should alternate third party payors, including Medicaid, the New Hampshire Health Protection Program and/or insurance available on the New Hampshire Insurance Exchange cover any of the services included in this contract.

IV. Limitations and restrictions of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds:

The Contractor agrees to use the SAPT funds as the payment of last resort.

Restrictions on SAPT Block Grant on State and Contractor expenditures include:
The State may not:

- Provide inpatient hospital services except under those conditions outlined in the regulations.
- Make cash payments to intended recipients of substance abuse services.
- Purchase or improve land.
- Purchase, construct, or permanently improve buildings or other facilities.
- Purchase major medical equipment.
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds. (in-kind)
- Provide financial assistance to any entity other than a public or non-profit private entity.
- Provide individuals with hypodermic needles or syringes.
- Expend more than the amount of Block Grant funds expended in FFY91 for treatment services provided in penal or correctional institutions of the State.

The Contractor shall not:

- Use any federal funds provided under this contract for the purpose of conducting testing for the etiologic agent for Human Immunodeficiency Virus (HIV) unless such testing is accompanied by appropriate pre and post-test counseling.
- Use any federal funds provided under this contract for the purpose of conducting any form of needle exchange, free needle programs or the distribution of bleach for the cleaning of needles for intravenous drug abusers.

V. Charitable Choice:

Federal Charitable Choice statutory provisions ensure that religious organizations are able to equally compete for Federal substance abuse funding administered by SAMHSA, without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries (see 42 USC 300x-65 and 42 CFR Part 54 and Part 54a, 45 CFR Part 96, Charitable Choice Provisions and Regulations). Charitable Choice statutory provisions of the Public Health Service Act enacted by Congress in 2000 are applicable to the SAPT Block Grant program. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

VI. Notwithstanding paragraph 18 of the General Provisions of this Agreement P-37, an amendment limited to adjusting amounts within the budgets and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of Governor and Executive Council.

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102A

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF DRUG AND ALCOHOL SERVICES

Nicholas A. Toumpas
Commissioner

Nancy L. Rollins
Associate
Commissioner

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6100 1-800-804-0909
FAX: 603-271-6105 TDD Access: 1-800-735-2964

G&C Approved
Date 6/5/13
Item # 102A

50.6% Federal
47.4% General

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug and Alcohol Services, to exercise renewal options with vendors by increasing the price limitations by $7,596,887 in aggregate from $7,596,890 in aggregate to $15,193,777 in aggregate for a continuum of substance abuse treatment services state-wide and extending the completion date from June 30, 2013 to June 30, 2014, effective July 1, 2013 or date of Governor and Council approval, whichever is later.

Summary of contracted amounts by vendor:

Vendor	Amount
Child and Family Services of New Hampshire	$86,803
Concord Hospital, Inc.	$74,406
Families First of the Greater Seacoast	$28,922
Families in Transition	$332,530
Greater Nashua Council on Alcoholism	$1,356,945
Headrest, Inc.	$251,450
Horizons Counseling Center, Inc.	$189,576
Manchester Alcoholism Rehabilitation Center	$1,120,599
The Mental Health Center of Greater Manchester, Inc.	$27,114
Monadnock Family Services	$97,819
Northern Human Services	$199,025
Phoenix Houses of New England, Inc.	$1,457,490
National Council on Alcoholism and Drug Dependence of Greater Manchester	$432,468
Southeastern New Hampshire Alcohol and Drug Abuse Services	$1,329,836
Tri-County Community Action Programs, Inc.	$611,904
TOTAL	$7,596,887

Funds to support this request are anticipated to be available in the following accounts in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts within the price limitation and amend the related terms of the contracts without further approval from Governor and Executive Council.

05-95-49-491510-2989 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, GOVERNOR COMMISSION FUNDS (100% General Funds)

05-95-49-491510-2990 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, CLINICAL SERVICES (34.4% General 65.6% Federal)

Please see attachment for financial details

EXPLANATION

The requested action seeks approval of 15 of 17 agreements that represent $7,596,887 of the $7,741,314 total anticipated to be spent state-wide to provide a continuum of substance abuse treatment services via the accounting codes listed. These services include community based outpatient, intensive outpatient, residential, transitional living, and recovery support services, including specialized treatment services for pregnant and parenting women and their children. This request seeks to exercise the renewal option that exists within each of the vendor contracts. The Department anticipates that the remaining two agreements will be presented to Governor and Executive Council on June 19, 2013.

Client eligibility for treatment services is targeted at those either unable to pay for services or able to pay only part of the cost of services, and who has or is suspected of having an alcohol or other drug abuse problem, and who is a resident of the State of New Hampshire or is homeless in NH. All clients discharged from treatment services supported by this contract will be referred to care coordination and recovery-support aftercare services as clinically appropriate, supported separately by the Federal Access to Recovery Grant.

The State is migrating toward a Resiliency and Recovery Oriented Systems of Care. Recovery-oriented systems of care are networks of organizations, agencies and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. In addition, these contracts will continue to allow the State to improve the quality and array of services available to clients. Quality improvement efforts include the exchange of data and information that will support "data driven" prevention and treatment programming to better address the needs to the region.

The New Hampshire Office of Energy and Planning reported the 2009 Population Estimates of New Hampshire Cities and Towns as 1,324,575. The National Survey on Drug Use and Health commissioned by the Substance Abuse and Mental Health Services Administration in 2008/2009 reported the following demographic data for New Hampshire:

- Alcohol Abuse: 97,630 (7% of population)
- Alcohol dependence: 44,850 (3% of population)
- Illicit Drug Abuse: 43,810 (3% of population)
- Illicit Drug Dependence: 32,240 (2% of population)
- Substance Abuse: 126,630 (10% of population)
- Needing but not receiving treatment for alcohol abuse: 93,990 (7% of population)
- Needing but not receiving treatment for illicit drug use: 39,390 (3% of population)

In addition, the New Hampshire Medical Examiner office reported 172 drug related overdose deaths in NH during 2010. The New Hampshire Administrative Office of the Courts reported 9,500 arrests and 5,000 convictions for Driving While Impaired in 2009. Approximately 90% of individuals arrested for Driving While Impaired have an underlying substance abuse disorder according to the National Institute on Alcohol Abuse and Alcoholism.

Should the Governor and Executive Council determine to not authorize this Request, agencies would not have sufficient resources to promote, implement and provide the array of services necessary to provide individuals with substance use disorders the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment service would place that Block Grant in jeopardy.

The vendors were originally selected for this agreement through a competitive bid process. This request covers services for the period July 1, 2013 to June 30, 2014, and anticipates exercising the option to renew for one additional year as provided all of the previous vendor contracts, pending availability of funding, the agreement of the parties and approval of Governor and Council. These services were contracted previously with the listed vendors in State Fiscal Year 2013 in the amount of $7,741,314 in the aggregate. This agreement represents level funding of all vendors.

The following performance measures will be used to measure the effectiveness of the agreements:

- Utilization criteria will be applied exclusively on a month-by-month basis according to the criteria below.

i. Contracts running at 90% to 100% of utilization in a given month will be reimbursed at 100% of the contracted rate for that month.
ii. Contracts running at 80% to 89% of utilization in a given month will be reimbursed at rate of 95% of the contracted rate for that month.
iii. Contracts running below 80% of utilization in a given month will be reimbursed at the rate of utilization for that month (for example for a given month in which utilization was 59% the contractor would be reimbursed at 59% of the contracted rate for that month).

- Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received. The following Access Criteria must be met for a minimum of 80% of prospective clients (from clients or referring agencies) for the month in which billing is being submitted:

i. Treatment contractors are required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.
ii. Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening.

- A minimum of 70% of clients, which have completed or otherwise are no longer receiving services, will have met the minimum retention standards for the modality of services received as noted below:

i. Have completed a minimum of 6 sessions of outpatient treatment services
ii. Have completed a minimum of 8 days of intensive outpatient treatment services – only those days in which a client has participated in minimum of 10 units (2.5 hours) of service per day (12 units per day is the standard for I intensive outpatient treatment services) may be counted.
iii. Have completed a minimum of 14 days of residential treatment service
iv. Has completed a minimum of 28 days in a transitional living/halfway house residential program.

Contractors, with the exception of those agencies that only offer outpatient services, are required to develop the capacity for group recovery support aftercare services for a minimum of 25% of the number treatment clients (including outpatient and transitional living program clients) they are under contract to serve. Group recovery support aftercare services are services that are consistent with an individual's recovery plan that prevent relapse and enhance or remove barriers to recovery. Recovery Support Services include, but are not limited to, guidance in financial management, parenting, vocational training, life management and spiritual counseling as well as transportation and child-care. These group recovery support services are for clients discharged from substance use disorder treatment services provided under contract with the Bureau of Drug and Alcohol Services on behalf of the Department, which may include clients that had received SUD treatment from the Contractor or a different agency. Contractors are only allowed to access these services for their clients or clients that had received substance use disorder treatment from a different agency through the statewide care coordination program under agreement with the Bureau of Drug and Alcohol Services on behalf of the Department.

All treatment programs under contract with the Bureau of Drug and Alcohol Services on behalf of the Department are required to report on the National Outcome Measures (see attached) established by the Substance Abuse and Mental Health Services Administration, as required in the Federal Substance Abuse Prevention and Treatment Block Grant, via the Electronic Health Record/Web Infrastructure Treatment System. The Department of Health and Human Services reserves the right to consider Contractor performance across all of the domains in future funding decisions. The Contractor is expected to meet or exceed these percentages as measured by the Electronic Health Record/Web Infrastructure Treatment System.

Area served: State-wide

Source of Funds: 52.6% Federal Funds from Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant and 47.4% General.

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Nancy L. Rollins
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF COMMUNITY BASED CARE SERVICES

BUREAU OF DRUG AND ALCOHOL SERVICES

Nicholas A. Toumpas
Commissioner

Nancy L. Rollins
Associate Commissioner

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6100 1-800-804-0909
FAX: 603-271-6105 TDD Access: 1-800-735-2964

May 24, 2012

Approved by: G+C
Date: 6/20/12
Item No.: 162
Contract No.: 102415

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Community Based Care Services, Bureau of Drug & Alcohol Services, to enter into an agreement with Tri-County Community Action Programs, Inc. (Vendor #177195), 30 Exchange Street, Berlin, NH 03570, to provide for a continuum of substance abuse treatment services, in an amount not to exceed $611,907.00 to be effective July 1, 2012 or date of Governor and Council approval, whichever is later, through June 30, 2013. Funds are available in the following accounts for State Fiscal Year 2013:

05-95-95-958410-5365 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: COMMISSIONER, DCBCS TREATMENT & PREVENTION, ALCOHOL AND OTHER TREATMENT

Fiscal Year	Class/Object	Class Title	Job Number	Amount
SFY 2013	102-500734	Contracts for Prog Svc	95846501	$281,447.00
			Subtotal	$281,447.00

05-95-95-958410-1388 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: COMMISSIONER, DCBCS TREATMENT AND PREVENTION, GOVERNOR

Fiscal Year	Class/Object	Class Title	Job Number	Amount
SFY 2013	102-500734	Contracts for Prog Svc	95848501	$137,281.00
			Subtotal	$137,281.00

05-95-95-958410-1387 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: COMMISSIONER, DCBCS TREATMENT & PREVENTION, TREATMENT-PREVENTION-STATE

Fiscal Year	Class/Object	Class Title	Job Number	Amount
SFY 2013	102-500734	Contracts for Prog Svc	95841387	$193,179.00
			Subtotal	$193,179.00
			Total	$611,907.00

EXPLANATION

The purpose of this agreement is to provide a continuum of substance abuse treatment services such as community based outpatient, intensive outpatient, residential, transitional living, and recovery support services, including specialized treatment services for pregnant and parenting women and their children, statewide

Client eligibility for treatment services is targeted at those either unable to pay for services or able to pay only part of the cost of services, and who has or is suspected of having an alcohol or other drug abuse problem, and who is a resident of the State of New Hampshire or is homeless in NH. All clients discharged from treatment services supported by this contract will be referred to care coordination and recovery-support aftercare services as clinically appropriate, supported separately by the Federal Access to Recovery Grant.

The State is migrating toward a Resiliency and Recovery Oriented Systems of Care. Recovery-oriented systems of care are networks of organizations, agencies and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. In addition, this contract will allow the State to improve the quality and array of services available to clients. Quality improvement efforts include the exchange of data and information that will support "data driven" prevention and treatment programming to better address the needs to the region.

The New Hampshire Office of Energy and Planning reported the 2009 Population Estimates of New Hampshire Cities and Towns as 1,324,575. The National Survey on Drug Use and Health commissioned by the Substance Abuse and Mental Health Services Administration in 2008/2009 reported the following demographic data for New Hampshire:

- Alcohol Abuse: 97,630 (7% of population)
- Alcohol dependence: 44,850 (3% of population)
- Illicit Drug Abuse: 43,810 (3% of population)
- Illicit Drug Dependence: 32,240 (2% of population)
- Substance Abuse: 126,630 (10% of population)
- Needing but not receiving treatment for alcohol abuse: 93,990 (7% of population)
- Needing but not receiving treatment for illicit drug use: 39,390 (3% of population)

In addition, the New Hampshire Medical Examiner office reported 172 drug related overdose deaths in NH during 2010. The New Hampshire Administrative Office of the Courts reported 9,500 arrests and 5,000 convictions for Driving While Impaired in 2009. Approximately 90% of individuals arrested for Driving While Impaired have an underlying substance abuse disorder according to the National Institute on Alcohol Abuse and Alcoholism.

Should the Governor and Executive Council determine to not authorize this Request, agencies would not have sufficient resources to promote, implement and provide the array of services necessary to provide individuals with substance use disorders the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment service would place that Block Grant in jeopardy.

Tri County Community Action Programs, Inc., was selected for this agreement through a competitive bid process. A Request for Proposals was posted on the Department's web site on March 6, 2012 through April 2, 2012. In addition, a bidder's conference was held on March 12, 2012.

A total of 19 proposals were received. A review committee of three professionals reviewed each proposal. All reviewers have between three to twenty years experience managing agreements with vendors for various public health programs. Areas of specific expertise include: maternal and child health; substance abuse prevention and treatment; chronic and communicable diseases; and public health infrastructure. Eighteen of the proposals were selected for funding based on review criteria that included availability of funds, consistency with stated funding priorities, technical score, and equitable geographic distribution. The agency that was not selected did not meet the minimum scoring criteria established for funding. The Bid Summary is attached.

This request covers services for the period July 1, 2012 to June 30, 2013, with an option to renew for one additional year, pending availability of funding, the agreement of the parties and approval of Governor and Council. These services were contracted previously with this agency in State Fiscal Year 2012 in the amount of $611,907.00. This agreement represents level funding.

The following performance measures will be used to measure the effectiveness of the agreement:

- Utilization criteria will be applied exclusively on a month-by-month basis according to the criteria below.

i. Contracts running at 90% to 100% of utilization in a given month will be reimbursed at 100% of the contracted rate for that month.

ii. Contracts running at 80% to 89% of utilization in a given month will be reimbursed at rate of 95% of the contracted rate for that month.

iii. Contracts running below 80% of utilization in a given month will be reimbursed at the rate of utilization for that month (for example for a given month in which utilization was 59% the contractor would be reimbursed at 59% of the contracted rate for that month).

- Treatment contractors shall respond to calls requesting services, whether an initial or subsequent call, from clients or referring agencies as soon as possible and within at least 2 business days following the day the call was received. The following Access Criteria must be met for a minimum of 80% of prospective clients (from clients or referring agencies) for the month in which billing is being submitted:

i. Treatment contractors are required to conduct initial eligibility screening as soon as possible, ideally at the time of first contact (direct communication by phone or in person) with the client or referring agency, but not later than 5 business days following the date of first contact.

ii. Those who have screened eligible for services will start receiving services, whether for the identified level of care or interim services, within 10 business days follow the eligibility screening.

- A minimum of 70% of clients, which have completed or otherwise are no longer receiving services, will have met the minimum retention standards for the modality of services received as noted below:

i. Have completed a minimum of 6 sessions of outpatient treatment services (OP)

ii. Have completed a minimum of 8 days of intensive outpatient treatment services (IOP) – only those days in which a client has participated in minimum of 10 units (2.5 hours) of service per day (12 units per day is the standard for IOP services) may be counted.

iii. Have completed a minimum of 14 days of residential treatment service

iv. Has completed a minimum of 28 days in a transitional living/halfway house residential program.

Area served: Statewide.

Source of Funds: 46% Federal Funds from Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant, 50.85% General Funds and 3.15% Other (Highway) Funds.

In the event that the Federal or Other Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,

Nancy L. Rollins
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

NLR/df

Program Name	CFS	Con Hosp.	Fam. 1st	FIT	Easter Seals	FOR-NH	GC HOC	GNCA	Headrest	Horizons	MHCGM	MFS	NHS	Phoenix	NCADD	SENHS	TYC	Tri-CAP	NESCT
Contract Purpose	TX&RSS																		
RFP Score Summary																			

RFA/RFP CRITERIA	Max Pts	CFS	Con Hosp.	Fam. 1st	FIT	Easter Seals	FOR-NH	GC HOC	GNCA	Headrest	Horizons	MHCGM	MFS	NHS	Phoenix	NCADD	SENHS	TYC	Tri-CAP	NESCT
Experience and Capacity	15	14.00	13.00	15.00	15.00	13.00	13.00	11.00	12.00	12.00	14.00	15.00	13.00	15.00	13.00	12.00	15.00	12.00	13.00	10.00
Approach	50	42.00	46.00	48.00	48.00	47.00	39.00	41.00	47.00	42.00	46.00	40.00	43.00	48.00	45.00	42.00	48.00	38.00	42.00	27.00
Budget	25	24.00	25.00	25.00	24.00	23.00	18.00	23.00	20.00	22.00	18.00	25.00	19.00	24.00	16.00	22.00	22.00	23.00	23.00	16.00
Financial Sustainability	10	7.50	8.30	9.00	10.00	7.00	0.00	7.50	6.90	8.30	9.50	9.00	6.50	9.50	7.20	6.50	7.50	7.20	8.30	5.60
Total	100	88.00	92.00	97.00	97.00	90.00	70.00	82.00	86.00	84.00	88.00	89.00	82.00	97.00	81.00	83.00	93.00	81.00	87.00	58.00
BUDGET REQUEST		$120,256	$85,000	$27,207	$406,796	$2,221,666	$47,050	$116,428	$1,750,112	$285,000	$245,963	$30,000	$153,454	$244,501	$2,615,553	$813,951	$1,329,836	$87,567	$747,691	$930,630
BUDGET AWARDED		$36,303	$74,406	$28,922	$322,530	$1,120,599	$539,238	$369,418	$1,356,945	$251,250	$189,576	$27,114	$97,819	$199,025	$1,457,490	$432,268	$1,329,836	$75,013	$611,907	$0

RFP Reviewers

	Name	Job Title	Dept/Agency	Qualifications
1	Tym Rourke	Sub. Use Disorders	Grantmaking/GC	All reviewers have between 3-20 years experience managing agreements with vendors for various DHHS and DOC programs. Areas of specific expertise include Maternal and Child Health; Substance Abuse
2	Pamela Sullivan	Youth Counselor	SYDC	
3	Heidi Young	Program Specialist	DCYF	
4	Bernie Bluhm	Prog. Planner/Rev. Spec.	Family Services	
5	Alan West,Ph.D.	Psychologist/VA	TX/Co-occurring	
6	Mary Miller	Prog. Spec. IV	OCPH	
7	Michelle Ricco	Prog. Spec. IV	DPHS	
8	Kathleen Hessefort	Internal Auditor I	BDAS/FBO	
9	Lindy Keller	Administrator I	BDAS-RAD	
10	Michael Lawless	Prog. Spec. IV	BDAS/CSU	
11	Bruce Blaney	Regional Coordinator	BDAS-CSU	
12	Jim Shanelaris	Administrator I	BDAS-FBOU	
13	Linda Parker	Prog. Spec. IV	BDAS-CSU	
14	Rosemary Shannon	Administrator I	BDAS-CSU	
15	Rob O'Hannon	ATR Prog. Spec.	BDAS/ATR	
16	Jaime Powers	Tx&Rec. Serv. Coord.	BDAS/ATR	
17	John Sweeney	Systems Dev.	BDAS/IT	
18	Michael Rodgers	Assistant Administrator	BDAS	
19	Jeffrey Metzger	Sr. Mgmt. Analyst	BDAS/PSU	
20	Ann Crawford	Regional Coordinator	BDAS/PSU	
21	Valerie Morgan	Administrator I	BDAS/PSU	

Revised: [illegible]