Attachment B

FY 2022 and FY 2023 Primary Provider Services

I. AGENCY RESPONSIBILITIES/PROGRAM DESCRIPTION

Primary Provider services are those referring to the Primary Case Holder such as the Case Manager, Supports Coordinator or Therapist. Such services are to assists individuals served to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist individuals served in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. For children and youth, a family driven, youth guided planning process should be utilized.

II. PROGRAM GOALS (Performance Outcome Measures)

A. All required paperwork, including service documentation and claims for payment, are submitted according to the MCCMH Policy and Medicaid Provider manual. BOARD personnel will review documentation for timeliness and accuracy on a monthly basis.

B. AGENCY will comply with all Key Performance Indicator (KPI) standards set forth by MDHHS that are applicable to the services contracted by BOARD with AGENCY. The AGENCY will complete the "Twin 14" form in FOCUS to evidence KPI standards. Listed below are additional Performance Outcomes pertinent to this contract, which will be measured.

1. Additional Performance Outcome Measures

a. Active Engagement in Treatment. Actively engaging the individuals served in treatment early on, as well as at times of crisis and decompensation, relates highly to a positive treatment prognosis.

i. It is expected that the individual served will receive a minimum of six (6) billable professional services within the first forty-five (45) days of completion of the individual served intake to the AGENCY for seventy-five percent (75%) of individuals served.

ii. It is expected that Case Manager will have face to face Case Management contact with existing open cases within twenty-four (24) hours of inpatient psychiatric hospital admission, as part of an active discharge planning process.

iii. If the individual served inpatient psychiatric hospital admission extends beyond one week, the individual served Case Management Agency will have face to face Case Management contact with existing open cases at

a minimum of one (1) billable episode each week of the inpatient psychiatric hospital admission, as part of an active discharge planning process.

b. Recidivism. Inpatient psychiatric hospitalization recidivism. The AGENCY will track and address inpatient psychiatric hospital recidivism rates of the individuals served that are open with the AGENCY.

i. It is expected that individuals served will be readmitted for an inpatient psychiatric hospital episode less than fifteen percent (15%) of the time within thirty days (30) of the last inpatient psychiatric hospital episode discharge.

c. The AGENCY will utilize the current methods and standards of the Diagnostic and Statistical Manual (DSM-V) and LOCUS. Additionally, the AGENCY will review, measure and update individual served LOCUS score upon the Initial Assessment, Re Assessment and Annual Assessment, Person Centered Planning, Period Review and thereafter.

d. The SIS Supports Intensity Scale Assessment is expected to be completed at least once every three years. If persons/guardian declines or refuses the SIS completion, the SIS must be offered at least annually thereafter. Clear documentation regarding refusal must be provided when requested and documented within the Electronic Health Record.

d. Child and Adolescent Functional Assessment Scale (CAFAS). The AGENCY will complete the CAFAS at the time of the Intake Assessment, every ninety (90) days following Intake Assessment, and at the time of discharge from all CMHSP offered services.

i. The AGENCY will review and update the individual served CAFAS score at every defined interval ninety-five percent (95%) of the time.

ii. As CAFAS scores are reviewed and updated, it is expected that individuals served will demonstrate improvement or maintenance of their CAFAS score seventy-five percent (75%) of the time.

iii. If an individual served is receiving an evidence-based practice (i.e. TFCBT, CBT, PMTO, PTC), the expectation is that the CAFAS will continued to be utilized beyond the first year. Further, if at any time the individual served is receiving an evidenced based practice the CAFAS will be continued to be utilized.

e. Primary Care Physician.

i. It is expected that the individuals served Primary Care Physician is clearly identified in the individuals served EMR with evidence of coordination with Primary Care Physician and the AGENCY ninety-five percent (95%) of the time.

ii. Any physical condition identified in the Assessment and/or Plan of Service will have engagement with appropriate medical professional for follow-up ninety-five percent (95%) of the time.

f. Psychiatric Appointments.

i. It is expected that the individual served will complete an appointment with the AGENCY psychiatrist within 14 days of an inpatient psychiatric hospitalization discharge.

g. Rule Out and Not Otherwise Specified Diagnoses. The lead clinical agency is responsible for maintaining the most updated clinical information for individuals served EMR.

i. The use of "Rule Out" diagnoses are discouraged, however, when it is necessary for a clinician to provide a rule out diagnosis, it is expected that any rule out diagnosis that is provided will be ruled out or accepted with updated clinical evidence to support that diagnosis, within six (6) months of that rule out diagnosis being issued. The clarification of the rule out diagnosis should occur within six (6) months, .

ii. The use of "Not Otherwise Specified" (NOS) diagnoses are discouraged, however, when it is necessary for a clinician to provide a NOS diagnosis, it is expected that any NOS diagnosis that is provided will be addressed with updated clinical evidence to support a more precise diagnosis, or additional clinical evidence to support the continuation of the NOS diagnosis, within six (6) months of that NOS diagnosis being issued. The review of the NOS diagnosis should occur within six (6) months.

h. Reason for Discharge. The AGENCY will provide clear and thorough documentation which details individuals served reason for discharge from the AGENCY. ALL reasons for discharge must be documented.

i. Individual Served Satisfaction. The AGENCY will, on at least an annual basis, complete a survey of individual served satisfaction with services and share results with the BOARD. The individual served satisfaction survey format will be approved by the BOARD prior to implementation by the AGENCY.

ii. The AGENCY will achieve a 95% level of individual served satisfaction, based on the survey instrument.

j. Technical Review Audit.

i. The AGENCY will achieve an overall score of 95% or better on the technical review audit conducted by the Board.

2. Additional Performance Outcome Measures specific to Residential Case Management

a. Pre-placement Visit (PPV). The PPV is a very important component of the residential placement process. It is expected that a PPV be completed prior to every residential placement. A PPV is not restricted by location and can occur in various settings, such as the licensed residential home, hospital, shelter, family home, etc.

i. It is expected that a pre-placement visit (PPV) will be scheduled for the individual served within forty-eight (48) hours of receiving notification from the Access Center of the intent to seek placement of the individual served with identified Residential Agency,

ii. It is expected that a pre-placement visit (PPV) be completed for the individual served by the AGENCY within seven (7) days of receiving notification from the Access Center of the intent to seek placement of the individual served with identified Residential Agency,

C. The AGENCY will track all KPI's and respond to BOARD staff when obtaining all KPI information on a timely basis.

III. SCOPE OF SERVICES:

A. The AGENCY shall provide the individual served with services which are medically necessary and prospectively authorized by MCCMHS Managed Care Operations Division (MCO). The AGENCY has the responsibility to ensure that individuals served meet eligibility criteria. The BOARD has the expectation that the AGENCY will follow eligibility criteria and provide medically necessary services to individuals served who the PIHPs/CMHSPs have responsibility for.

B. The services identified by CPT code in the Attachment D Reimbursement Schedule are available services to be authorized and provided to persons served. These are the only services which may be billed.

C. If the Access Manager from the MCO Division agrees that the requested services are medically necessary, prospective authorization shall be provided to the AGENCY. If the Access Manager determines the request, of the completed document, is not medically necessary with the request, the request will be denied and notice of appeal rights will be provided to the individual served and to the requesting clinician.

D. The role of the AGENCY will be to ensure that all appropriate services have been requested and are in place.

IV. PROCESS FOR SCOPE OF SERVICES

A. ENTRY CRITERIA

1. For individuals served who are hospitalized at the time of referral from the Managed Care Division, the AGENCY shall become an active part of the discharge planning from the hospital facility.

    a. After referral of the individual served to the AGENCY, the AGENCY will complete an assessment and recommend the proposed Level of Care appropriate for the individual served to the Managed Care Division.

    b. The Managed Care Division will review the AGENCY's summary and advise the AGENCY of the Managed Care Division Level of Care determination. If appropriate, the AGENCY can proceed to arrange placement in the agreed upon Level of Care with assurance that authorization will be provided by the Managed Care Division to support the placement. The AGENCY should continue contact with the Managed Care Division if the requested Level of Care changes prior to placement.

    c. If the individual served requires out-of-county services, the AGENCY will contact the Managed Care Division to secure services.

2. For individuals served referred to the AGENCY from the community, the Managed Care Division shall determine individual served eligibility and provide referrals to the AGENCY for children, adolescents, and adults.

    a. The AGENCY shall make available appointment times, optimally within 72 hours, but no longer than 14 calendar days for adults and children, from the date of the initial telephone referral. Date of the telephone referral counts as "Day 1". The appointment time, AGENCY name, location, and telephone number shall be provided to the individual served at the time the appointment is scheduled.

b. The AGENCY will receive an authorization for prospectively approved services via FOCUS. The prospective authorization shall have an effective date, a lapse date, and an itemized service menu array. Only services approved in the service array and provided by the AGENCY between the effective date and the lapse date of the authorization shall be considered for payment.

c. Initiation of on-going treatment services must commence within 14 calendar days from the date of the initial assessment. On-going service is defined as face-to-face contact. Date of the assessment counts as "Day 1". For residential cases the expectation is that the initiation of services will begin within 48 hours of placement and the residential provider must have the staff trained on the Person Centered Plan within that 48 hour time period.

3. MCCMHS Managed Care Division will arrange for continuity of care for individuals served discharged from local acute inpatient settings. Individuals served will be seen for follow-up care/services (face-to-face) within 7 days from the date of discharge. MCCMHS Managed Care Division will notify the AGENCY of the hospital discharge status.

4. If the individual served calls the AGENCY and requests to reschedule the Initial Appointment, the individual served must receive an appointment within 14 calendar days from the original request date. . If the AGENCY reschedules, they must maintain the original call date from the individual served to the Managed Care Division.

B. TRANSITION CRITERIA

1. Request for a change in level of care occurs when the individual served medically necessary need for service cannot be met by the services provided within the current authorization package and/or by the addition of available ancillary services to the current level of care or a decrease in the services needed.

a. To request a change in the level of care at the AGENCY, the treating clinician must request that change from the MCCMHS Managed Care Division by providing clinically supported documentation to the Managed Care Division. If the Access Manager agrees that the requested change in level of care is medically necessary, prospective written authorization for the new service package shall be provided to the AGENCY. If the Access Manager determines the request, of the completed document, is not medically necessary with the request, the request will be denied and notice of appeal rights will be provided to the individual served and to the requesting therapist. If the AGENCY is not utilizing FOCUS then the documents must be legible.

b. If, at any time during the authorized treatment, the treating clinician feels that

the individual served requires services which are outside the scope of the AGENCY to provide, the treating clinician shall contact the MCCMH Managed Care Division and provide the clinical rationale and supporting documentation to the Access Manger, with the request that responsibility for treatment of the individual served be assumed directly by MCCMHS. MCCMHS Managed Care Division Access Center shall provide the AGENCY with the appointment date, time and location.

2. The need to request continuation of services occurs when there is a medically necessary reason for treatment to continue beyond the lapse date, and/or number of services delineated in the original authorization.

   a. To request continuation of services from the Managed Care Division the treating clinician will make the request for continuation of services to the Managed Care Division up to 30 days prior to the lapse date of the current prospectively authorized service package or when authorized services are exhausted, whichever is sooner. If the Access Manager agrees that the requested continuation of services is medically necessary, authorization will be provided to the AGENCY. If the Access Manager determines the request, of the completed document, is not medically necessary with the request, the request will be denied and notice of appeal rights will be provided to the individual served and to the requesting clinician.

C. SUPPORTING INDIVIDUALS USING SELF-DETERMINATION ARRANGEMENTS

1. AGENCY may choose to support individuals served wishing to self-direct services.

2. In supporting individuals served in choosing to self-direct services, AGENCY shall:

   a. Follow the provisions of MDHHS Managed Specialty Supports and Services Self-Determination Policy Contract Attachment and MCCMHS self-determination policies and procedures and ensure AGENCY self-determination policies and procedures are consistent therein.

   b. Identify staff to act as a liaison between MCCMHS and AGENCY in supporting individuals served at AGENCY choosing to use self-determination arrangements. Liaison shall be responsible to:

      i. Attend quarterly self-determination provider meetings led by the MCCMHS Self-Determination Administrator;
      ii. Share information received at the quarterly meetings with AGENCY staff;
      iii. Ensure AGENCY staff offer choice of models (Agency with Choice or Direct Hire using a Fiscal Intermediary) and make use of the person-centered planning process in coming to a consensus on the

appropriateness of a desired model for successful implementation of plan goals and outcomes;

iv. Ensure AGENCY staff are supported in implementing, monitoring, and resolving issues related to self-determination arrangements for persons served at AGENCY.

3. AGENCY shall audit self-determination cases on a regular basis to ensure that at minimum:

a. Documentation supports the following: the person's Individual Plan of Service documents the amount, scope and duration of services to be delivered using self-determination arrangements; the name of contracted fiscal intermediary or contracted Agency with Choice provider, as appropriate; the name of managing employer if other than the individual served; a sufficient back-up plan for call-offs and employment terminations; a consensus that the chosen self-determination arrangement and involvement of natural supports are appropriate.

b. Authorizations for services to be delivered through self-determination are not requested until AGENCY receives an executed Self-Determination Agreement from the individual served, guardian, parent, and/or personal representative (as applicable).

c. Applicable Employment Agreements or Agency with Choice Agreements are in place prior to services beginning;

d. Case Management is provided at least once a month;

e. Case Managers review at least 10% of self-determination time sheets/service notes from each pay period;

f. Documented efforts are made to resolve identified discrepancies with Medicaid documentation requirements or service delivery when deficiencies are noted; opportunity for problem resolution is provided preferably using the person-centered planning process;

g. When documented attempts to resolve identified problems fail, AGENCY provides written notice to the individual served indicating the reason(s) for a decision to terminate a self-determination arrangement.

D. EXIT CRITERIA

1. Optimally, termination of treatment by the AGENCY occurs when the goals identified in the Person Centered Process have been attained. There may be occasions when termination of treatment occurs for other reasons.

a. The AGENCY will document in FOCUS on the Discharge Summary (check name of document)_and then they will close the admission.

b. The AGENCY will follow the MCO Manual as it relates to Advance Action Notice and Adequate Action Notice for both Medicaid and non-Medicaid individuals served.

c. The AGENCY will follow the MCO Manual as it relates to outreach standards.

2. In any case where the AGENCY disagrees with a denial or reduction of service authorization resolution shall progress according to the "Contract Provider Appeals" policy (MCO Policy 2-006).