Statement of Work
Primary Behavioral Healthcare Services

Target Geographical Area for Implementation:

☐ Arenac County ☐ Bay County ☐ Other:

Consumer Populations to be Served:

☐ Adults with Serious Mental Illnesses
☐ Children with Serious Emotional Disturbances
☐ Adults and/or Children with Developmental Disabilities
☐ Other:
☐ Persons with Substance Use Disorders
☐ Other:

Services to be Provided:

Provider is engaged pursuant to this render the Services listed and defined below to the consumer populations in the geographic areas identified herein.

Service Definition Number	Service Title	HCPCS Code	Unit Type	Estimated Volume	Unit Rate	Estimated Total Value
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
Estimated Total Annual Contract Value:						

Total estimated number of individual consumers to be served under this Agreement: _____

Service Definitions:
Refer to most recent HCPC Code Book and Medicaid Provider Manual.

Exceptions: N/A

Other Conditions:

1. Individuals must be assessed initially and annually thereafter. The results of the assessment must substantiate that the individual meets eligibility for specialty mental health services and that services provided are medically necessary.

2. BABHA will reimburse the Provider up to the contracted rate for DBT services, less any payments made by the primary insurance (total reimbursement not to exceed the contracted rate). Provider must bill the primary insurance.

3. Provider is encouraged to transition from individual therapy to a group modality where appropriate.

4. Authorization limits for adult Targeted Case Management and adult Supports Coordination are as follows:

   T1017 48 max (up to 5 per month for the first 6 months, and 3 per month for the remaining 6 months)
   T1016 30 max (up to 3 per month for the first 6 months, and 2 per month for the remaining 6 months)

   Additional units may be requested/authorized with clinical justification.

A.1 Provider Specific Services Requirements:

In addition to the duties and obligations set forth in the Agreement, Provider shall comply with the following specific requirements for Services rendered by **Primary Behavioral Healthcare Providers**:

A.1.1 All staff who work with individuals shall have, at a minimum, successfully completed the required training courses in **Exhibit D: Provider Training Requirements**. Training shall be arranged by the Provider and provided by BABHA (where available) or by training organizations or resources that follow a DCH curriculum and are approved in writing by BABHA.

A.1.2 In addition to the licensing, training and staffing requirements set forth in the Agreement, Provider will ensure that its staff is adequately trained to provide the Services specified in the Agreement and this Statement of Work (SOW) and in the consumer's Person Centered Plan (PCP) for which the Provider is responsible. Provider will make reasonable efforts to attend the consumer's PCP, when invited to do so.

A.1.3 Staff members, including psychiatrists, who are designated as Child Mental Health Professionals (as defined under the Children's Diagnostic and Treatment Designation) must meet the requirements for that designation, including documented participation in twenty-four (24) clock hours of child/family focused training each calendar year, as well as other core child mental health-specific training. This training may be a mix of CEU/CME credits and self-directed study. All trainings focused on children/adolescents that is consistent with the scope of practice will count toward the required total. Provider must maintain a database of training hours for all designated staff. The database will be provided to staff of BABHA upon request.

A.1.4 A Provider providing services to children shall complete a Central Registry Check through MDCH that shows the individual is not known to have been convicted of abuse or neglect of a child. This should be completed upon hire and annually thereafter. Provider staff working with children must be trained and rated as reliable in the administration of the CAFAS and PECAFAS, at least every two (2) years, and able to administer functional rating scales online.

A.1.5 Documentation:

a) Provider is required to utilize the Phoenix Electronic Medical Record (EMR) as dictated by BABHA guidelines. At a minimum Providers must complete:

Phoenix Sections	Reason
1. Assessment for External Providers including attachment of PDF image of the clinical assessment and electronic signature. This is used in lieu of the calendar and clinical assessment in Phoenix. Includes entry of key data, including but not limited to: BH-TEDS data elements; functional assessment scales/surveys and scores, including the PEC/CAFAS, DECA, LOCUS and RAS, as appropriate to the population; Service Eligibility and Disposition and Health/Safety warnings	• Coordination of Care • MDHHS reporting requirement • Service eligibility and medical necessity
2. DD Assessment (i.e., "DD Proxy Measures") for any individuals being served who have intellectual/ developmental disabilities	• MDHHS reporting requirement
3. Enter data into Phoenix screens or directly fax remaining clinical documents. BABH EHR staff provide the new fax number and work with the provider's staff as needed. (It is BABHA's preference for reporting purposes that this information be data entered into Phoenix.) Clinical documents that must be provided include: • Person Centered Plan, including PCP Pre-Plan and PCP Addendums • PCP Review of Progress (Periodic Review) • Crisis Plans • Consents to Treat and Acknowledgement of Receipt/HIPAA form • Coordination of Care Consents and Letter to Doctor • Ability to Pay (Insurance Policies/Funding Sources) form • Discharge Summary • Advanced/Adequate Notices (for appeals/grievances) • Death Report • Progress notes (to the extent possible and upon request) • In addition, if psychiatric services are included in the provider's contract, then Psychiatric Evaluations, Medication Reviews, Consents for Medications must also be provided by direct fax to Phoenix.	• Coordination of Care • Compliance with MDHHS Medicaid Manual, Contract and Mental Health Code Requirements
4. Complete and/or update any fields in the "Consumer Information" section of Phoenix that is not already covered in the Assessment for External Providers, such as name, address, emergency contacts, etc. Guardian information must be updated for children and individuals with developmental disabilities if applicable, in Phoenix.	• Coordination of Care
5. For new admissions, complete the Appointment Status Update screen in lieu of using the Phoenix calendar/scheduler particularly when completing Clinical Assessment and Person Centered Plans. Located under Assessments & Screenings then Screenings/Referrals by Provider	• MDHHS reporting requirement
6. The Financial Determination in the Insurance Policies/ Funding Sources screen is completed to capture required income information.	• Ability to Pay Assessment process required by MDHHS
7. Medication Services • New referrals-individuals who have never seen a BABH prescribers or who have been closed for more than 90 days need the medication clinic package authorized (PE bundle, RN assessment, H0031, E&M bundle) in the Interim plan.	• Coordination of Care

Phoenix Sections	Reason
• Full PCP needs services authorized for the duration of the PCP. If the Psychiatric Evaluation has already happened, then just medication review units are needed, if not, then authorize the package. • Discharge-Any potential meds only requests need to be discussed with assigned prescriber and cc'd to the BABH Clinic Practice Manager. • All Action Notices are copied to the BABH Clinic Practice Manager; be specific if closed to all services or if there are still CSM services being rendered somewhere else. Include psychiatric services for all action notices where the individual has dropped out of treatment. • Notify and close any ancillary services like skill building services, etc. • Copy the BABH Clinic Practice Manager on all Discharge Summaries for shared cases. • Attendance Problems - Notify prescribers via Phoenix messaging if an individual is not showing for treatment and is expected to be action noticed.	

b) Assessments must be completed within 14 days of the initial referral. Assessments must be completed prior to any scheduled PCP Meeting.
c) The assessment will inform the treatment plan.
d) Person Centered Planning (PCP) must be conducted with each individual served to create the Individual Plan of Service (IPOS) within 45 days of the on-set of services.
e) If the Provider is the primary case holder, all services provided to the individual must be reflected in the IPOS.
f) Re-Assessments are completed annually if the person is still in service prior to the PCP meeting.
g) Progress Notes must be completed within one (1) business day of service provision.
h) Provider staff will keep communications confidential either by using the Phoenix messaging system or using encrypted email.

A.1.7 **Prescribers only:** Provider understands that Bay-Arenac Behavioral Health (BABH) is complying with the Electronic Health Record (EHR) Incentive Program, created by the American Recovery and Reinvestment Act. Provider agrees to assist BABH in meeting the obligations and objectives set forth and to take such steps as necessary to allow BABH to realize the benefits of the EHR Incentive Program, including but not limited to participating in the Medicaid EHR Incentive Program as an Eligible Professional, using Certified EHR Technology, and providing attestations of adoption, implementation, upgrading and meaningful use of such technology as requested or required by BABH or other federal or state authority.

If BABH's EHR is the primary electronic health record used by the Provider, Provider reassigns to BABH the right to receive any payments made in connection to Provider's participation as an Eligible Professional in the Medicaid EHR Incentive Program. Provider understands and agrees that BABH will collect and retain any payments made for the implementation, adoption, upgrade, and/or meaningful use of health information technology systems, including but not limited to certified EHR technology, by its employees or independent contractors. Provider authorizes BABHA to work on its behalf to submit the information required for meaningful use attestation and registration through the Centers for Medicaid and Medicare Services

Registration and Attestation System, as well as the Michigan Department of Community Health CHAMPS system.

A.1.9 Advance Directives. **(Core outpatient facilities only)**

A.1.9.1 Provider is responsible for ensuring that all Medicaid Advance Directive requirements are met, including, without limitation: (i) documentation of advance directive execution in the medical record; (ii) education of staff regarding advance directive requirements; and (iii) providing consumers with written information regarding advance directives and applicable state law;

A.1.9.2 Provider must maintain written policies and procedures for advance directives in compliance with 42 CFR 422.128 and BABHA policies and procedures for same. Provider must provide a copy of its policy to adult enrollees.

A.2. Credentialing and Privileging.

A.2.1 Credentialing and Re-Credentialing Requirements are delineated in Exhibit E of this Agreement;

A.2.2 Licensed Independent Practitioners ("LIPs") must request and be assigned clinical responsibilities by BABHA;

A.2.3 Provider and BABHA will work together to define clinical responsibilities;

A.2.4 Provider must follow the credentialing and privileging policies and procedures of BABHA, including, without limitation, C7-S01-T13, Credentialing and Privileging of LIPs;

A.2.5 LIPs are prohibited from providing services to consumers of BABHA until clinical privileges have been granted;

A.2.6 For physician services, if the Provider's LIP designates an outside LIP to cover his/her absence, and coverage exceeds over 13 consecutive days or 72 consecutive hours, the Provider's covering physician must be credentialed and privileged by BABHA prior to providing the coverage;

A.2.7 Provider shall notify BABHA of any and all changes related to staffing or status of Provider's LIPs prior to the LIPs providing services to BABHA consumers.

A.2.8 BABHA shall review and assess the performance of all contract personnel on an annual basis.

A.2.9 Credentialing and Privileging (CARF accredited only).

A.2.9.1 If Provider has been accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"), then Provider shall have its own credentialing policies and procedures consistent with applicable BABHA policies and procedures and CARF requirements. Provider shall ensure that it conforms to CARF standards that are applicable to the Services rendered. Additionally, Provider shall: (i) define its clinical responsibilities in writing; (ii) ensure that all Services provided by individuals who are LIPs will be within the scope of his or her clinical responsibilities; and (iii) have written evidence available for review by BABHA.

A.2.9.2 Licensed physicians and psychologists of the Provider organization must be privileged (only) by BABHA using the following policy and procedure:
C07-S01-T13 – Credentialing and Privileging of Licensed Independent Practitioners;

A.2.9.3 If the Provider's LIP designates an outside LIP to cover his/her absence, and coverage exceeds over 13 consecutive days or 72 consecutive hours, the Provider's covering physician must be credentialed by the Provider and privileged by BABHA prior to providing the coverage.

A.2.9.4 Provider shall notify BABHA of any and all changes related to staffing or status of Provider's LIPs prior to the LIPs providing services to BABHA consumers.

A.2.9.5 BABHA shall review and assess the performance of all contract personnel on an annual basis.

A.3 Performance Requirements and Indicators

A.3.1 Primary Healthcare Integration:

The Provider agrees to coordinate service delivery with the recipients' health care providers, including each recipient's primary health care provider. Providers are responsible for obtaining recipient consent to release and/or exchange information with the recipient's primary health care provider, or other providers, and with that consent, agrees to inform the primary health care provider of the initiation of services, to engage in discussion with the primary health care provider of any significant change in the course of treatment or care, including medication changes, and to integrate into the Providers' treatment plan input received from the primary care physician.

A.3.2 Recovery Oriented Systems:

BABHA and its Provider Network will ensure recovery oriented care for all individuals served. Clinical practices and supports for individuals and their families must project hope, communicate the expectation of recovery, and empower people to exercise choice and control over their lives. Services must be provided following the four major dimensions and ten guiding principles will be the central elements for treatment and supports provided throughout the BABHA system of care. Providers will seek to increase knowledge and participate in ongoing training to assure competency and understanding of a recovery oriented system of care. Providers will promote and monitor the use of effective practices that assist in recovery including but not limited to; services provided by peer advocates and specialists, wellness, recovery and relapse prevention plans, strength based recovery oriented treatment plans, transition and discharge planning at the onset of treatment, as well as encouraging crisis planning, and psychiatric advance directives. All service providers will develop a formalized and implement an ongoing system to monitor clinical practices, services and supports, and will strive to promote consumer empowerment, self-determination, peer support and a recovery oriented system of care. (Policy C04-S05-T06 and Substance Abuse and Mental Health Services, SAMHSA.)

A.3.3 Trauma Informed Services:

BABHA and its Provider Network will ensure a Trauma-Informed System of Care is provided for all individuals served. All providers will ensure that their staff understand the prevalence of trauma and the impact that trauma plays in the lives of people seeking mental health and addiction services as well as the staff that support them. A Trauma-Informed System of Care uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent re-traumatization and will facilitate the person's participation in treatment. An organizational assessment will be completed every three years to evaluate the level of trauma sensitivity within the agency. Initial and ongoing

educational opportunities for staff training will be provided on the principles of trauma informed care. BABHA and its Provider Network will utilize appropriate screening and assessment tools for trauma for all populations served and will implement Evidence Based Treatment as clinically appropriate. BABHA and its Provider Network will develop policies, procedures and practices to address secondary trauma stress for the staff who work with individuals with trauma. BABHA and the Provider Network will collaborate with community organizations, agencies and coalitions to support the development of a trauma informed community that promotes healthy environments for all individuals. (Policy C04-S05-S07 and the DHHS/CMHPS Medicaid Contract Amendment 2)

A.3.4 Consumer Satisfaction:

A.3.4.1 Clinical staff will obtain and document consumer feedback on satisfaction with services on at least a monthly basis. Documentation will be maintained in a progress note and/or quarterly report.

A.3.4.2 All CMHSP-sponsored consumers will be requested to participate in a standardized consumer satisfaction process that is adopted by the Provider.

A.3.4.3 The results of the consumer satisfaction measurement process will be available to BABH at least annually, or per the time frame specified in provider policies or procedures pertaining to consumer satisfaction reporting.

A.3.5 Billing and Claims:

a) Provider is encouraged to submit claims using the online billing module available to BABHA providers.
b) If submitting paper claims, at least 90% of submitted claims will be accurate for purposes of immediate processing and reimbursement.
c) All Coordination of Benefits (COB) claims shall be submitted using paper claims with a copy of the Explanation of Benefits (EOB) from the primary insurance(s) attached.
d) Standard practices shall be to submit claims as soon as practical after the delivery of service. All claims must be submitted 90 days of the delivery of service, or within 90 days of receipt of the EOB from the primary insurance..

A.3.6 Performance Indicators: **Core OUTPATIENT facilities ONLY**

Dimension 1: Access

a. The percentage of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (Standard = 95%)

b. The percentage of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)

c. The number of discharges from a psychiatric inpatient unit who are seen for follow up care within 7 days. (Standard = 95%)

d. Percentage of face to face assessments with professionals that result in decisions to deny CMHSP services.

e. The percentage of mentally ill adults served living in their own residence.

Dimension 2: Quality (Satisfaction and Outcomes)

a. The percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge (15% or less within 30 days)

b. Consumer functioning improvements as measured by a BABHA or MDCH mandated tool or measure [See "Outcomes Measurement" section of this report]

c. Consumer Satisfaction

d. Substantiated recipient rights complaints

e. #/Proportion of substantiated grievances and appeals/filed

f. 95% of all cases show evidence of coordination or attempts to coordinate with primary care physician

g. Outcome data specific to Evidence Based Practices

Dimension 3: Cost

a. Prior year cost per consumer compared to current year cost per consumer.

b. Total cost of care

c. Administrative expense

Dimension 4: Utilization

a. 95% of previously open consumers who experience an episode of psychiatric hospitalization will receive follow-up services within seven days of discharge from the inpatient setting.

b. Average inpatient length of stay (open case management cases)

c. Average case management length of stay

d. Average case management service volume

e. 75% of consumers on anti-depressant medication will receive follow-up at least at 12 weeks and six months to determine medication compliance and efficacy.

f. Benchmark rate of readmission to inpatient setting at 30 and 90 days post discharge and 365 days post discharge

g. Benchmark rate of readmission to case management at 30 and 90 days post discharge and 365 days post discharge