

**Sub-State Purchasing of Managed Behavioral Health Care:  
An Analysis of County-Level  
Managed Care Contracts**

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# Table of Contents

<b>Acknowledgments</b> .....	3
<b>Introduction</b> .....	4
Background.....	4
Research Methods.....	5
<i>Solicitation of Contracts</i> .....	5
<i>Study Questions</i> .....	5
<b>Findings</b> .....	6
The Two Medicaid Contracts.....	7
The Other County Contracts.....	7
<i>Ambiguity</i> .....	7
<i>Benefits and Service Duties</i> .....	7
<i>Service Delivery Systems</i> .....	8
<i>Relationships to Other Parts of the Health Care System</i> .....	8
<i>Data and Reporting</i> .....	9
<i>Performance Standards</i> .....	9
<b>Conclusions and Implications</b> .....	10
<b>Appendix: Contractual Language Excerpts by Study Domain</b> .....	13
<i>Benefits and Service Duties</i> .....	13
<i>Service Delivery Systems</i> .....	19
<i>Relationships to Other Parts of the Health Care System</i> .....	22
<i>Data and Reporting</i> .....	24
<i>Performance Standards</i> .....	26

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# Introduction

## Background

This study is an outgrowth of the work begun several years ago by the Center for Health Services Research and Policy (formerly the Center for Health Policy Research) of the School of Public Health and Health Services at the George Washington University Medical Center analyzing Medicaid managed care contracts. Now in its third edition, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*<sup>1</sup>, is the seminal work focusing on the contractual relationships formed between state Medicaid agencies as the purchasers of health services for the Medicaid population and the managed care organizations providing those services. Our examination of state contract provisions revealed substantial diversity in the approaches taken by the states and the degree to which they allowed managed care organizations the flexibility to address various issues without explicit contractual guidance. Yet the goal of our research was not to make judgments as to what constituted good or bad contract language; instead, the primary goal of the study was to serve as a self-help tool for the states.

From the early days of this research effort, an important component of our overall work on managed care contracting was specialized focused research on the use of managed care to provide services for Medicaid-covered individuals with mental illness and substance abuse addiction. For example, in 1998 the Center issued a special report funded by the Substance Abuse and Mental Health Services Administration (SAMSHA), U.S. Department of Health and Human Services, that examined the manner in which Medicaid agencies provided behavioral health services to enrollees through both primary and carve-out contracts.<sup>2</sup> Because of the greater prevalence of behavioral health disorders among the low-income population and the critical role that Medicaid plays in assuring that individuals with behavioral health problems receive appropriate care, the Special Report provided public purchasers with a specialized tool to assist them in designing and evaluating Medicaid managed behavioral health care programs.

For this study, SAMHSA asked us to analyze county-level managed health care contracts that include behavioral health services. SAMHSA has indicated that sub-state entities, particularly counties, are beginning to explore the feasibility of contracting with managed care organizations, both to control costs and to improve coordination of services for the mental health or substance abuse systems they manage. In commissioning these various contract studies, SAMHSA was primarily interested in tracking the development of these new types of managed behavioral health care procurements and contracting practices, as well as determining whether there were exemplary commercial behavioral health provisions that could be adapted to public sector contracts.

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<sup>1</sup> Rosenbaum, S., *et al.*, [Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3<sup>rd</sup> Edition](#). June 1999. The George Washington University Medical Center.

<sup>2</sup> Rosenbaum, S., *et al.*, [Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, Special Report: Mental Illness and Addiction Disorder Treatment and Prevention](#). March 1998. The George Washington University Medical Center.

## Research Methods

### *Solicitation of Contracts*

Beginning in the summer of 1998, we contacted key individuals and groups knowledgeable about county-level behavioral health contracting to obtain guidance on where such contracts may exist. We interviewed officials from the National Association of Counties, the National Association of County and City Health Officials, the National Association of County Behavioral Health Directors, and various state- and county-level government officials.

We learned from the key informant interviews that very few county-level, non-Medicaid, managed behavioral health care Requests for Proposals (RFPs) and contracts exist. With few exceptions, the counties were not the purchasers of behavioral health services. Rather, the counties were most often contract “makers” (i.e., drafters and signatories to the contracts financed via dollars passed through from a state-level agency), not “buyers” of services using county funds.

We did, however, receive six county-level contracts and RFPs that address behavioral health services from six counties representing five states:<sup>3</sup>

- Two Medicaid contracts, both of which were essentially state pass-throughs to the counties via, for example, the Community Mental Health Services Program (Michigan and Pennsylvania);
- One Medicaid/Non-Medicaid blend contract, which includes coverage for non-Medicaid eligible persons who meet non-Medicaid eligible medical necessity criteria (a Washington State county);
- Two Child Welfare contracts, one of which covers children and families residing in the county when children are in legal custody of the county human services agency and for the other county when in protective custody (a Colorado county and an Ohio county (#1)); and
- One comprehensive Employee Health Benefits contract for full-time county employees (Ohio county (#2)).

### *Study Questions*

We approached the examination of the county-level contracts from the perspective that they, like state Medicaid managed care contracts, could possibly be characterized by vagueness and ambiguity, especially with regard to the non-Medicaid county contracts. One reason for this may be that counties might not yet have enough experience purchasing services under a non-entitlement program. We examined the contracts for two very general questions:

1. To what extent were there vague or ambiguous contractual issues that could raise problems, both from a county perspective in terms of direct or residual liability, and from a beneficiary perspective?

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<sup>3</sup> For purposes of confidentiality, the names of the individual counties are not disclosed. The two counties in Ohio that participated in this study are identified as County #1 and County #2. Health plan names are also not disclosed and are indicated as “[MCO].”

2. When counties used different sources of funds to purchase managed care services that include behavioral health benefits, how did the contracts differ? In other words, what choices were counties making with regard to the substantive components of the non-Medicaid contracts? For purposes of this question we considered five different analytical domains:

- a. Benefits and Service Duties;*
- b. Service Delivery Systems;*
- c. Relationships to Other Parts of the Health Care System;*
- d. Data and Reporting; and*
- e. Performance Standards*

These are some of the same contract domains that were previously used in analyzing state Medicaid managed care contracts, and include a special emphasis on issues of importance to individuals needing behavioral health services. In addition, we noted both similarities and differences in the ways counties have drafted their contract provisions, based on the populations for whom these services are being sought.

Excerpts of contract language organized by each of the above domains appear in the Appendix to this Issue Brief.

## **Findings**

For a useful point of comparison to the county-level findings, a brief summary of the major findings from the state Medicaid managed care contract study, “Negotiating the New Health System,” follows:

- States are not buying off-the-shelf products: The contracts indicate an effort on the part of state agencies to develop comprehensive and detailed agreements with managed care plans that meet specific needs of individuals being served.
- There is wide variation in the contracts, both in terms of organization of the contracts themselves and in their substantive provisions. At the same time, compared to the 1996 and 1997 contracts, the 1998 contracts from the study’s 3rd Edition indicate that as states gain managed care experience, they are moving toward greater inclusion and specificity in their contracting practices.
- States are buying closed systems where beneficiaries can only use network providers.
- While many of the contracts are silent or vague on relationships between managed care organizations (MCOs) and the larger health system, states appear to be paying increased attention to building such relationships to facilitate the sharing of responsibility for insured individuals.

- Few states have developed a comprehensive approach to data collection and reporting.

## The Two County Medicaid Contracts

As anticipated, we found little variation between these two county contracts and state-level Medicaid contracts. We expected this similarity for two reasons: first, because the purchase and delivery of the contracted services were to a large extent set by state and federal Medicaid law; and second, because where these counties decided not to “make,” but rather to “buy” the services requested in the state RFP, they did not develop wholly new RFPs or contracts, but instead generally used the state’s documents. For these reasons, the focus of our analysis is on the other non-Medicaid and Medicaid blend contracts as covered below.

## The Other County Contracts

By way of contrast to the Medicaid contracts, the other county contracts analyzed were more varied, as we also expected. The contract language excerpts cited below are from the three wholly non-Medicaid and the one Medicaid/non-Medicaid blend contracts.

### *Ambiguity*

Just as we previously did for state Medicaid managed care contracts, we reviewed these county contracts for language that could be characterized as vague and/or ambiguous. While vagueness or ambiguity could be due to the inexperience of the contracts’ drafters, it could leave the counties open to residual liability, depending upon interpretation of the language. This is especially an issue of concern when matters of contract dispute arise.

The following contract excerpts illustrate ambiguity and/or vagueness in the terminology employed:

The agency shall approve clear instruction to hospitals concerning Agency procedures for approving length of stay extension at the time of admission or post admission certification.

.  
. .  
.

The Agency shall ensure treatment coordination and support to nursing homes for clients discharged from the [State Hospital] Geriatric Medical Unit. **[Washington State County Contract]**

The Contractor will work cooperatively with other community services providers. Coordination will be maintained at an individual case level. Whenever possible low or no cost services will be located and utilized. **[Colorado County, Appendix A]**

### *Benefits and Service Duties*

In terms of the scope of benefits and imposition of service duties, counties are also not buying standardized products. The agreements indicate an effort to develop managed care benefit packages that either meet specific needs of the intended beneficiaries or limit the financial

expenditures or potential liability of the county. For example, in one RFP the behavioral health benefits covered include:

- For mental health, 30 inpatient days per year and 20 outpatient visits per year, which includes crisis intervention and diagnostic and short-term therapy.
- For alcohol and drug abuse, the only services include are detoxification and one rehabilitation per lifetime.

Another RFP includes the following services:

- 24-hour, 7-days-per-week, in-home crisis intervention;
- Outpatient and inpatient mental health including full psychiatric and psychological testing, assessment, and treatment;
- Day treatment hospitalization for children; and
- Assessment and treatment for substance abuse.

### *Service Delivery Systems*

Compared to the state-level contracts, the county-level contracts appear to be more flexible with, and interested in, service delivery options. In fact, the documents spoke widely to the issue of service delivery and provider networks.

- One RFP required managed care proposals to provide a percentage match of primary care providers (PCP) to the current plan's PCP selections.
- This same RFP also required potential contractors to outline how out-of-area or out-of-network coverage could be designed and offered to address the needs of dependents living outside the county, including benefit design, claims administration, utilization review services, and member education.
- One contract spelled out requirements to “ensure” that specified providers are available to meet the service needs of 15 special needs groups including, for example, homeless mentally ill persons. The absence, however, of specific numerical or qualitative standards renders the meaning of “ensure” unclear.

### *Relationships to Other Parts of the Health Care System*

The non-Medicaid documents varied in terms of the level of attention directed to building relationships with the larger health system that may share the responsibility for insured individuals. One RFP did not mention the issue at all. On the other hand, the other three documents did address this issue, for example:

The Agency shall ensure that all certified vendors have working agreements and/or contractual relationships and/or documentation of consistent collaboration at multiple administrative levels for service provision with schools, community-based health and human service vendors, and relevant state agencies in their service area in order to complement and maximize available resources. These agreements/contracts/other documents will describe at a minimum, the responsibilities of each party, how coordination occurs, the target populations involved, referral mechanisms, and links to collaborate in monitoring and quality assurance activities. **[Washington State County Contract]**

### *Data and Reporting*

There is not yet a comprehensive or consistent approach to data collection and reporting issues in the contracts, largely due to the lack of this type of contracting to date. Two example provisions are as follows:

Vendors will be expected to provide detailed claim reports sufficient for Hamilton County analysis purposes, including detailed utilization and provider payments by place of service and type of claim. **[Ohio County #2 Contract]**

The Agency shall continue the development and implementation of a [County] MHD approved utilization review system, involving a sampling of client records (adhering to the County Contract Monitoring Manual, Appendix C., Data Verification & Sample Size Guidelines) from each vendor, that accomplishes the following objectives:

- Assess overall accuracy of client diagnosis and tier placement;
- Assess vendor compliance with WAC 275-57 requirements for client assessment, development and monitoring of Individual Tailored Care Plans;
- Conduct Review of services received without pre-authorization;
- Provide review of ongoing care to effect individual client outcomes;
- Assess intensity of service for individuals to determine appropriateness;
- Review flagged populations or individuals.

**[Washington State County Contract]**

### *Performance Standards*

There is quite a variable range of contract specifications in the county documents regarding performance standards. One RFP was actually silent on the issue. One contract asked only the following questions of potential contractors with regard to its access standards:

- (1) Does the PCP perform as a gatekeeper?
  - (a) May women self-refer to an OB/GYN?
  - (b) Are there other specialists to whom members can self-refer?
- (2) What is the number of hospitals, PCPs, pediatricians, OB/GYNs, other specialists, and pharmacies in your network? And
- (3) What are your timelines for urgent office visits, non-urgent symptomatic office visits, and non-symptomatic office visits? **[Ohio County #2 Contract]**

In sharp contrast, another RFP has three full pages and some 30 provisions related to service and outcome monitoring, an excerpt of which follows:

#### PERFORMANCE REQUIREMENTS

1. Service Delivery

- a. The Agency shall ensure that 100% of [health plan] individuals who are referred to a vendor for outpatient services and who have Medicaid coverage or meet non-Medicaid criteria are tiered.
  - b. The Agency shall ensure that 100% of detained or incarcerated mentally ill offenders (MIO) who are referred to the Agency are assessed and tiered as appropriate.
2. Outpatient Authorization/Utilization
- a. The Agency shall pre-authorize 100% of all benefits listed in the Policy and Procedure Manual as requiring pre-authorization.
  - b. All concurrent and retrospective reviews shall be completed as outlined in the Policy and Procedure manual. The reviews shall also include the Blended Funding Project, for which the County has a contract with [\*\*\*] Educational Service District. A schedule for all these reviews shall be developed for the contract period for approval by the County with the first billing package of this contract. The schedule may be amended by mutual agreement on a quarterly prospective basis.
  - c. The Agency shall ensure that 80% of all tier requests requiring manual review will receive an authorization decision within four (4) working days and 100% receive an authorization decision by the end of the sixth (6) working day.
  - d. The Agency shall ensure 100% of LTR placements are pre-authorized.
  - e. The Agency shall ensure 100% of LTR residents shall receive at least one continued stay review within one year from the date of admission.
  - f. The Agency shall review 100% of supervised living (SL) residents in open status who started SL service prior to 1996, for integration with treatment plans and appropriateness of placement.
  - g. The Agency shall review and approve/deny excess utilization requests including Medicaid Personal Care, Special Needs, Service Based Add-On, and Exception to Policy.
  - h. The Agency shall provide agreed upon criteria indicator reports monthly or quarterly, as required.
- [Washington State County Contract]**

## **Conclusions and Implications**

Although they do not represent a scientific sample of all county-level managed care contracts that include behavioral health services, these contracts do provide a glimpse into the contracting approaches and concerns of counties as purchasers of health services. Just as CHSRP's findings with respect to state Medicaid managed care contracts have implications for other large purchasers, so, too, do the findings of this study raise policy issues for both states and counties as they carry out their roles as purchasers of health services for both Medicaid and non-Medicaid beneficiaries, as well as for state and county employees.

Given the small number of contracts reviewed for this study, caution should be exercised in extrapolating these findings to other counties and states beyond our small sample. Some counties

(for example in Ohio and Washington) have had county-level mental health entities contractually purchasing non-Medicaid services for quite some time, though they have used a program grant methodology rather than using risk-based managed care models. While county-based purchasing of Medicaid managed care services is still in a nascent stage,<sup>4</sup> county-based purchasing of non-Medicaid, and other non-entitlement managed behavioral health services is at an even more preliminary level of development. It may be premature to draw conclusive qualitative judgments about this level of contracting.

There are, however, several salient issues in county-based purchasing of health services that merit ongoing study and monitoring:

- Counties' ability and willingness to assume financial risk as purchasers of non-Medicaid behavioral and other health services are constrained by the size and stability of their budgets and the levels and sources of their revenues (which are much more limited than that of states). Another important factor in counties' willingness to assume financial risk is the existence of sufficient numbers of enrolled beneficiary populations to create viable risk pools. The extent to which a county's projected expenditures are exceeded by actual expenditures may present potential difficulties for the county to tap into other revenue streams to make up for end-of-year shortfalls in these contractual health-related expenditures. This implies development of county-level expertise in devising realistic capitation and case payment rates, and/or discounted fee-for-service reimbursement systems.
- Counties will need to ensure that they have sufficient administrative infrastructures in place in order to effectively develop and implement these contracting processes, from drafting RFPs to awarding contracts to monitoring compliance with their terms. Decisions will need to be made about whether the county itself will institute quality assurance procedures, or whether they will be contracted out to private sector firms that specialize in benefits management, enrollee encounter and outcomes data, utilization review, provider profiling, etc.
- Counties may need to consider whether the number of beneficiaries for whom they are purchasing services constitutes a sizeable enough market share to enable them to be on equal negotiating footing with MCOs. In particular, MCOs will want to know that the enrollment base comprises enough individuals that risk can be adequately spread among them.
- Unlike Medicaid contracting, where a defined minimum level of benefits is required by state and federal Medicaid laws, there is a potential for wide variation in the scope of, and access to, health services when non-entitlement contracts are negotiated on a county-by-county basis. The findings from this study have demonstrated this, even with a small sample of contracts. This is particularly

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<sup>4</sup> See, for example: "County Purchasing Options for Prepaid Publicly Funded Health Programs in Minnesota: Findings of the Metro Counties Health Care Purchasing Steering Committee Efforts." Hennepin County Health & Human Services Policy Center. May 1998. Available at <http://www.co.hennepin.mn.us/hhspsc/MedicaidPolicy/CountyPurchasing/MetroReport/metroreportexecsum.htm> Accessed October 7, 1999.

important for metropolitan areas which encompass multiple counties and where enrollees may often change their residences between counties. States may need to consider establishing contractual “floors” that mandate minimum levels of statewide service provisions for eligible populations, regardless of their county of residence.

- In previous research conducted by CHSRP that included a county engaging in county-based purchasing of Medicaid services, some officials of large MCOs expressed frustration over having to separately negotiate multiple contracts with multiple counties.<sup>5</sup> This was a particular concern for MCOs with statewide, and often multi-state, operations (which is increasingly the case due to the proliferation of MCO mergers and acquisitions). While the MCO officials in that study acknowledged the importance of recognizing differential needs between counties, they suggested that negotiating with “consortia” of counties with similar needs would contribute to administrative efficiency and better uniformity and standards of service provisions in the contracts.
- In counties which simultaneously act as purchasers, insurers, and providers of health services, for example a county which both purchases Medicaid services from MCOs and runs its own county-sponsored MCO (which often enrolls Medicaid-eligibles and state and county employees), potential conflicts of interest will need to be addressed by building the appropriate “firewalls” between these governmental functions.

The future of the devolution of powers from the federal- to the state-, and now the county-levels entails significant challenges for counties which assume the potential risks, and enjoy the possible benefits, that contracting for behavioral health services can present. Given the importance of delivering accessible, high quality, and cost-effective behavioral health services to individuals in need of them, SAMHSA is in a unique position to provide the ongoing monitoring of the changes that may occur as a result of these shifts in points of accountability.

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<sup>5</sup> Mauery, D. *et al.* “An Evaluation of Emerging Relationships Through Memoranda of Understanding Between Managed Care Organizations and Public Health Agencies: Implications for Population-Based Communicable Disease Prevention and Control Programs and Public Health Policy.” June 1998. Center for Health Policy Research. The George Washington University Medical Center.

# Appendix: Contractual Language Excerpts by Study Domain

## A. Benefits and Service Duties

### III. SERVICE REQUIREMENTS...

#### C. Outpatient Authorization

1. The Agency shall use the county Medical Necessity Criteria policy to determine the appropriate level and type of care for eligibility to service. Tier benefit services shall be targeted for pre-authorization and reviewed when identified by flags placed on tier requests for quality, utilization and/or specific tier designations jointly agreed to by the County and the Agency.
2. The Agency shall ensure that:
  - Clinical Care Coordinators are qualified mental health professionals with graduate degrees, specialist designation, and experiences as per WAC 275-57.
  - Authorization services provided by the Clinical Care Coordinators addresses appropriate services needs and intensity, service outcomes and alternative(s) for clients.
  - Provider requests for authorization are made as a result of face-to-face assessments.
  - Direct client services are provided by appropriate, qualified, vendor staff per WAC 275-57, and shall include consultation with Mental Health Specialists (children, minority, disability, and geriatric).

#### D. Residential Authorization

The Agency shall ensure that County approved electronic systems for residential authorization are maintained. At a minimum, the systems shall include the following characteristics and components:

- Screening
- Authorization
- Concurrent review
- Waitlist management
- Continued stay review

#### E. Inpatient Authorization

1. The Agency shall collaborate with the County in order to develop integrated management of outpatient and inpatient services.
2. The Agency shall provide 24 hour authorization and facilitation of discharge planning services for voluntary inpatient psychiatric treatment for children up to age 21, and for adults (age 21 and older) as per the terms of Exhibit VII to this contract.... **Washington State County Contract**, Exhibit VI, page 3.

The following are carve-out contract minimum program requirements....

### **I. Adult Crisis Services**

The Agency shall provide responsive and accessible crisis intervention and resolution for [\*\*\*] County residents who are not enrolled in the Prepaid Health Plan and who meet the crisis services eligibility criteria as defined in the Standardized Initial Crisis Screening Protocol (SICSP)....

#### **B. Crisis Services**

The following crisis services will be available Monday – Friday, 9:00 a.m. – 6:00 p.m. excluding holidays negotiated with the Agency:

1. “Live-body” telephone access via a dedicated line;
2. Immediate access to a mental health professional for telephone requests for crisis services;
3. Crisis intervention and stabilization services provided by professional staff trained in crisis management;
4. Psychiatric evaluation and medication management services when clinically indicated;
5. Outreach crisis stabilization services;
6. Scheduled NDAs;
7. Chemical dependency consultation;
8. Consultation with an appropriate clinical specialist when such services are necessary to ensure culturally appropriate crisis response;
9. Response to persons placed in a hospital diversion bed by the CDMHPs. Response will be no later than next working day. The response will include discharge planning. The vendor will be responsible to provide the follow-up in the event a subcontractor is unable to make a timely follow-up;
10. Case referral capacity—the Crisis Clinic can make a same day appointment when all NDA slots are filled;
11. Linkage to long term (mental health or other) care as appropriate; and
12. In addition to the above services, one or more NDAs will be provided at one service site on Saturdays. Staff will be available at this service site between 9:00 a.m. and 3:00 p.m.... **Washington State County Contract**, Exhibit VIII, pages A1-A2.

### **II. Children’s Crisis Respite Foster Care Beds**

The Agency shall contract with a vendor for:

- A. The ability to provide crisis respite care with 24-hour access for a minimum of three mentally ill children and youth six to 18 years old referred by the Children’s Crisis Response Team. The CCRT is the single access point for referral into the beds.
- B. Services to children who are experiencing acute mental health crisis and need care to preserve their placement, provide for alternative placement, or as part of a plan to be used as support to a family in the care of their disturbed child.

- C. Case management services and coordination of services with the referring agency.... **Washington State County Contract**, Exhibit VIII, page A-3.

### III. Children’s Crisis Response Team (Children’s Regional Crisis Team)

- A. The Agency shall ensure that any [\*\*\*] County child between 3 through 20 years of age who meet the crisis eligibility criteria as defined in the Standardized Initial Crisis Screening Protocol, Section VII, Attachment D, Policy & Procedural Manual, may call for screening, eligibility determination, assistance and referral for further service through a single 24-hour county-wide telephone number provided through the Crisis Clinic.... **Washington State County Contract**, Exhibit VIII, page A-4

### IV. Children’s Crisis Services

The Agency shall provide responsive and accessible crisis intervention and resolution for [\*\*\*] County residents who are not enrolled in the Prepaid Health Plan....

#### B. Crisis Services

The following crisis services will be available Monday – Friday, 12:00 – 8:00 p.m. excluding holidays negotiated with the Agency:

1. “Live-body” telephone access via a dedicated line;
2. Immediate access to a mental health professional for telephone requests for crisis services;
3. Crisis intervention and stabilization services provided by professional staff trained in crisis management;
4. Psychiatric evaluation and medication management services when clinically indicated;
5. Outreach crisis stabilization services;
6. Scheduled Next Day Appointments, according to the Next Day Appointment Minimum Requirements, Section VII, Attachment C, Policy & Procedure Manual;
7. Chemical dependency consultation;
8. Consultation with an appropriate clinical specialist when such services are necessary to ensure culturally appropriate crisis response;
9. Response to persons placed in a hospital diversion bed by the CDMHPs. Response will be no later than next working day. The response will include discharge planning. The vendor will be responsible to provide the follow-up in the event a subcontractor is unable to make a timely follow-up;
10. Case referral capacity—the Crisis Clinic can make a same day appointment when all NDA slots are filled;
11. Linkage to long-term (mental health or other) care as an appropriate. **Washington State County Contract**, Exhibit VIII, page A8-A10.

## V. Children's Intensive Crisis Diversion Beds

- A. To prevent the hospitalization of children and youth in crisis by providing emergency respite, stabilization, and appropriate evaluation of service needs, the Agency shall ensure this service accepts children on a no decline, emergency basis and shall be available for intake 24 hours a day seven days a week. When there is an opening, there shall be availability for intake through the Children's Crisis Response Team (CCRT) or through the authorization authority for voluntary inpatient services.
- B. Eligible children to be served are those:
- who have severe emotional and behavioral problems,
  - who do not require involuntary commitment, and
  - who do not fit into the juvenile justice system,
  - who are up to the age of 18,
  - who might otherwise be voluntarily hospitalized.... **Washington State County Contract**, Exhibit VIII, page A10-A11.

## VII. Emergency Telephone Services

- A. The Agency will contract with vendor to provide crisis telephone services 24 hours a day, seven days a week, including telephone screening, initial assessment for triage, and referral services, to any person experiencing a psychiatric crisis and/or emergency, or any person, agency or mental health professional acting on behalf of that person, for the purpose of arranging voluntary or involuntary emergency mental health services.... **Washington State County Contract**, Exhibit VIII, page A-12.

## VIII. Evaluation and Treatment Facility Services

- A. The Agency shall provide through service vendor contract(s): no more than 60 residential evaluation and treatment beds; a minimum of seven (7) seclusion and restraint rooms; a program of services for involuntarily detained and/or committed mentally ill adults; specialized assessment and discharge planning for those involuntarily detained and/or committed mentally ill adults who abuse chemicals (MICA); and a program specifically for the evaluation and treatment of persons 55 and older.

Eligible persons for this service shall include adults 18 and older who have been involuntarily detained by a CDMHP for a 72-hour evaluation and treatment period or committed by the [\*\*\*] County Superior Court for a 14-day period of evaluation and treatment under 71.05 RCW. Also admitted will be adults referred by the CDMHPs through the revocation process provided in WAC 275-55. These persons shall be admitted in conformance with the admission criteria approved by the County and the [\*\*\*] County Patient Placement Committee.

Persons with primary substance abuse diagnosis shall be discharged within five days of admission, unless such discharge place the person at risk for becoming dangerous to self or others as a result of mental disorder.... **Washington State County Contract**, Exhibit VIII, page A-15.

## IX. Geriatric Crisis Services

- A. The Agency shall ensure that Countywide, specialized, out-of facility crisis services will be available for older adults who are not currently authorized for a Prepaid Health Plan (PHP) tier benefit....
- F. The services provided will include:
- crisis intervention
  - comprehensive mental, medical, social, and functional assessments,

- prompt referral and linkage to mental health, aging, and health care providers,
- consultation, care planning and education for families or other care providers, mental health providers, aging services providers, and health care providers,
- telephone consultation for the Crisis Clinic and the CDMHPs. **Washington State County Contract**, Exhibit VIII, pages A17-A18.

#### **X. Adult Hospital Diversion Beds**

- A. The Agency shall provide a hospital diversion bed service through vendor service contract(s), for persons facing immediate involuntary hospitalization shall have access to an alternative supervised bed in a less restrictive setting. Eligible persons for this service must be aged 18 or older who meet all of the following criteria: are in crisis; a mental disorder cannot be ruled out; are at immediate risk for voluntary or involuntary psychiatric hospitalization; are able to self-ambulate; and, are willing to receive this service. One hospital diversion bed will be reserved exclusively for access by the CDMHPs. The remaining beds will be accessible either by the CDMHPs or the authorization authority for voluntary inpatient services. **Washington State County Contract**, Exhibit VIII, page A-18.

#### **XI. Interpretation/Translation Services**

- A. The Agency shall contract with a vendor to provide 24 hour a day, seven days a week county-wide interpretation translation services to ensure access to mental health crisis, brief intervention, and/or residential services to any child or adult who requires crisis services, brief intervention services from a certified mental health vendor who do not normally have staff who are fluent in the required language(s), or residential services....

D. The following services, at a minimum, will be available:

1. for crisis and brief intervention services: interpretation/translation for initial assessment and development of the initial intervention plan. Services are to be provided in the setting most appropriate to the need of the client. If an interpreter provides services to a child or adult who is then involuntarily hospitalized by the CDMHPs, the interpreter must be available to testify at the commitment hearing if the information he/she interprets is necessary to establish the grounds for initial detention. For sign language interpreters, testimony will be limited to that defined by RCW 2.42.160.
2. for supervised living and intensive residential services: initial interpretation/translation to assist the treatment staff and the staff of the residential facility in developing a culturally appropriate treatment plan; and interpretation/translation at residential community meetings. **Washington State County Contract**, Exhibit VIII, pages A 19-20.

#### **XII. Parent Advocacy Program**

- A. The Agency shall ensure that the parents of children in the mental hospital system or other child-serving system will have available support services and information to help find appropriate services for their children and sources of support for themselves. **Washington State County Contract**, Exhibit VIII, page A-20.

#### **XIII. Residential Services**

- A. Persons authorized for a Prepaid Health Plan (PHP) tier benefit will live in the community as normally as possible, with minimal dependence on public safety and acute care resources. Residential services shall be

provided to persons while authorized for a PHP tier benefit and who are placed by a designated vendor placement liaison. **Washington State County Contract**, Exhibit VIII, pages A-21.

The [\*\*\*] County Department of Human Services (Department) and [MCO] agree to provide a cooperative administrative structure through which the behavioral treatment needs of children and their families eligible for and receiving welfare services can be met.... **Colorado County M.O.U.**, page 1.

- The [MCO] will assume all risk for clinically necessary mental health treatment services as described in the current Medicaid contract between the [MCO] and the State. The [MCO] will pay for all treatment authorized. A provider network is being built which will include the Child Placement Agencies (CPA).... **Colorado County M.O.U.**, page 1.
- The [MCO] will develop a mental health treatment plan for each child with the CPA and other appropriate parties involved. Once developed, the Department will review and approve the plan. The Department has review and approval authority and responsibility on all cases placed in its care for placement and supervision. The [MCO] has final authority for treatment payment authorization decisions and determination of clinical necessity for payment purposes. **Colorado County M.O.U.**, page 2.
- A CPA that has integrated therapeutic services into their foster care program may be selected to enter into an agreement negotiated with the [MCO] to directly provide treatment services for the target population. The CPA shall accept as full reimbursement a negotiated case rate. This option is called Option A.
- The [MCO] will not purchase treatment services from its network providers for those children placed in CPA's which are not selected for Option A. This will be called Option B. **Colorado County M.O.U.**, page 2.
- The [MCO] will perform utilization management (UM) on all mental health treatment services provided under this MOU to include services directly delivered by CPA employed therapists and by network therapists. Utilization management will incorporate a level system and a standard assessment performed jointly by the [MCO] and the Department. Periodic reassessments will be completed to adjust levels and care plans. UM function will include documentation of services for utilization reporting and for quality management; concurrent review of services based on effectiveness and appropriateness to the family services plan and standard treatment guidelines. **Colorado County M.O.U.**, page 3.

*Involvement in Community Mental Health...*

- 2.) Counseling and other therapeutic services to children in foster care and their families shall be provided under the direction of the [M.O.U. Partner].... **Colorado County**, Appendix A, page 13.

**Involvement in Community Mental Health...**

- 3.) The [M.O.U. Partner] shall authorize, fund, monitor and, when appropriate, directly provide counseling, psychological and other therapeutic services to foster children and their families. The [M.O.U. Partner] may sub-contract with the CPA's or other providers for such services.... **Colorado County**, Appendix A, page 13.
- 3.2.4. Mental health and substance abuse services must be available for both parents and children but may be provided either directly by the Provider or network or through referral. How these services will be provided

and funded must be made clear in the proposal and written agreements with all organizations and professionals who will provide the services included.

TABLE 1  
REQUIRED SERVICES  
(All services apply to the entire family unless otherwise noted.)

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Intake of referred cases.</li> <li>• Assessment of all the needs and strengths of the family and child including continuous assessment of risk.</li> <li>• Case management in accordance with the O.A.X. and Ohio Revised Code (O.R.C.)</li> <li>• 24 hour, 7 day, in-home crisis intervention.</li> <li>• Homemaker.</li> <li>• Home health including visiting nurses.</li> <li>• Parenting skills building and education.</li> <li>• Home-based services.</li> <li>• Transportation.</li> <li>• Outpatient and inpatient mental health including full psychiatric and psychological testing, assessment and treatment.</li> <li>• Partial hospitalization (day treatment). (Children only.)</li> <li>• Treatment for children who are sexually acting out and for children who commit sexual abuse.</li> <li>• Assessment and treatment for substance abuse.</li> <li>• Programming for children with developmental disabilities.</li> <li>• Advocacy for and assistance in accessing services including providing transportation when necessary.</li> <li>• Medical services including inpatient care and treatment. (Children only.)</li> </ul> | <ul style="list-style-type: none"> <li>• Emergency aid for household items and expenses that, if paid, can prevent placement.</li> <li>• Protective day care and day care for working foster parents.</li> <li>• Crisis placements, emergency shelter care and respite, to stabilize a home or placement situation.</li> <li>• Foster care services for children at all levels and for all types of need including therapeutic but not medically fragile.</li> <li>• Residential treatment for children including secure facilities for those who may be dangerous to themselves or to others.</li> <li>• Intermediate residential programs for children who cannot live in a family setting but do not require residential treatment and for “step-down” from residential placement to community, family settings.</li> <li>• Services to promote and achieve reunification.</li> <li>• Independent living arrangements for adolescents who will not be reunited with their families before age 18.</li> <li>• Aftercare and linkage to community services for families and children, when children are reunified with their family and when a case is closed.</li> </ul> |
|--|--|

**[Ohio County #1 Request for Proposals]**

## B. Service Delivery Systems

### Service Delivery

- A. The Agency shall ensure geographic accessibility to tier benefits, crisis services, and carve out services with in [\*\*\*] County for those who meet criteria for service.
  
- B. The Agency shall ensure that a range of specialized vendors are available to meet the service need of the following fifteen special needs groups:
  - Children under six years
  - Older adolescents (18-21 years)
  - Ethnic minorities
  - Sexual minorities
  - Deaf and hard of hearing persons
  - Mentally ill chemical abusing adults and adolescents
  - Medically compromised homebound
  - Homeless mentally ill persons

- Persons with a developmental disability and mental illness
  - Persons with a mental illness and AIDS
  - High utilizers of inpatient services
  - High utilizers of jail services
  - Borderline personality disordered persons
  - Victims of Torture
  - Persons with Post Traumatic Stress Disorder
- C. The Agency shall ensure that outpatient crisis response services are provided to any person in crisis who meets the crisis eligibility criteria.
- D. The Agency shall ensure that outpatient community-based services are provided for clients who meet the medical necessity criteria.
- E. The Agency shall make reasonable attempts to assign PHP eligible persons to an available and clinically appropriate service location that is convenient to the client and provides culturally competent services.
- F. The Agency shall participate in service system evaluation efforts conducted by the [County Mental Health Department] and/or the State Department of Social and Health Services (DSHS)... **Washington State County Contract**, Exhibit VI, pages 1-2.

### **Program Requirements...**

#### **C. Service Delivery...**

2. The Agency shall participate with the [County Mental Health Department] in refining the methods for authorization of acute psychiatric care and continue to develop strategies for accessing alternatives to such care. This planning must include good faith efforts to include consumers, families of consumers, allied system partners, as well as key stakeholders (in accordance with WAC 275-57)....
7. For voluntary acute care which meets the following criteria, the Agency shall review and determine the need for continued inpatient care:
  - a. The stay exceeds, or is expected to exceed, the number of days established at the 75<sup>th</sup> percentile, as published in the most recent edition of *Length of Stay in PAS Hospitals Diagnosis, United States Western Region* and adopted by the department as the official guideline;
  - b. Extended care is appropriate and necessary based on medical necessity guideline; and
  - c. The care is provided by hospital (listed in Attachment A-1) paid on a ratio of costs to charges basis, or by Western State Hospital and Children's Long-term Inpatient (CLIP).
8. The Agency shall approve clear instructions to hospitals concerning Agency procedures for approving length of stay extensions at the time of admission or post admission certification.
9. The Agency shall approve or reject continued stay in acute care settings for [\*\*\*] County residents whose involuntary treatment under RCW's 71.34 or 71.05 in acute care settings exceeds 20 days. The Agency shall collaborate with [County Mental Health Department] and courts to develop policies, procedures, and a process to perform this requirement. For a minor on a 180-day court order, continued stay in the acute care setting cannot be denied until a placement is available in a long-term inpatient setting or another appropriate discharge is effected.
10. The Agency shall have a children's mental health specialist review the length of stay and appropriateness of acute inpatient care to all minors who are admitted by their parents, if the minor will remain in acute care longer than 60 days. This review must be completed no later than 55 days after admission.

If the Agency concludes that continued inpatient care is not medically necessary, the Agency will consult with the [County Mental Health Department] Following development of a joint recommendation, the Agency shall write a recommendation for discharge to the professional person in charge of the inpatient facility serving the minor.... **Washington State County Contract**, Exhibit VII, pages 3-4.

K. Vendor Network Management...

3. The Agency Shall perform the following services:
  - Design and construct appropriate service contract instruments that include all specifications of the standard requirements (boilerplate) of this contract.
  - Negotiate and implement service contracts.
  - Monitor service contracts for fulfillment of program requirements.
  - Monitor vendor compliance with State and Federal statutes, including, but not limited to the Single Audit Act requirements established in the federal Office of Management & Budget Circular A-133. Such monitoring shall consist of the timely receipt, review, and write response to the vendor to correct any audit findings of a management letter.
  - Identify and implement corrective action plans addressing vendor service deficiencies or non-compliance.
  - Collaborate with the County to develop a methodology and use of vendor profiling information.
  - Conduct contract compliance site visits during the contract period.
  - Incorporate by reference the County Policy and [MCO] Procedure Manual and the [\*\*\*] Data Dictionary in vendor contracts.... **Washington State County Contract**, Exhibit VI, page 7.
  
- The [MCO] will use its provider network for the provision of treatment services. Exceptions will be considered in order to maintain continuity of care and in case where specialized expertise not available in the network is required. Providers recommended by the CPA's may be offered network membership according to credentialing criteria developed pursuant to this agreement and as determined appropriate by the [MCO]. **Colorado County M.O.U.**, page 3.

**Involvement of Community Mental Health...**

1. [health plan name] – [MCO] shall be a partner through an MOU which defines their commitments to the CPA project and the methodology for the transfer of funds for therapy to children placed with all CPAs. They will contract individually with the CPAs around the implementation method of their provision of and/or payment for the children's therapy services.... **Colorado County**, Appendix A, page 12.

*Involvement of Community Mental Health...*

- 4.) A CPA that has integrated therapeutic services into their foster care program may be selected to enter into an agreement negotiated with the [M.O.U. Partner] to directly provide treatment services for the target population. The CPA shall accept as full reimbursement a negotiated case rate from the [M.O.U. Partner]. This option is called Option A.
- 5.) The [M.O.U. Partner] will purchase treatment services from its network providers for those children placed in CPA's which are not selected for Option A. This will be called Option B.... **Colorado County**, Appendix A, page 13.
  
- 11.) Treatment costs which have been a part of the rate for some CPAs are not included in the matrix or the \$600 administrative rate above. The Department and [\*\*\*] Mental Health have developed a memorandum of

understanding creating a funding structure and service provision structure to assure that all children placed out of home in CPA's participating in this contract, and their families, will receive needed behavioral health services. This Agreement provides a means for the CPA's to be included in the treatment provider network.

- 12.) Each CPA participating in this Agreement will be contracting with [MCO] in order to become a participating provider in their network. That contract will be used to address compensation method agreements and accountability concerns as well as credentials and other issues. **Colorado County**, Appendix C, page 24.

**4.8.1 Subcontracts for the Provision of Client Services:** [County] reserves the right to approve or disapprove any subcontracts entered into by the Provider for the purpose of completing the provisions of this contract prior to entering into subcontracts. [County] reserves the right to approve any change in Provider's subcontracts during the term of this Agreement prior to the change and in writing. If Provider suspends or restricts a subcontractor, it must notify [County] in writing of that suspension or restriction. *All restrictions, obligations, and responsibilities which apply to the Provider as the principal contractor shall also apply to the subcontractors. The Provider shall include language passing on these restriction, obligations and responsibilities in all of its subcontracts.*

Provider shall maintain a written code of standards of conduct governing the performance of its employees engaged in the award and administration of any subcontract. No employee, officer or agent of Provider or subcontractor shall participate in the selection of a contract if a conflict of interest, real or apparent, would be involved.

Provider agrees to have no subcontracts which contain any provisions which provide incentive, monetary or otherwise, for the withholding of medically necessary treatment or services to clients or services necessary for the protection of a child from abuse or neglect.

Provider agrees not to subcontract, partner or develop any paid business relationship with any agency or organization that is providing services to [County] clients under subcontract, partnership agreement or other paid business relationship, to any other agency, company or organization that has entered into an Agreement with [County] for the provision of child welfare services under a managed care system. **[Ohio County #1 "Core Contract," Attachment 10 to "Agreement for the Provision of a Continuum of Child Welfare Services Under a Managed Care System"]**

## C. Relationships to Other Parts of the Health Care System

### L. COORDINATION WITH OTHER AGENCIES AND SYSTEMS

1. The Agency shall ensure that all certified vendors have working agreement and/or contractual relationships and/or documentation of consistent collaboration at multiple administrative levels for service provision with schools, other community-based health and human service vendors, and relevant state agencies in their service area in order to complement and maximize available resources. These agreements/ contracts/ other documents will describe at a minimum, the responsibilities of each party, how coordination occurs, the target populations involved, referral mechanisms, and links to collaborate in monitoring and quality assurance activities.
2. The Agency shall ensure that all certified vendors establish collaborative relationships with their area Community Service Office (CSO) to provide complete new application and re-certification application packets on behalf of all clients authorized for Tier 2, 3a, and 3b benefits. Vendors may continue to opt for voluntary protective payee status for clients served.
3. The Agency shall participate with the County in the development and implementation of a plan to ensure that all tiered clients who are incarcerated or detained receive care management services during their incarceration/detainment. The plan will focus on discharge planning, and that these clients receive a face-to-face outpatient service within 15 calendar days post release.

4. The Agency shall provide all authorization and financial accounting support necessary to ensure that the Blended Funding Pilot Project is paid appropriately for the duration of the County contract with [\*\*\*] Educational Service District.... **Washington State County Contract**, Exhibit VI, page 8.

G. Utilization Management...

4. The Agency shall ensure discharge planning coordination for all [\*\*\*] County residents in designated wards at [State Hospital]. The Agency shall ensure that intensive case management community transition services are provided, when appropriate, to [\*\*\*] County residents discharged from [State Hospital].
5. The Agency shall ensure treatment coordination and support to nursing homes for clients discharged from the [State Hospital] Geriatric Medical Unit.... **Washington State County Contract**, Exhibit VI, page 4-5.

**Exhibit VIII**

Carveout Contracts...

**Children's Crisis Respite Foster Care Beds...**

The Agency shall contract with a vendor for:

- F. Ensuring that the vendor has in place agreements with and maintains working relationships with DCFS and other serving agencies to deal with a division of responsibilities for treatment, case management, and planning with the child's family, including providing services that re culturally relevant whenever possible by consulting with minority agencies or specialists.
- G. Ensuring that the vendor develops a subcontract with a child-placing provider that is licensed by the State to provide foster care services, and approved by the county and/or [MCO], and being responsible for all financial arrangements with the child-placing agency.... **Washington State County Contract**, Exhibit VIII, page A-4.

**Coordinating Area Interagency Staffing Team**

- A. The Agency will collaborate with Children's Mental Health Advocacy Group (CMHAG), the Regional Policy Team (RPT), and the County in the continued development and implementation of the Coordinating Area ISTs, and on County/State Planning activities. The Agency shall also analyze and report outcome data on children and youth served by the ISTs.
  - B. The Agency will contract with three vendors to staff each calendar quarter for each vendor and record data in the [County] MHD/IS that a minimum of 15 seriously disturbed children/youth ages three to 18 years, who exhibit multiple problems and who have a history of special needs, involving at least two systems (*sic*). The number of children staffed shall be used as the basis of reimbursement.... **Washington State County Contract**, Exhibit VIII, pages 4, A-11.
- The Department and the [MCO] will work together to develop a specialized care coordinator training program and job description, to explore joint employment or contracting of individuals so trained, and to use these individuals to provide the integration between mental health and child welfare systems. **Colorado County M.O.U.**, page 3.
  - The Department, [MCO] and CPAs will work together to develop the concept of respite care and a system to provide respite care as a part of the continuum of services on such terms as they mutually agree. **Colorado County M.O.U.**, page 3.

### Contractor General Services:...

- 7.) The Contractor shall provide or have access to a wide array of services for children and families and shall assist families to obtain and coordinate such services. These services shall include but are not limited to Family Preservation, Economic Support, Housing Assistance, Health Care, Mental Health, Substance Abuse, Domestic Violence, Adoption and Post Adoption Services.
- 8.) Transitions Between different levels of services and providers will be planned and documented in the child's family service plan.... **Colorado County**, Appendix A, page 12.

### Practice:...

- 6.) The Contractor will work cooperatively with other community services providers. Coordination will be maintained at an individual case level. Whenever possible low or no cost services will be located and utilized.... **Colorado County**, Appendix A, page 15.

### 3.2. Continuum of Services

- 3.2.1. A full continuum of services must be available and include, as a minimum level of benefits *for both children and parents*, the services listed in Table 1 below. The services must either be provided by the lead agency, provided under a sub-contract with another agency or professional, or available through written agreement with another agency or professional. Evidence of how these services will be accessed, the length of time from referral to initiation of services, and how they will be provided must be included in the proposal. [COUNTY] must approve all sub-contracts or purchase agreements for services. [**Ohio County #1 Request for Proposals**]

## D. Data and Reporting

### G. Utilization Management...

3. The Agency shall continue the development and implementation of a [County] MHD approved utilization review system, involving a sampling of client records (adhering to the County Contract Monitoring Manual, Appendix C., Data Verification & Sample Size Guidelines) from each vendor, that accomplishes the following objectives:
  - Assess overall accuracy of client diagnosis and tier placement;
  - Assess vendor compliance with WAC 275-57 requirements for client assessment, development and monitoring of Individual Tailored Care Plans;
  - Conduct Review of services received without pre-authorization;
  - Provide review of ongoing care to effect individual client outcomes;
  - Assess intensity of service for individuals to determine appropriateness;
  - Review flagged populations or individuals.... **Washington State County Contract**, Exhibit VI, page 4.
- The [MCO] or its designee will maintain accounting documentation. Financial reports as agreed to will be shared with the [County] Department of Human Services not less than quarterly. The Department, CPA's and [MCO] have all agreed to monitor all aspects of this system and to make adjustments as appropriate in the various rate structures involved. **Colorado County M.O.U.**, page 2.

- The [MCO] will work with the Department to develop a mutually consistent and effective MIS system for this project. **Colorado County M.O.U.**, page 3.
- The [MCO] will participate with the Department and CPA's to define Department directed efforts to establish appropriate outcomes, measures and data collection for baselines and concurrent evaluation. **Colorado County M.O.U.**, page 4.
- The Department will work with the [MCO] to develop a mutually agreed upon Customer Service evaluation and provider satisfaction evaluation of the mental health services. **Colorado County M.O.U.**, page 3.

#### A. Data Reporting Capabilities

1. Eligibility may be reported through a variety of media: tape, hard copy, and diskette. Your organization is expected to process this information in all formats received.
2. Vendors will be expected to provide detailed claim reports sufficient for [\*\*\*] County analysis purposes, including detailed utilization and provider payments by place of service and type of claim. Enclose a copy of a sample report showing plan expenses compared to your book of business.
3. Vendors will be expected to be able to electronically submit claim data to [\*\*\*] County on a special request basis. [\*\*\*] County assumes there will be no charge for such quarterly electronic claim submission unless specified by the vendor in the proposal. **Ohio County #2 R.F.P.**, page 10.

### 3.3.5 Management Information Systems (MIS)

- 3.3.5.1. Provider must enter all required data directly into [County] MIS system, *[COUNTY MIS SYSTEM]*. Parallel systems may be maintained and reports generated from those systems subject to negotiation and agreement in the final contract. [COUNTY] will not pay the costs of maintaining that portion of a separate system that duplicates what is available in *[COUNTY MIS SYSTEM]*. Hardware and staff cost incurred while training to utilize *[COUNTY MIS SYSTEM]* must be borne by Provider. [COUNTY] will provide the trainer and training materials. Provider must describe in detail how [COUNTY]' *[COUNTY MIS SYSTEM]* will be provided current data on an ongoing basis. [COUNTY] must always be able to determine the current status of children and where they are living.
- 3.3.5.2. Provider must have, as a minimum requirement, one computer with a 200 MHz Pentium processor or higher, 32 MB of RAM, 2GB SCSI or EIDE hard drive, AMI/Award BIOS, 56 KB modem, a CD-ROM drive, a 2MB MPEG-1 or MPEG-2 compliant video card, and an ISP/Internet access (a server) with Netscape or Internet Explorer for each 200 children being served at any point in time.  
  
Provider must list all computer and communication equipment with their specifications in the proposal. Provider must describe its, and the network's, if that is applicable, computer systems, management information system, and communication system, including all records copying and transmittal.
- 3.3.5.3. Records must be maintained according to the procedures currently in effect at [COUNTY]. This includes maintaining on 13 section case file for each case in one location with the original of all records and case documentation. Original court records provided to [COUNTY] as the holder of custody will be sent to the Provider by the next working day after receipt by [COUNTY]' Data Management Department within three (3) days of closure of the case. If the case is reopened, [COUNTY] will send Provider a CD-ROM disk containing a digitalized facsimile of all the records. Information on [COUNTY]' record requirements will be made available to prospective Proposers.

3.3.5.4. The accounting system must permit the reconciliation described in section 4. and permit verification of expense by case and service provided. Daily records of client contacts and services must be maintained by the direct service workers and reported to [COUNTY]. These records must provide at least the same information as [COUNTY]'s Records of Activities (ROAs) and Notice of Change (NOC) currently completed by [COUNTY] staff.

3.3.5.5. It is likely that [COUNTY] will implement a new MIS system during the next two years either on its own or as part of the development of a statewide system. Transition to the new system should not require any changes in hardware. Software costs will be borne by [COUNTY]. Provider's costs incurred for training, any changes in procedure, and changed in hardware, if required, will be borne by Provider. Any costs that arise in adapting a parallel system to the existing or a new MIS system must be borne by Provider.

3.4.1. Data will be collected and reported from [COUNTY MIS SYSTEM] at least monthly on the following:

3.4.1.1. Average client contact by risk level, case status (i.e., services in-home, or reunification), person contacted, location, and type of contact or service.

3.4.1.2. Overall status of all cases referred, e.g., open voluntary, open court ordered, placement voluntary, placement court ordered, reunified, closing motion filed, closed and, receiving after-care/follow-up services.

3.4.1.3. Other statistics such as the location of children and length of stay. **[Ohio County #1 Request for Proposals.]**

## E. Performance Standards

### D. PERFORMANCE REQUIREMENTS

#### 3. Service Delivery

c. The Agency shall ensure that 100% of [health plan] individuals who are referred to a vendor for outpatient services and who have Medicaid coverage or meet non-Medicaid criteria are tiered.

d. The Agency shall ensure that 100% of detained or incarcerated mentally ill offenders (MIO) who are referred to the Agency are assessed and tiered as appropriate.

#### 4. Outpatient Authorization/Utilization

i. The Agency shall pre-authorize 100% of all benefits listed in the Policy and Procedure Manual as requiring pre-authorization.

j. All concurrent and retrospective reviews shall be completed as outlined in the Policy and Procedure manual. The reviews shall also include the Blended Funding Project, for which the County has a contract with [\*\*\*] Educational Service District. A schedule for all these reviews shall be developed for the contract period for approval by the County with the first billing package of this contract. The schedule may be amended by mutual agreement on a quarterly prospective basis.

k. The Agency shall ensure that 80% of all tier requests requiring manual review will receive an authorization decision within four (4) working days and 100% receive an authorization decision by the end of the sixth (6) working day.

l. The Agency shall ensure 100% of LTR placements are pre-authorized.

- m. The Agency shall ensure 100% of LTR residents shall receive at least one continued stay review within one year from the date of admission.
- n. The Agency shall review 100% of supervised living (SL) residents in open status who started SL service prior to 1996, for integration with treatment plans and appropriateness of placement.
- o. The Agency shall review and approve/deny excess utilization requests including Medicaid Personal Care, Special Needs, Service Based Add-On, and Exception to Policy.
- p. The Agency shall provide agreed upon criteria indicator reports monthly or quarterly, as required.

5. Billing and Payment

- a. The Agency shall ensure a 98% accuracy rate on all transactions that result in a vendor reimbursement and/or adjustment.
- b. The Agency shall ensure that 100% of uncontested errors in vendor payments will be corrected within five business days of either the discovery of the error by the Agency or the County, or notification by a vendor of an error.
- c. The Agency shall provide a report to the County on biennial quarterly revenue and the expenditure reports, by vendor, within six weeks of the end of each biennial quarter. The Agency shall suspend payments on service contracts to those vendors failing to meet submission timelines, until submission occurs.
- d. The Agency shall provide a quarterly summary of third party payments to vendors for PHP clients thirty (30) working days after the close of each quarter. For those vendors showing a decline in third party payments from the previous quarter, the Agency shall investigate the cause(s) and stimulate a renewed effort at the vendor to solicit third party payment.

6. Service Parity

- a. The Agency shall ensure annual service provision to at least a minimum of 384 clients who are deaf or hard of hearing, and for whom sign language or other non-verbal communication methods are the primary mode of communication in the person's home.
- b. The Agency shall ensure annual service provision to at least a minimum of 246 clients who are medically compromised homebound.
- c. The Agency shall ensure annual service provision to a minimum of 682 clients who self identify as a sexual minority.
- d. The Agency shall ensure that during each half year period of this contract the following numbers of people receive a mental health service:

Ethnicity	Children 0-17 Years.	Adults 18-59 Years.	Elders 60+ Years
African American	1128	1687	209
Asian/Pacific Islander	305	890	237
Hispanic	562	605	87
Native American	200	319	29
Caucasian	3735	N/A	2436

- e. The Agency shall ensure that the [State Hospital] daily in-residence census utilization does not exceed the [\*\*\*] County patient target as per DSHS/MHD contract; as recorded by [State Hospital] data reports.

- f. The Agency shall ensure that PASARR (Pre Admission Screening and Annual Residential Review) identified persons with reported mental health needs are provided a face to face service within thirty (30) days following the Agency's receipt of a PASARR referral.
- g. The Agency shall ensure PHP or carve out services are provided to a minimum of 6443 eligible individuals who are not covered by Medicaid.

7. Capacity Management

- a. The Agency shall ensure that by June 30, 1998 a profile of tiered non-Medicaid, including [health plan] clients will be completed to determine historical conversion rates to Medicaid benefits, in order to establish a County-wide standard for converting clients from non-Medicaid to Medicaid status with possible differentials based on client demographics.

8. Monitoring Service Quality

- a. The Agency shall submit a final version of its 1998 Quality Management Plan for County approval by April 30, 1998.
- b. The Agency shall report quarterly updates on the implementation of the Quality Management Plan and resulting Quality Improvement Projects.

9. Client Issues

The Agency shall report on complaints, grievances, and extraordinary occurrences on a quarterly basis and submit a year-end analysis report. All reports must include Ombuds Service data.

10. Vendor Relations

- a) The Agency shall produce vendor profiles in a format approved in writing by the County.
- b) The Agency shall submit a 1997 year-end profile by April 30, 1998 and a 1998 year-end profile of all vendors with the December billing package.
- c) The Agency shall report on the results of recredentialing.
- d) The Agency shall respond to all phone calls regarding Agency operational functions triaged by the County to appropriate Agency staff. Functional areas most likely to be triaged include clinical questions regarding authorization results or changes, provider reimbursement, and contract compliance. Any calls the Agency receives that are [County]/IS specific will be transferred to IS.

11. System Accountability measures

The Agency shall show improvement or meet specific targets in the following accountability measures based on 1996 or 1997 performance, whichever is better, as recorded in the [County] Report Card:

- 90% data accuracy and completeness based on the total average of [MCO] site visit data audits
- 95% of all services are reported within the data timelines policies
- 95% of all vendor based concurrent reviews are reported within policy timelines
- maintain or improve level of functioning
- decrease the incidents of voluntary hospitalization
- decrease the duration of voluntary hospital bed use
- decrease the number of days it takes from hospital discharge until a face to face mental health service is provided
- reduction in the number of events of incarceration

- reduction in events of detention
- decrease the number of days clients are incarcerated
- decrease the number of days clients are detained
- decrease the number of days from jail/detention release until face to face mental health is provided
- reduction in homelessness system-wide
- increase in engagement of homeless clients into tier services
- maintain or acquire independent housing
- reduction in out-of-home placements for children
- maintain or acquire age appropriate activity system-wide
- maintain or acquire paid employment... **Washington State County Contract**, Exhibit VIII, pages 2-6.

#### H. PHP System Outcomes

1. The Agency shall review and analyze individual client outcomes in the following areas in a format and periodic timeframe that may be jointly developed by the Agency and [County] MHD staff and as approved by [County] MHD, with the aim of promoting achievement of the following outcomes for individuals:
  - Reduction in psychiatric symptoms.
  - Improvement in level of functioning.
  - Improvement in quality of life.
2. The Agency shall participate with the County in the review of PHP system outcomes as defined by the [County] MHD RSN report card and system accountability documents.
3. The Agency shall use ongoing clinical care review as a means of intervention to assist in improvement measures designed to evaluate the effectiveness of the PHP across established system accountability measures. **Washington State County Contract**, Exhibit VI, page 5.

#### I. Monitoring Service Quality

1. The Agency shall:
  - Ensure that individual client outcomes for service, as established by the medical necessity criteria are the focus of client care.
  - Maintain collaborative and productive linkages with the Ombudsman Service and the Quality Review Team.
  - Maintain policies and procedures to address client and vendor complaints and grievances.
  - Assess effectiveness of treatment plans and goals.
  - Monitor effectiveness and quality through a system of flags.
  - Assist in ongoing design of clinically appropriate tier benefit packages that fit the financial constraints of the PHP.
  - Assist the County in development of clinical best practice standards.
  - Assist the County in assessing consumer satisfaction....
4. The Agency shall maintain a Quality Management Plan. The Quality Management Plan includes, at a minimum, the following elements: focus on mental health system and individual client treatment outcomes; appropriate use and analysis of clinical guidelines and quality indicators; analysis of clinical care, the authorization process, and related services; implementation of Agency and vendor corrective action; and, a periodic evaluation of the Quality Management Plan itself. Specifically, the plan shall also meet the requirements of HCFA 42 CFR 434.34 and the state contract with the County for the 97-99 biennium.... **Washington State County Contract**, Exhibit VI, page 6.

## Program Requirements...

### C. Service Delivery...

15. The Agency shall make all reasonable efforts to assure that consultation with minority mental health specialists or geriatric mental health specialists occurs as appropriate so that care is culturally sensitive. Consultation can come from within hospitals or from vendors.... **Washington State County Contract**, Exhibit VII, page 5.

### Ongoing Authorization Performance Requirements

For all times when there is normal functioning telecommunications:

1. 90% of all decisions concerning approval of an emergent admission or certification of the need for acute care on an elective basis shall be made within one hour of the initial call.
2. 99% of decisions concerning approval of an emergent admission or certification of the need for acute care on an elective basis shall be made within three hours of the initial call.
3. 100% of decisions made in response to County-Designated Mental Health Professional (CDMPH) calls shall be made within one hour of the request.
4. Hospital stays (LOS) for all patients shall be no longer than an average of 12 bed days per admission for children under 21 or for adults 21 years of age and older who were admitted and discharged within each calendar quarter.
5. The Agency shall ensure that 92% of all voluntary admission records shall be complete at the close of each monthly reporting period.... **Washington State County Contract**, Exhibit VII, page 6.

## Exhibit VII

### Adult Crisis Services...

#### C. Outcomes...

4. Agency will meet the following response times for crisis services:
  - 4 hours for emergency situations; the next working day for urgent crisis situations;
  - All vendor crisis phones shall be answered within 5 rings. Crisis phones shall be answered by qualified persons who are proficient or can immediately access personnel proficient in the use of TT or alternate language, for the hearing impaired and limited English proficient population(s).... **Washington State County Contract**, Exhibit VIII, page A-3.

### 3.4. Quality Assurance: Service and Outcome Monitoring

#### 3.4.1. Service Monitoring

Service provision will be monitored by [COUNTY] against indicators of increased risk to children and expectations for client contact and service documentation.

- 3.4.2.1. A liaison from [COUNTY] will be assigned to provide monitoring and technical assistance in child welfare to Provider during the first year. It is anticipated that this person's full efforts will be allocated to technical assistance and that they will be available on site every working day during at least the first six months. They will be available to advise and will not be given authority to overrule Provider's decisions.

- 3.4.2.2. Monitoring of client files will occur more frequently during the first year of the contract. Random monitoring in the first year will occur within the first 30 days of referral and at least every 90 days thereafter. In subsequent years, monitoring of client files will at minimum occur every six months.
- 3.4.2.3. Critical incidents must be reported the same day if they occur before 5:00 p.m. and by 9:00 a.m. if they occur before 5:00 p.m., and will be subject to quality assurance case monitoring. These will include but may not be limited to:
- 3.4.2.3.1. Death or injury to a child.
  - 3.4.2.3.2. Occurrence of open case maltreatment,
  - 3.4.2.3.3. Hospitalization of a child, and
  - 3.4.2.3.4. Violation of any licensing or O.A.C. rules.
- 3.4.2.4. Specific indicators will be monitored daily from [COUNTY MIS SYSTEM]. Examples of indicators currently being considered include:
- (1) Lack of monthly face to face contact with children.
  - (2) Number Of Days a Child Remains In Temporary Custody
  - (3) Increase in level of risk as assessed on the ME-FRAM
  - (4) Parent visitation occurring less than indicated in the case plan,
  - (5) Parent participation in the case plan is none or partial.
  - (6) Voluntary Protective Services (VPS) case open longer than 6 months.
  - (7) Court Ordered Protective Services (COPS) case open longer than 9 months.
  - (8) Temporary Court (Ordered) Custody (TCC) case open longer than 12 months without a request for PCC.
  - (9) Birth of a child subsequent to case opening,
  - (10) Move a more restrictive placement exceeds 14 days in duration, and
  - (11) "AWOL" family not located within 30 days of last contact.

Cases identified using these and the critical incident indicators will be reviewed by [COUNTY] staff using a tiered level of response. Possible responses include client record review and phone contact and/or meeting with the assigned caseworker, casework supervisor, Provider utilization/Quality Assurance (QA) staff, administrative staff, or the entire service team. If the indicator has occurred more than a defined number of times within a set time period (to be determined), a corrective action plan will be required. Development and implementation of a corrective action plan will have deadlines and will be monitored by [COUNTY] QA staff. Specifics of the monitoring process, indicators, and identified thresholds will be included in the contract.

- 3.4.2.5. Specific thresholds have been identified for the following indicator:
- (1) Monthly Face-To-Face Contact With Children
    - Of all children being served, no fewer than 80% will be seen face-to-face every 30 days.
    - 90% of children being serviced, no fewer than 90% will be seen face-to-face every 60 days.

#### 3.4.2.6. Outcome Monitoring

The effectiveness of service programs in producing results for children will be tracked using outcome measures. As mentioned above, other key indicators of program functioning that are not as closely related to child-centered outcomes will also be monitored. Each outcome measure has a threshold or goal that has been utilized by [COUNTY]. The ability of the Provider to achieve or improve upon these threshold levels will be monitored during the period of the contract. Standardized 5% and 10% proportional slippage levels will be calculated for each goal. Slippage beyond 5% results in a "caution" status, more than 10% slippage results in an "alert" status. Depending on the nature of the outcome/indicator, monitoring and reporting of findings will be carried out on monthly, quarterly, and biannual

basis. Summaries of all findings will be produced at least every six months. Financial penalties for failure to produce outcomes within 10% of the thresholds may be included in the contract.

The outcomes and the thresholds are listed below. The data on [COUNTY]' actual experience is provided in Attachment 2.

- (1) Protection from Maltreatment
  - (a) Of children served on the open caseload, 100% will not experience substantiated CAN (Child Abuse Neglect).
  - (b) Of children being served in paid placement, 100% will not experience substantiated CAN.
- (2) Recidivism Of Substantiated & Indicated Child Abuse and Neglect (CAN) Reports
  - (a) CAN recidivism within 6 months no greater than 7%.
  - (b) CAN recidivism within 12 months no greater than 12%.
- (3) Number of Days A Child Remains In Temporary Custody
  - (a) Median length in days children remain under Temporary Custodian no greater than 85.
  - (b) Percent of children remaining under temporary custody after 6 months no greater than 40%.
  - (c) Percent of children remaining under temporary custody after 12 months no greater than 25%.
- (4) Moves During A Substitute Care Placement Episode
  - (a) No fewer than 45% leave care with only 1 placement (no moves)
  - (b) No fewer than 25% leave care with 2 placements (1 move)
  - (c) No more than 12% leave care with 3 placements (2 moves)
  - (d) No more than 16% [leave] care after 4 or more placements (3 or more moves)
- (5) Non-Recidivism Of Closed Cases (Case Reopens)

Of children whose cases are closed each quarter, 92% will not reopen within 6 months.
- (6) Entry Rate Of Children Into Long-Term-Foster Care (LTFC)

No more than 1% of the children in custody will enter LTFC every 6 months.
- (7) Serving Children In The Community
  - (a) Of children being served, no fewer than 75% ages 0-12 will reside with their families.
  - (b) Of youth ages 13 and over being served, no fewer than 55% will reside with their families.
- (8) Serving Children Without Taking Custody

Of all children served, no fewer than 55% will have never been in custody during the life of their case.
- (9) Reunifying Families Safely And As Timely As Possible
  - (a) Of children leaving custody, no fewer than 80% will return to their families.
  - (b) Of children leaving custody, no fewer than 75% will have been in custody under 1 year.
- (10) Least Restrictive Placements

Of children in custody, no fewer than 85% will be in a family-like placement (vs. group/institutional care). **(Ohio County #1 Request for Proposals)**