EXHIBIT A

CONTRACT PROGRAM ATTACHMENT

The purpose this attachment is two-fold. First it is to describe the expectations and conditions inherent in accepting a contract with the MHR Board. These expectations and conditions define how contracted services are to be delivered, the policies that are to be followed, and how services are to be coordinated between MHRB contract agencies. The second purpose is to describe the "service philosophy" of the MHR Board. The Board values accountability, access, appropriateness, and acceptability of services. Providing accessible, appropriate, acceptable, and accountable services to consumers is the ultimate aim of the Board. Toward that end it is vital that all agency staff members read and understand the Program Contract Attachment. It will posted it on the MHRB Website and will be available to be picked up from the Board offices. Agency administrators should inform and encourage all staff members to thoroughly read and understand it.

ACCESS TO ALCOHOL, DRUG ADDICTION AND MENTAL HEALTH SERVICES

It is the intention of the MHR Board that all residents of the Board area have ready access to needed alcohol, drug addiction and mental health services. This is particularly important when providing core and/or mandated services or when providing services to a targeted or priority population. While the MHR Board recognizes that under certain limited circumstances an agency may find it necessary to deny services, the Board also recognizes that contract agencies and Boards function together to provide a safety net that is designed to protect both individuals and society. In order for the safety net to function properly, the following elements must be incorporated.

Emergency Services/Self-identified Emergency Requests

These services are to be available on a 24-hour basis, with the agency having the responsibility of making its 24-hour telephone number known to the public and to consumers. A person calling with a self-identified emergency must be seen within two (2) hours. Self-identified emergencies are to be given the same level of response as those identified as an emergency by a mental health or alcohol/drug professional or other official. If the person cannot be seen within this time period the Director of Mental Health Programs or the Director of Alcohol and Other Drug Programs or Chief Program Officer must be notified in writing within one working day of the call.

Service Requests by County Agencies

Attentive and rapid responses to requests by county agencies shall be expected. Requests for *non-emergency* service are to be completed within ten working days. If an agency requests service and identifies the request as an *emergency,*

the emergency services/self-identified emergency timeframes above should be followed.

- Court Service Requests: Assessments requested by the courts are to be completed, typed and submitted to the court within (5) five working days of the request. The court may identify a small percentage of these assessments as emergencies. Emergency assessments need to be completed, typed and submitted to the court within two working days.
- If the Agency cannot provide the service(s) to the requesting agency within the timeframes given, the Director of Mental Health Programs or the Director of Alcohol and Other Drug Programs or Chief Program Officer must be notified in writing within two working days.

DENIAL OF SERVICES

Consumers may be denied services only for valid clinical reasons, for issues of safety, or when the continuation of service to a particular consumer severely impedes the ability of others to receive adequate treatment and care. Serious efforts to modify and/or adapt standard service delivery practices to meet consumer needs shall be made. Service termination by the agency may be considered only after all reasonable efforts to accommodate a consumer's needs have been made.

When services are denied, particular attention must be given to maintaining client rights (numbers 3, 4, 9, 15, and 16 for mental health clients and 3,4,13,and 14 for AOD clients). A transition plan is to be developed with the active participation of the client. Consumers are to be given a copy of their rights and the address and phone number of the MHR Board. In response to client requests, MHR Board staff may, when necessary, refer the consumer to an alternative treatment provider and may deduct the cost of service from the original (denying) agency.

Failure of the consumer to regularly keep appointments may result in the client being notified that if they wish to continue to receive services, they are required to contact the agency and reschedule an appointment or otherwise verify their desire to continue treatment. Inactive cases may be terminated according to approved agency policies consistent with Ohio Department of Mental Health and/or Ohio Department of Alcohol and Drug Addiction Services certification standards.

TRAINING REQUIREMENTS

Agencies are to hold a minimum of two trainings per year with local emergency room staff, physicians, law enforcement personnel, and other appropriate authorities for the purpose of educating them regarding accessing crisis response services. Trainings should be appropriately advertised and documented. Board staff are to be notified two (2) weeks before the training. A

written summary of participant questions and the evaluation results are to be sent to the Board within seven (7) days of the training date. Appropriate follow up with attending agencies and individuals is to be provided within ten working days of each training.

WAITING LIST MANAGEMENT/ EMERGENCY AND NON-EMERGENCY SERVICES

Agencies must be particularly careful that reliance on a voice mail answering system does not become an impediment to clinical care. Whenever possible, calls to MHRB agencies should be answered by a live voice. If voice mail is the initial point of contact, the system should be as “user friendly” as possible and must have a clear option to directly reach a staff person.

CLIENTS RECEIVING MEDICAID REIMBURSEMENT

All clients who are identified as needing emergency services, including individuals who are self-identified, shall be offered face-to-face services on a timely basis. It is very important that the clerical/intake staff answering the phone have adequate training to identify potential emergency or urgent situations and be instructed to transfer such calls to a qualified professional for additional screening and triage. Callers may not always identify the urgency of their situation, therefore it is vital that clinically appropriate procedures be followed to identify and engage critical clients.

Individuals seeking non-emergency services are to be offered an appointment within ten working days of initial contact. If these timelines cannot be met the following procedure is to be followed:

1) Within ten working days of the initial request for an appointment, the individual will be scheduled for a “clerical intake” appointment. (There may be situations where clients may appropriately be sent a letter outlining the following information including the right to seek a different provider and transportation options).
2) During the “clerical intake” appointment the client will be informed that, as a Medicaid recipient, they are free to seek services from any Medicaid provider.
3) Clients are to be given a list of Medicaid providers in the area, including addresses and contact information.
4) Clients are to be informed that the local county Department of Job and Family Services (DJFS) will give gas vouchers or provide transportation to and from appointments for Medicaid services. Clients are to be given the address and phone number of the appropriate entity at the local county DJFS.
5) If the client chooses to receive services from your agency, an appointment should be scheduled as soon as possible. If the client chooses to seek services from another agency, every effort should be made to assist them.

The Ohio Department of Alcohol and Drug Addiction Services provides the following guidelines regarding the placement of clients on waiting lists for services:

"Clients with a non-emergency status shall be placed on assessment and treatment waiting lists under the following conditions:

a) An appointment date for assessment cannot be offered within three (3) working days of the initial contact; and
b) An appointment date for treatment service cannot be offered within five (5) working days of determination of treatment need (assessment).

Treatment providers shall establish waiting lists for clients with a non-emergency status, including those that receive interim services, if an appointment date for treatment services cannot be offered. Waiting lists shall include a unique client identifier."

Contract agencies of the MHR Board who provide alcohol and other drug addiction prevention and treatment services must comply with the Ohio Department of Alcohol and Drug Addiction Services guidelines on waiting lists, pregnant women and intravenous drug users.

INDIGENT CLIENTS RECEIVING REIMBURSMENT FROM THE MHR BOARD
All clients who are identified as needing emergency services, including individuals who are self-identified, shall be offered services on a timely basis. Individuals seeking non-emergency services are to be offered an appointment within two weeks (10 working days) of the initial request for services. If these timelines cannot be met the following procedure is to be followed:

1) Within ten working days of asking for an appointment, the client will be scheduled for a "clerical intake".
2) During the "clerical intake" appointment the client will be informed that, as an MHR Board client, they are free to receive services from any MHR contract agency that provides the service they are seeking, regardless of the county in which the provider is located.
3) Clients are to be given a list of MHR contract providers including addresses and contact information.
4) If the client chooses to receive services from your agency, an appointment should be scheduled as soon as possible. If the client chooses to seek services from another agency, every effort to assist them should be made. The local county DJFS does not provide transportation for non-Medicaid eligible clients.

   The funding to cover the cost of services for these clients, including Medicaid match dollars, will be deducted from the allocation of the agency at which

they first sought service. It is the responsibility of the accepting agency to document such clients and report billing information to the Board.

INSURANCE OR 100% SELF-PAY CLIENTS

Insurance and self-pay clients (clients who are not entered into the MACSIS system) are not covered under Board contracts and thus any waiting lists for these clients are to be addressed with the insurance carrier or the individual.

BOARD RESPONSE TO AGENCY DELAY IN SERVICE AVALIABILITY

If an agency is unable to schedule services within the above listed time frames, they are to inform the Director of Mental Health Programs or the Director of Alcohol and Other Drug Services or Chief Program Officer within one working day. An emergency meeting will then be held to review the situation and develop a plan to reduce the waiting time. Any of the following options may be included in the plan:

1) Board staff participation in agency utilization review meetings;
2) A reallocation of Board contract service category allocation levels;
3) Agency reassignment of existing staff;
4) Emergency allocation of additional Board funding;
5) Emergency allocation of Agency reserve funding; and
6) Other options as determined based on individual circumstances.

SERVICE SPECIFICATIONS

Community Support Services: Community support services are to be delivered: (1) as needed for the client, and (2) outside of the clinical offices, a majority of the time. Case managers must be in contact with a client no less than once a month unless a reduced treatment intensity is clinically supported in the case file.

Psychiatric Services: Clients of the agency who are SMD and receiving medication through an agency psychiatrist must be seen by the physician at a minimum of every ninety (90) days unless reduced treatment intensity is clinically supported in the case file.

Chief Clinical Officer: When the designated Chief Clinical Officer will not be available, one must be designated in his/her absence and the Board must be notified (Director of Mental Health Programs or Chief Program Officer). Role expectations for Chief Clinical Officers include:

- Represent or delegate representation at all court hearings where clients are committed to the Board
- The Chief Clinical Officer shall as frequently as practicable, and at least once every thirty days, examine or cause to be examined every patient and, whenever he determines that conditions justifying involuntary hospitalization or commitment no longer pertain, shall, except as provided in 5122.21(c), discharge the patient not under indictment or conviction for crime and immediately make a report of the discharge to the Department of Mental Health.

Referrals to Regional Programs Funded by the MHR Board: Regional programs such as Women's Recovery Center and Creekside Detox / PES are to be equally available to all residents of the MHRB region. If a referring agency has difficulty gaining admission to a regional program, the referring agency is to contact the MHRB prior to seeking admission to a program outside the MHRB region. The MHRB staff will then contact WRC or Creekside to determine admission status and identify barriers to receiving treatment.

This provision does not apply to Medicaid clients who are not seeking referral assistance and clearly state their desire to seek admission to a Medicaid eligible program outside the MHRB region.

Referrals to non-MHRB Contract Agencies: Referrals for mental health or drug/alcohol services are always first to be referred to a MHRB contract agency. Only when MHRB contract agencies confirm that they do not have the capacity to provide the necessary services are referrals to non-MHRB contract agencies to be made.

DETOX SERVICES

MHRB-funded sub acute detoxification services (detox) are provided regionally through TCNBHS, at the Creekside facility in Xenia, Ohio. Funding for this service is included in the TCNBHS allocation. McKinley Hall is responsible for conducting assessments for Clark County residents to determine if detox is appropriate and necessary. TCNBHS is responsible for conducting assessments for Greene County residents to determine if detox is appropriate and necessary. Mental Health, Alcohol and Drug Services of Madison County is responsible for conducting assessments for Greene County residents to determine if detox is appropriate and necessary. McKinley Hall is responsible for arranging transportation for Clark County residents. Mental Health, Alcohol and Drug Services of Madison County is responsible for arranging transportation for Madison County residents

TCNBHS, McKinley Hall and Mental Health, Alcohol & Drug Services for Madison County are to follow the client through detox and coordinate appropriate treatment services upon discharge from detox.

UTILIZATION REVIEW REQUIREMENTS

For Providers of Alcohol, Drug and Mental Health Treatment Services

The Board's foremost concern in having a Utilization Review structure for adults and youth who do not have insurance or Medicaid is that people who need mental health services have access to appropriate, quality treatment in a timely manner. Board staff will work with agency staff to assure the availability of appropriate services and to monitor quality of care. Reporting of Utilization Review Services should be directed to the Director of Drug and Alcohol Programs or Director of Mental Health Programs, dependent on the type of services under review. If the appropriate director is unavailable and immediate notification or contact is needed, the Board's Chief Program Officer should be contacted. Any issues or disputes that arise regarding an individual client may be presented to the Board's Chief Program Officer for review.

It is the intention of the MHRB staff, in cooperation with Agency staff, to closely monitor and evaluate the utilization patterns of consumers who receive an unusually large amount of services. These consumers will generally be identified by monitoring billing activity through MACSIS. When these consumers are identified, a meeting will be held which will include appropriate Board and Agency staff. The purpose of the meeting will be to review current and past service usage, current clinical needs and future service delivery plans. Board and Agency staff will collaboratively plan for future service delivery.

The Board reserves the right to directly participate in Agency UR meetings, as needed. Areas for potential Utilization Review include, but are not limited to, waiting list management, access to inpatient care, residential and or detox service, state hospital utilization, coordination of services between agencies, and

other alcohol, drug, or mental health services. Program audits may be conducted before UR meetings and may trigger focused utilization review procedures. It is expected that the number of focused program audits and utilization review meetings will be substantially higher than in previous years.

INPATIENT CARE / CRISIS STABILIZATION

In order to be eligible to receive Board payment for clients not covered by Medicaid, Insurance or Self-pay, the following process must be followed.

Pre-screening:

- All pre-screening for inpatient services must be done either by Mental Health Services (Clark and Madison Counties) or TCN Behavioral Health Services (Greene County), or a designated out-of-county pre-screener.

- If a client is covered by insurance, pre-certification contact must be made or the agency risks non-payment by the Board.

- The Board's Director of Mental Health must receive a completed "INPATIENT HOSPITAL REVIEW/APPROVALS" form (attached) within one full working day after **any** psychiatric admission.

State Psychiatric Hospital Admissions:

- No one is to be admitted to a state hospital unless prescreened **face-to-face** by the agency or a designated pre-screener in another county. It is recommended that agency staff (CCO, therapist, Clinical Supervisor, Case Manager, and Client Rights Officer) review the admission as a team as soon as possible.

- The Board staff that is responsible for "state hospital on-call" **must authorize all voluntary or civil commitments before hospitalization.**

- A pre-screening form must be faxed to the hospital by the referring agency before the client is transported to the hospital.

Private Psychiatric Units:

- The MHR Board expects a high level of cooperation and coordination of services between agencies within the MHRB region. Toward that end, when Mental Health Services for Clark and Madison Counties (MHS) wants to admit one of their patients into Greene Memorial Hospital (GMH) for psychiatric services, they are to contact TCNBHS Creekside, who will consult with their on-call psychiatrist regarding hospital admission. MHS is not to contact GMH directly or refer the patient to the GMH ER. Alternatively, TCN is to work through MHS to facilitate in-patient admission for Greene County patients. Failure to follow this procedure jeopardizes MHRB reimbursement.

- Within one full working day of admission, the pre-screening agency and/or hospital must fax or telephone the admission information to the Director of Mental Health Programs or Chief Program Officer.

- If a concern arises over appropriateness of admission, the Director of Mental Health Programs or Chief Program Officer will call and/or meet with hospital and pre-screening staff.

- If the admission is deemed inappropriate, the Director of Mental Health Programs or Chief Program Officer will notify the pre-screening agency and the hospital immediately.

- The hospital **or admitting agency** is responsible for initiating the process for Medicaid determination in the appropriate county. The Board will not remit payment for “Board Clients” **unless notification of Medicaid denial is received.**

- The hospital **or admitting agency** must provide a review of each client’s status every three (3) days of the inpatient stay by fax or telephone to the Director of Mental Health Services or Chief Program Officer.

- The Director of Mental Health Services or Chief Program Officer is to be notified of hospital discharges within one full working day of discharge.

Community Support: Community Support staff must be actively involved in inpatient treatment and discharge planning for clients who are eligible for this service. Community Support staff must meet with the client within two full working days of release from an inpatient unit and continue intensive contacts to assure a smooth and positive transition back into the community and to assure that strong supports are in place.

Use of Crisis Stabilization Unit / Creekside

All agencies are strongly encouraged to consider crisis stabilization through Creekside as an alternative to hospitalization and as a step down option from hospitalization when making decisions regarding appropriate clinical care. MHRB on-call staff have been instructed to discuss crisis stabilization with agency staff when questions arise regarding adult hospitalizations, availability of psychiatric beds, and state hospital admissions. Such discussions will include clinical appropriateness and necessity of hospital admissions, and the consideration of “stepping down” a previously admitted patient into a less restrictive level of care.

ADDITIONAL ACCREDITATION

As an additional indication of quality service delivery, the Board encourages all appropriate agencies to acquire and maintain accreditation from a nationally recognized body such as JCAHO or CARF.

SCHOOL BASED SERVICES

The MHR Board recognizes the importance of providing services in a natural environment, and encourages efforts to offer services to children and youth in school settings. However, using such an approach creates significant reimbursement challenges, particularly in regards to billing Medicaid. Medicaid rules specifically prohibit billing Medicaid for services that are free to non-Medicaid recipients. The exception to this rule involves students with an Individual Education Program (IEP). Eligible services provided to IEP students may be billed to Medicaid, even though they are free to non-Medicaid eligible students, provided that the IEP addresses the need for such services. If the student is Medicaid eligible but does not have such an IEP, the service cannot be billed for Medicaid reimbursement.

It is the responsibility of any effected provider agency to insure that all Medicaid rules are followed; specifically that Medicaid services are not improperly billed. Agencies that have questions regarding this matter are encouraged to contact the MHRB staff.

CONSIDERATION GIVEN FOR SERVICES TO ADULTS WITH SEVERE MENTAL ILLNESS

The MHR Board strongly believes that all services, with the exception of “availability services” such as crisis response services, should be paid on a fee-for-service basis. However, the Board also believe that fee-for-service reimbursement should not impede appropriate clinical care, particularly in regards to individuals with severe mental illness. In many instances consumers with severe mental illness (SMI) require considerable support and encouragement to engage and remain in treatment. With this in mind, agencies providing community psychiatric support services to adult SMI consumers may need “consideration” regarding unit production, fee-for-service, and the cost of providing proactive community based services to consumers with SMI. Operationally, this means that if agencies providing such services fall short in their production of CPS services, Board staff will seriously review giving consideration during the annual reconciliation process.

OUTCOMES

The MHR Board is committed to purchasing efficient and effective services for the citizens of our region. Valid and reliable consumer outcome data is vital to this effort. In addition to the outcome mandated by ODADAS and ODMH, the MHR Board will be working with agencies to identify and produce specific and meaningful consumer outcome information. It is anticipated that this information will be presented to the Board at least semi-annually. Board staff will contact agencies to review their specific outcome procedures and collaboratively work evaluate the need for potential changes or additions.

REPORTING REQUIREMENTS

All agencies are to comply with the attached reporting requirements. All reports are to be submitted electronically using the Board's secure shell system.