Concordia
BEHAVIORAL HEALTH

APPROVED BY AHCA

Kimberly Houston, MA
Behavioral Program Analyst

10/22/12 to 08/31/15

By: Bureau of Managed Health Care,
Behavioral Health Care Unit

Concordia Behavioral Health
Provider Manual

Behavioral Health Program for Florida Medicaid Enrollees

MEDICA HEALTH PLANS

"Delivering Responsive and Compassionate Behavioral Health Care"

TABLE OF CONTENTS

I.	INTRODUCTION TO CONCORDIA BEHAVIORAL HEALTH	3
II.	THE BEHAVIORAL HEALTH PROGRAM FOR FLORIDA MEDICAID ENROLLEES	5
III.	COVERED SERVICES, LIMITATIONS AND EXCLUSIONS	6
IV.	EMERGENCY CARE	8
V.	ACCESS TO CARE STANDARDS	11
VI.	CARE COORDINATION: AUTHORIZATIONS & REFERRALS	12
VII.	UTILIZATION MANAGEMENT PROGRAM	19
VIII.	QUALITY MANGEMENT AND IMPROVEMENT PROGRAM	25
IX.	CLAIMS	32
X.	PROVIDER SERVICES	37

APPENDIX

A.	COVERED SERVICE REQUIREMENTS	45
B.	HOSPITAL DISCHARGE PLANNING GUIDELINES	54
C.	SERVICE VISION AND CORE TREATMENT VALUES	55
D.	ENROLLEE-CENTERED CARE	56
E.	PROMOTING CULTURAL & LINGUISTIC COMPETENCE – SELF-ASSESSMENT	58
F.	WEB-BASED TRAINING RESOURCES	61
G:	MEDICAL RECORDS STANDARDS: CHART REVIEW GUIDELINES	62

I. INTRODUCTION TO CONCORDIA BEHAVIORAL HEALTH

Welcome to Concordia Behavioral Health. We would like to thank you for choosing to actively participate in our Provider Network and for sharing our commitment to ensure that enrollees have access to quality compassionate behavioral healthcare.

This Provider Manual has been developed to help inform and guide your relationship with us.. The Manual aims to describe our mission, values and philosophy, expectations, relevant aspects of our services, and policies and procedures essential to delivering effective, quality care. You will find that our policies and procedures are based on State and Federal regulations and standards set and established by accrediting agencies, the healthcare industry and Concordia's Health Plan clients. When Concordia updates and amends the Provider Manual in response to regulatory changes and/or internal (organizational) policy revisions, notifications will be made in a timely manner and we will provide you with a summary of the changes. Our updated Provider Manual will also be available to you on our website at www.concordiabh.com to download in .PDF format.

We hope you find our Manual helpful and informative. It hopes to address some of the most commonly asked questions providers have. If you have further questions about our processes or need to reach us, our numbers and emails are provided below. We welcome comments and suggestions.

Main Phone Number:	Local (Miami-Dade): 305-514-5300 TTY: 305-514-5399	Toll Free: 855-541-5300
Via Email:	Care Coordination and Advocacy: Provider Relations: Credentialing: Claims:	advocacy@concordiabh.com providers@concordiabh.com credentialing@concordiabh.com claims@concordiabh.com

Concordia's business hours are Monday through Friday 8:30 AM to 5:30 PM. Additionally, there is always a Concordia Care Advocate available to you 7 days a week, 24 hours a day for urgent and emergency situations, benefit decisions, and other care related questions.

We look forward to building a strong and effective partnership with you and always welcome your questions, comments and suggestions.

MISSION AND VISION

To provide a more responsive and compassionate behavioral health care experience.

CORE VALUES

Compassion

Do unto all persons as you would have them do unto you.

Walk in the shoes of others.

Integrity
Never compromise quality, ethics and morals.
Honor commitments.

Creativity
Think outside the box – innovate.
Create the future – maximize its endless possibilities.

Gratitude
Be grateful for the opportunity to employ and serve.

Diligence
Work hard. Excel.

PHILOSOPHY, EXPECTATIONS AND GOALS

At Concordia we are dedicated to administering an ***integrated*** care delivery system that ensures all behavioral healthcare services are clinically responsive, safe, timely, cost-effective, and delivered in a compassionate manner. We hold ourselves to the highest standards and strive to be a socially conscious company that makes a positive difference in the lives of enrollees and those with whom we work. We are committed to continually reviewing and improving *every* process and system to ensure excellent behavioral care outcomes.

The founders of Concordia have been involved in all aspects of the healthcare system. While recognizing that our principal commitment is to the health and well-being of enrollees, we are ultimately guided by a genuine interest in the satisfaction of ALL who are involved in the care delivery process and aim to exceed the expectations of enrollees and Provider-partners. At Concordia, we want to ensure that enrollees receive the most appropriate behavioral healthcare services available in the least restrictive environment possible. We will exercise flexibility in the utilization of resources to achieve a good clinical result. We will work to establish a collegial, cooperative and collaborative relationship with our Network of Practitioners and Providers. Among the benefits you will find in partnering with us are:

- A Company that aims to support the growth of our Provider Partners and that will work to minimize the time our Providers spend on non-client centered practices (e.g., excessive paperwork or waiting for responses)

- A Provider Relations Department and staff that is responsive to the needs of our Providers and strives to foster respectful and mutually beneficial partnerships

- A Utilization Management (UM) team and clinical staff that sees our Network Providers as colleagues – healthcare professionals whose clinical judgment is valuable, who share a vested interest in the care of enrollees and whose time is honored and respected

- Care Coordinators who are trained to facilitate the referral and pre-authorization process

- Care Advocates (Licensed Clinicians) who are accessible 7 days a week, 24 hours a day to manage requests for service, facilitate referrals and authorizations, assist and help

guide level of care transitions, make care and utilization determinations fairly and answer any coordination of care or UM question that may arise

- A Claims department and personnel dedicated to the timely and accurate processing and payment of claims submitted by our Providers for covered authorized services

- A Concordia team that is open to studying and embracing innovative methods for administering effective and responsive behavioral healthcare to enrollees

At Concordia we hold one overriding expectation of our Network Providers – that they join us in promoting high-quality, cost-conscious, compassionate care to enrollees. We believe that instilling trust in the enrollees through our actions and empowering them to make informed decisions regarding their treatment and health are basic aspects of quality care. This enhances their recovery process, contributes to treatment compliance and improves the outcome. Enrollees need to know that when it comes to their behavioral health care, our Network Providers listen attentively, remember their individual stories, respond compassionately, welcome their questions and invite their active participation in the planning of care.

Concordia believes that collaboration and coordination of care by treating practitioners contributes to the delivery of safe, effective and clinically appropriate treatment. Communicating with the enrollee's Primary Care Physician (PCP) is a central piece of this process. We request that our Providers explain the importance of this process to enrollees so that they provide written consent for these communications early in treatment. Concordia Providers can avail themselves to our forms designed to aid this process or use their own.

II. THE BEHAVIORAL HEALTH PROGRAM FOR FLORIDA MEDICAID ENROLLEES

Medicaid is a joint federal and state (authorized by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations) medical assistance program that helps with the medical costs of people with low incomes and limited resources. The federal government sets guidelines for services and pays part of the cost. Each state designs and operates its own Medicaid program based on federal and state guidelines. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code, F.A.C. and is administered in Florida by the Agency for Health Care Administration (AHCA). The Department of Children and Families (DCF) is the state agency responsible for Florida Medicaid eligibility determinations except SSI.

- **About the Medicaid Population:** Among recipients of Medicaid are some of the most needy in our community. Those who receive Supplemental Security Income (SSI) – a federal cash assistance program for low-income aged, blind and disabled individuals – are automatically eligible for Medicaid. Within the spectrum of behavioral health problems, we find some of the most ill in this population: children/adolescents with serious emotional disorders (SED) and adults with severe and persistent mental illness (SPMI). Individuals in these groups require well integrated services capable of bridging the gap between the private and public health care sectors and the "formal" professional support system and "informal" supportive resources in the community. Many enrollees are dually diagnosed with a mental health illness and a substance abuse disorder. Other Medicaid enrollees have complex medical conditions or serious physical disabilities that co-occur with a serious psychiatric disorder. In sum, Medicaid enrollees often present

with serious circumstances and illnesses that require effective coordination of care by state institutions, medical health providers and behavioral health professionals.

- **About the Opportunities:** The ethnic, cultural and linguistic diversity found in the Medicaid population mirrors the richness of our South Florida Community. At Concordia, we will increase our understanding of diverse cultures, fine-tune our ability to communicate cross-culturally and enhance our cultural competence. We ask our network providers do the same throughout their varied practices, facilities, and programs. We encourage our network providers to implement practice models and clinical techniques that have proven to go beyond the important and central task of symptom management to ensure the use of clinical components that *empower.* This includes models that are *person-centered*, *strength-based* and known to enhance *resilience and* promote personal *dignity* and *self-worth*. Concordia also encourages network providers to use evidence based practices associated with recovery-oriented models of care that promote hope, seek to bring meaning into people's lives, and promote the development of a stronger and more enduring sense of self.

III. COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

A. COVERED SERVICES

The following chart includes the behavioral health covered services for Medicaid enrollee's that meet medical necessity criteria for the respective service and level of care. Concordia will require pre-authorization for some services, but not all and will pre-authorize services based on various factors that include enrollee choice, provider qualifications and proximity to the enrollees, and the level of care that best meets the enrollee's clinical presentation. Licensed clinicians will monitor treatment through Concordia's concurrent review processes that are outlined in the next section of this manual. Our clinical staff can be reached 24 hours a day, 7 days a week.

All services must be provided by licensed mental health professionals as specified in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and in the Mental Health Targeted Case Management Coverage & Limitations (the Medicaid Handbooks). We urge you to review them and download a copy to use as reference. They can be accessed in the Provider Section of AHCA (Agency for Health Care Administration) Florida Medicaid website.

Service	Specifics
Inpatient Hospital Services *(Mental Health Diagnosis)*	ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, and 315.9
Crisis Intervention Services – Crisis Stabilization Units (CSU) *(Mental Health Diagnosis)*	Used as a downward substitution for inpatient psychiatric care when determined medically appropriate.
Outpatient Hospital Services	ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293

(Mental Health Diagnosis)	through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
Psychiatric Physician Services *(Mental Health Diagnosis)*	For psychiatric specialty codes 42, 43, 44 and ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, and 315.9
Community Mental Health Services	ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9); and for these procedure codes H0031; H0031HO; H0031HN; H0031TS; H0032; H0032TS; H0046; H2000; H2000HO; H2000HP; H2010HO; H2010HE; H2010HQ; H2012; H2017; H2019; H2019HM; H2019HN; H2019HO; H2019HQ; H2019HR; H2019HR67; T1015; T1015HE; or T1023HE
Targeted Case Management *(Mental Health)*	Children: T1017HA; Adults: T1017
Mental Health Intensive Targeted Case Management *(Mental Health)*	Adults: T1017HK
Community Substance Abuse Services (Not Covered through Concordia. Concordia does facilitate coordination of these services when necessary. These services are covered through fee for service system)	When the appropriate ICD-9 CM diagnosis code (290 through 290.43, 293.0 through 298.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9) has been documented: H0001; H0001HN; H0001HO; H0001TS; H0047; H2010HF; H2012HF; T1007; T1007TS; T1015FH or T1023HF

B. SERVICE REQUIREMENTS

(See Appendix A: Service Requirements)

C. NON-COVERED SERVICES

The following is a list of the behavioral health services Concordia does ***not*** cover for Health Plan-Medicaid enrollees:

- Specialized Therapeutic Foster Care
- Therapeutic Group Care Services
- Behavioral Health Overlay Services
- Community Substance Abuse Services
- Residential Care
- Statewide Inpatient Psychiatric Program (SIPP) services
- Clubhouse Services
- Comprehensive Behavioral assessment
- BH services to enrollees assigned to a FACT team by the DCF Substance Abuse and Mental Health Program (SAMH) Office.

- **Long-Term Care Institutional Services** (in a nursing facility, an institution for persons with developmental disabilities, specialized therapeutic foster care, children's residential treatment services or state hospital services) are ***not*** covered. Please contact a Concordia Care Coordinator or Care Advocate if a Medicaid enrollee requires Long-Term Care Institutional Services. The Concordia representative will consult the Medicaid Area Field Office and/or the local DCF SAMH (Administrative) Office for assistance in identifying appropriate methods of assessment and referral. Concordia is responsible for the transition and referral to appropriate service providers.

- **Substance Abuse Services:** Medicaid enrollees will receive Medicaid-funded substance abuse services through the fee-for-service system. Concordia shall coordinate and integrate mental health and substance abuse services for enrollees, using the Florida Supplement to the American Society of Addictions Medicine Enrollee Placement Criteria for the coordination of mental health treatment with substance abuse providers as part of the integration effort (Second Edition ASAM PPC-2, July 1998). For enrollees with co-occurring disorder, the Concordia practitioner providing current mental health service to the enrollee must ensure that the coordination is reflected in their individualized treatment plans.

- **Enrollees Assigned to a FACT team:** Concordia is ***not*** responsible for the provision of behavioral health services to enrollees assigned to a FACT team by the DCF Substance Abuse and Mental Health Program (SAMH) Office.

- Enrollees in Area 10 (Broward County – Only*)* – Florida Safe Families Network (FSFN): Concordia is *not* responsible for providing behavioral health services to Enrollees with open Florida Safe Families Network (FSFN) Cases. Such Area 10 (Broward) enrollees shall receive their behavioral health services through FFS Medicaid or through the Area 10 child welfare delivery system once that system is implemented.

  (For all other counties) – Child Welfare Prepaid Mental Health Plan (CWPMHP): Concordia is *not* responsible for providing behavioral health services if those enrollees are also enrolled in the Child Welfare Prepaid Mental Health Plan (CWPMHP). Those enrollees shall receive their behavioral health services through the CWPMHP.

Provision of BH Services When Not Covered by the Enrollees Health Plan: If Concordia determines that an enrollee is in need of behavioral health services that are *not* covered under the Health Plan/Medicaid Contract, Concordia will assist in referring the enrollee to the appropriate provider. When needed, Concordia shall request the assistance of the Agency's local field office or the local DCF SAMH Office for referral to the appropriate service setting. Concordia is responsible for the transition and referral of the enrollee to appropriate providers.

IV. EMERGENCY CARE

A. (24/7) ACCESS & AVAILABILITY: Enrollees with emergencies have access to behavioral healthcare immediately. Concordia is wholly committed to ensuring the safety of it all its enrollees and understands that a behavioral health emergency can arise any time of day or night. Concordia ensures the availability of emergency services and care 24 hours a day, 7 days per week.

Toll-Free Emergency Line: **1-855-541-5300/305-514-5300**

In each county it serves Concordia has designated an emergency service facility that operates twenty-four hours a day, seven days a week, with Registered Nurse coverage and on-call coverage by a behavioral health specialist.

Linguistic Access: For Limited English Proficient (LEP) enrollees, Bilingual (English / Spanish) staff enrollees are available. Concordia accommodates all other non-English speaking enrollees through a telephonic translation service. For those with hearing impairment, we provide a TTY: **305-514-5399**

Approval: Emergency BH services are approved without prior authorization when a prudent layperson, acting reasonable, believes that an emergency exists, or an authorized representative acting for Concordia has authorized the provision of emergency services

Notification: Emergency Service Providers must make a reasonable attempt to notify Concordia within twenty-four (24) hours of the enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification, or is unable to orally identify himself/herself when presenting for behavioral health services, the provider shall notify Concordia within twenty-four (24) hours of learning the enrollee's identity. The emergency service provider should attempt to notify Concordia within twenty-four (24) hours or on the next business day. Concordia will not deny claims payment based on lack of notification for emergency services. When a retrospective (post service) review of the emergency care is required, Concordia will consider the presenting symptoms and the enrollee's belief that a true emergency existed.

B. KEY DEFINITIONS:

- **Emergency Medical (MH) Condition:** Concordia uses and applies the definition of *"emergency medical condition"* provided by the Balanced Budget Act (BBA, 1997) as:

  > "A medical condition manifesting itself by acute symptoms of sufficient severity *(including severe pain)*, *such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part."*

- **Emergency Behavioral Health (MH) Services:** Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility. [Florida Statute 395.002.(9)]

C. ADDITIONAL EMERGENCY PROVISIONS:

- **Baker Act Examinations:** Concordia will not deny emergency behavioral services for enrollees presenting at receiving facilities for involuntary examination under the Baker Act / court-ordered commitment.

1. The receiving facility will make every effort to notify the Health Plan within twenty-four (24) hours of receiving the enrollee.

2. The Health Plan will begin coordinating the enrollee‘s care upon notification by the receiving facility.

3. A stabilized condition is determined when the physician treating the enrollee decides that the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the Health Plan (42 CFR 438.114(d)(3).

- **Lack of Parental Consent:** Concordia will **not** deny claims for Emergency Services and Care received at a Hospital due to lack of parental consent.

D. PROTOCOL: OUTPATIENT CRISIS INTERVENTION

If a Concordia enrollee presents to you in a crisis situation and is in need of immediate medical attention, 9-1-1 should be called. If the enrollee's crisis does not need immediate medical attention, Concordia will authorize one to two evaluation sessions so that you can further assess the enrollee's need, acuity of symptoms and make necessary treatment recommendations. If the enrollee has an adequate support system and can be safely treated on an outpatient basis, this level of treatment can be arranged with a Concordia Care Advocate. If you determine that his/her condition and/or current mental state requires a higher level of care or more intensive treatment, such as a potential inpatient hospitalization, our Care Advocate will assist you in coordinating the hospitalization and in facilitating a timely, safe transfer. Enrollee safety is our primary concern.

When a Concordia enrollee has been admitted to an intensive or acute treatment setting, it is our policy that discharge planning begin at the time of their admission. Prior to their discharge, we require that an enrollee have an after-care appointment scheduled with a Network Provider within 7 calendar days of discharge. Our licensed Care Advocates will follow-up with the enrollee to remind him/her of the after-care appointment.

As part of Concordia's Network of Providers all MD practitioners are expected to be either directly accessible to enrollees in an emergency situation, have an on-call provider acting in their place for admitting purposes or a service that provides direction to an enrollee seeking emergency services. Organizational providers must either be accessible or have an on-call staff available to enrollees seeking emergency care. All other providers/practitioners must have an on-call arrangement for their enrollees in crisis.

V. ACCESS TO CARE STANDARDS

Concordia is committed to making access to care as convenient and timely as possible for all enrollees.

ACCESS CONSIDERATIONS: Four cornerstone principles serve as the foundation to our care standards. For Concordia, access is determined by services/care that are:

1. **Available:**
    - Can handle service referral without placing enrollee on a long waiting list
    - Located relatively near enrollees,
    - Hours of operation that are reasonable and convenient
2. **Appropriate:**
    - The service is medically/clinically indicated and practice is evidenced based
    - Provider is licensed/certified, practicing within the scope of their experience and expertise
    - Providers and facility/office personnel are sensitive to and incorporate individual and cultural values
    - Communication with other behavioral health providers or medical providers
3. **Affordable and Effective:** Service that offer value: clinically effective and cost-efficient
4. **Acceptable:** The enrollee must find the service suitable and agreeable – they must feel welcomed, respected, well-regarded and cared for. Enrollee satisfaction is key.

A. ACCESS TIMEFRAME STANDARDS: Our standardized access to care guidelines and timeframes are established to help guide this process, internally (utilization and care management) and externally, among our Network Providers. Through our Utilization Management (UM) and Quality Improvement (QI) processes, Concordia continuously monitors, measures and evaluates service performance to ensure that we, as an organization, and our network service providers are meeting or exceeding them. We count on our contracted Network Providers meeting or exceeding the access standards when accepting our referrals and setting up appointments for enrollees.

The access standards are as follows:

Concordia's Access To Care Standards – Medicaid Enrollees		
Situation	**Description**	**Timeframe**
Emergency	Emergency mental health services are defined as those services that are required to meet the needs of an individual who is experiencing and acute crisis resulting from mental illness, which is at the level of severity that would meet the requirement for involuntary hospitalization, pursuant to Chapter 394.463, F.S., and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.	Must have access to behavioral health emergency service **immediately and/or or 24 hours a day, 7 days per week**
Urgent	Urgent behavioral healthcare are those situations that require immediate attention and assessment, though the individual is not	Must have access to urgent care services within **24 hours**

	in immediate danger to self or others, and is able to cooperate in treatment.	
Routine "Sick Care"	Non urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated.	Must have access to routine "sick care" service **within seven (7) calendar days**
Routine "Well Care"	Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated.	Must have access to routine "Well Care" services **within one (1) month**
Psychiatric Consults		These should occur within **24 hours** for routine consults.
Psychological Testing		Evaluations should be done within **30 days**.

Enrollees with emergencies have access to behavioral healthcare immediately (24 hours a day, 7 days per week)

VI. CARE COORDINATION: AUTHORIZATIONS & REFERRALS

Main Numbers:	Local (Miami-Dade): 305-514-5300 Toll Free: 855-541-5300 TTY: 305-514-5399
Fax Number::	Local (Miami-Dade): 305-514-5301
Email:	Care Coordination and Advocacy: advocacy@concordiabh.com
Mailing address:	Concordia Behavioral Health Attn: Care Coordination and Care Advocacy Department 7190 SW 87th Avenue, Suite 204 Miami, FL 33173

A. CARE COORDINATION STAFF:

- **Staff Availability and Access**: Representatives from all Concordia departments are available to personally assist you in all ways that enhance the service you provide.
  - *Routine (Non-Urgent) Contact:* While we are accessible at all times, we appreciate that you contact us during our regular business hours on matters that are non-urgent. Our business hours are: Monday – Friday from 8:30AM to 5:30 PM EST [Eastern Standard Time].
  - *After hours Service Calls/Emergencies:* as described previously in Section IV Emergency Services. Calls received through our after hours service are responded to within thirty (30) minutes from receipt of call. For urgent and emergent needs, UM determinations are immediately addressed and appropriate action(s) taken.

- **Role of the Care Coordinator in the Initial Authorization & Referral Process**: When enrollees contact Concordia with a request for service Concordia's Care Coordinators assist in arranging needed care. Their tasks include but are not limited to:

    - Conducting the initial screening to identify the presence of an emergent/urgent/complex need and engaging a Care Advocate (licensed BH professional) in the process when necessary
    - Determining the nature of routine requests and service needs
    - Confirming enrollees' identifying information (name, phone, date of birth, and zip code)
    - Verifying eligibility and benefits – informing enrollee of any limitations and/or financial obligations, when applicable. (When an enrollee's health plan excludes coverage for needed care/service, the care coordinator provides information about available care options, community resources, coordinates referrals, and/or may seek the assistance of a Care Advocate)
    - Identifying access to care barriers and helping to, effectively, remove/minimize them
    - Guiding enrollees through the steps of the referral and authorization process until successfully linked to the service

- **Role of the Care Advocate in the Initial Authorization & Referral Process:** If the request is determined to present an emergent, urgent or complex need, the Care Coordinator immediately transfers the enrollee to a licensed Care Advocate who assesses the need, screens for the presence of imminent risk(s) and takes immediate measures to help ensure enrollee safety. The Care Advocate determines the most appropriate level of care, arranges disposition and coordinates the provision of the needed service.

B. GENERAL STANDARDS, REQUIREMENTS AND CONSIDERATIONS:

- Concordia has established authorization policies for all covered Medicaid services
- Concordia determines enrollee eligibility for behavioral health services through:
    - Their health plan eligibility and benefit coverage at time of service request,
    - The type of service requested, and
    - Medical necessity / clinical criteria, level of care (LOC) guidelines.
- To ensure fairness and equity all authorization decisions/utilization review determination are made by licensed clinical staff consistently applying Concordia's standardized medical necessity criteria. Concordia's Care and Coverage Guidelines and Level of Care criteria (LOC) are utilized when necessary.
- When appropriate/necessary, the requesting provider is consulted / peer-to-peer review is coordinated.
- All concurrent reviews are conducted with oversight by the Medical Director and supervision by the Director of Utilization Management; The Medical Director is available at all times for consultation on utilization decisions– 24 hours a day, 7 days a week.

- Any compensation to individuals or entities that conduct UM activities / care determination for Concordia is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
- Concordia strives to respond to all care determination requests expediently and meet or exceed the national, state and industry standards.

C. INITIAL AUTHORIZATION AND REFERRALS: OUTPATIENT (ROUTINE) SERVICES:

❖ **Enrollee Request for Initial Outpatient Authorization:** Enrollees can access initial outpatient behavioral healthcare services in various ways. For example, an enrollee or a designated enrollee representative (e.g., a family enrollee/authorized representative) can contact Concordia directly, an enrollee's Primary Care Physician (PCP), or a representative from the enrollee's health plan can contact Concordia to request services for the enrollee. Additionally, the request can come from a community Mental Health Center. At Concordia, we are committed to making access to care as convenient and timely as possible.

❖ **Provider Selection:** Once our Concordia Care Coordinator verifies that the enrollee is covered and eligible, they will guide the provider selection process. Concordia will generally refer Medicaid enrollees to Community Mental Health Centers; however, network providers are also available. If the enrollee has been previously treated by one of our practitioners, they are offered the opportunity to return in an effort to enhance continuity. When they are needing to be referred to a provider the selection process will consider such factors as:

- The enrollee's medical/clinical necessity, level of care, and the type of services that best meets their clinical needs
- (As the enrollee's condition permits) Any special needs, access requirements, individual preferences – including ethnic, gender, cultural, linguistic
- Whether the provider is eligible for participation in the Medicaid program and has an active Florida Medicaid provider number
- The provider's qualifications, expertise, scope of practice, the extent of their experience serving the particular population represented by the enrollee and his/her need – this is especially important in the case of adult enrollees who are severely and persistently mentally ill, with children/adolescents who are severely emotionally disturbed, with enrollees with an HIV status
- The provider's cultural and linguistic competence
- The provider's geographic proximity to the enrollee
- The provider's availability for a new referral

❖ **Enrollee Choice:** Concordia honors, respects and protects the enrollee's right to self-determination, participation in treatment planning decisions, and personal choice. Concordia allows each enrollee to choose among network providers to the extent possible and appropriate. The coordinator will offer the enrollee the names of qualified behavioral health care providers and their contact information, making every effort to match the enrollee's needs to providers who are best suited to meet them. If requested, the Coordinator will assist the enrollee with making an appointment with the provider that is within the required established access times. All services must be provided in an adequate and timely manner.

- **Provider Requests for Initial Outpatient Authorization:** Concordia's initial authorization policies are consistent with the provisions in the Medicaid Coverage and Limitations Handbooks. Some service will require pre-authorization and others will not. Services such as Targeted Case Management, Psychosocial Rehabilitation, T-Bos, and Psychological Testing will require ongoing concurrent reviews for medical necessity determinations related to this level of care. Concordia will distribute a Medicaid Authorization Policy Grid to our Network providers to facilitate this process. Prior to paying a claim, Concordia will always verify eligibility and benefits and ensure that the enrollee was eligible for the billed service on the respective billed date. Concordia will also ensure adherence to the service limitations listed in the Handbooks.

D. CONTINUED OUTPATIENT AUTHORIZATION: CONCURRENT REVIEWS

- **The Outpatient Treatment Plan:** Pre-authorization is required for continued treatment beyond what is stipulated in the Medicaid Authorization Policy Grid. If the enrollee's condition requires care beyond the outpatient services that Concordia initially authorized, providers must complete and submit a *Confidential Outpatient Care Advocacy Treatment Plan* with updated clinical information before exhausting the initial authorized visits. [See Appendix B: The form is available for download from our website's Provider Portal at www.concordiabh.com .]

  Once completed the Treatment Plan can be submitted to our Care Advocacy Department for review via any one of the following options:

  - e-mail: advocacy@concordiabh.com (as an attachment)
  - Via fax: Local (Miami-Dade): 305-514-5301 / Toll Free: 855-698-5301
  - Through the U.S. Mail: Concordia Behavioral Health

    Attn: Care Coordination and Care Advocacy Dept.
    7190 SW 87th Avenue, Suite 204
    Miami, FL 33173

- **Communication and Coordination of Care with Other Health Providers:** Please note that the *Confidential Outpatient Care Advocacy Treatment Plan* urges you to communicate with the enrollee's Primary Care Provider (PCP) to coordinate care after securing permission from the enrollee. Concordia policy requires such contact and considers it essential in promoting and ensuring safe, quality care. Medicaid also requires that Physicians coordinate medically necessary behavioral health services with the PCP and other providers involved with the enrollee's care. Communication and the coordination of care between behavioral health clinicians and PCPs improves the quality of enrollee care by:

  - Minimizing potential adverse medication interactions
  - Promoting early detection of medical conditions that might be contributing to or causing psychiatric symptoms
  - Providing more efficient and effective treatment
  - Reducing the risk of relapse for enrollees with substance abuse disorders
  - Promoting early identification of non-compliance with treatment

  High-risk communication criteria: The high-risk communication criteria identified below are some particular circumstances in which communication between behavioral health

practitioners/providers and medical care providers/specialists should occur to promote optimal, safe and effective behavioral health care:

- Enrollees with a pre-existing medical condition treated by their PCP with medications that may impact psychiatric symptoms
- Enrollees with behavioral symptoms that may be a side-effect of prescribed medication(s) or that may be masking an underlying undiagnosed/untreated medical disease (e.g., metabolic disease, neurological disorder or other medical condition that needing to be ruled out and treated, if present)
- Enrollees prescribed psychotropic medications by their PCPs
- Enrollees prescribed psychotropic medications by their Psychiatrist
- Enrollees with a history of substance abuse – especially a history of abusing prescribed medications
- Enrollees whose safety may be at risk – suicidal/homicidal/other impulses
- Enrollees whose mental status suddenly changes for the worse
- Enrollees with a history of recent falls (especially an elderly client)
- Enrollees who fail to improve or show sufficient response to behavioral treatment

Communication between Behavioral Health Providers: We also encourage the exchange of information between behavioral health practitioners that are providing concurrent care. We encourage our Network Providers to include this aspect of care in their standard practice and that enrollees be educated, early in treatment, about its importance to encourage that they provide a signed informed consent to release confidential information / authorize this essential communication during their episode of care.

❖ **Request for Authorization of Psychological Testing:** Psychological testing (standardized tests), when determined medically necessary, are covered for adults and children under certain conditions. It is not considered to be a routine part of the assessment process for any behavioral health service. Yet, psychological testing may play an important role in determining the appropriate course of treatment when the normal assessment process – i.e., clinical interview, mental status exam, medical and psychiatric history, bio-psychosocial assessment (including prior clinical assessments) – has not provided sufficient evidence to make a substantiated diagnosis, develop appropriate interventions, and formulate a meaningful treatment plan.

All psychological testing must be pre-authorized and conducted by a qualified licensed psychologist trained and experienced in administering the testing tool. The determination to utilize a psychological evaluation must be based on medical necessity for the purpose of appropriately treating a medical condition.

Some of the considerations our Care Advocate will take in arriving at a determination include, but are not limited by the following:

- Will the evaluation yield answers to diagnostic questions when other means of assessment (e.g., clinical interview, etc.) have been ruled out or exhausted?

- Will the evaluation help clarify the most appropriate diagnosis when presenting symptoms suggest two or more possible diagnoses?
- Is the testing integral to effective treatment planning and might it yield new information regarding the best form of treatment (testing that yields information that will not be applicable to treatment goals is discouraged)?
- Confirmation that the testing is not for purposes of research, educational evaluation, medical procedures or career placement.

❖ **The Role of the Care Advocate in Concurrent Reviews:** A Concordia Care Advocate (a qualified behavioral health professional, duly licensed to practice), with oversight by the Medical Director and Director of Clinical Operations, will review the updated information submitted. The review will take into consideration the clinical information provided, the information contained in the utilization management database regarding the enrollee's episode of care and other relevant information. The decision-making process will apply the medical necessity (clinical) as well as the benefit coverage criteria.

The Care Advocate may contact a provider to gather additional clinical information. We ask that you respond to their requests in a timely manner. Our Care Advocate will collaborate with you in ways that promote enrollee safety and enhance positive outcomes. They may discuss aspects of care such as: communication and coordination of enrollees' care with their Primary Care Provider (PCP), possible risk factors and their management, additional and/or alternative treatment options, clinical approaches or modalities, community resources to consider, discharge/termination criteria and planning process, aftercare considerations, and any other pertinent aspects of care that can contribute successful, effective treatment.

Concordia's Care Advocate can serve as a resource in ways such as:

- Help identify enrollees who are, or may be, at risk and collaborate with you to coordinate and deliver the appropriate care
- Facilitate communication and exchange of information between medical and behavioral health providers with enrollee consent
- Offer clinical consultations with medical staff
- Provide references for web-based resources and tools that can support informed decision-making involving care (e.g., relevant MH/SA evidenced based techniques, treatment options, innovative practices, ancillary community resources, etc.)
- Provide information regarding clinical practices that can promote stabilization and recovery, engage enrollee's active participation in treatment and increase the likelihood of positive treatment outcomes.

E. ACUTE INPATIENT AUTHORIZATIONS & OTHER INTENSIVE LEVELS OF TREATMENT

Initial Authorization: Except in the case of a behavioral health emergency, in enrollee acute care and intensive levels of care require pre-authorization. All requests are coordinated through the Care Advocacy Department with oversight by the Medical Director and supervision by the Director of Utilization Management. As in requests for outpatient services, determinations are based on the enrollee's health plan eligibility and coverage at the time of the request and medical necessity.

Authorization for Continued Care/Stay: Requests for authorization to continue acute inpatient levels of treatment require a concurrent review that is conducted telephonically. The review is performed by a Concordia Care Advocate. These telephonic reviews are scheduled in advance with the facility's utilization review staff / designee. Telephonic reviews may be conducted 24-hours a day / 7 days a week. The reviewer will gather sufficient information to enable a care determination, including an update on enrollee's clinical presentation, behavioral symptoms, level of function, treatment progress, and discharge planning. At minimum, when authorized, the services will be approved through the next business day for inpatient or urgent care initial review or concurrent review cases. Confirmation of certification/authorization for continued hospitalization or services will include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

Coordination of Hospital Discharge Panning: The concurrent review process for acute inpatient (hospital) treatment and care provided by a Crisis Intervention Unit (CSU) includes the coordination of discharge planning for psychiatric admissions and substance abuse detoxification to ensure inclusion of appropriate post-discharge care. This provision does not apply to admissions to residential settings that are ***not*** covered by the Health Plan. Appropriate discharge planning, at minimum, must include, but is not limited to:

a. Enrollees admitted to an acute care facility (in enrollee hospital or CSU) shall receive appropriate services upon discharge from the acute care facility.

b. Concordia shall have follow-up services available to enrollees within seven (7) (24) days of discharge from an acute care facility, provided the acute care facility notified Concordia it had provided services to the enrollees.

[See Appendix C: Hospital Discharge Planning Guideline]

F. NOTICE OF AUTHORIZATION

Notice of Authorization Concordia's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.

Once Concordia has pre-authorized care, we will automatically fax, mail or email a *Notice of Authorization* to the provider by the closing of the next business day. The *Notice of Authorization* provides the authorization number and effective dates for authorization to providers and non-participating providers.

It is important to confirm the accuracy of the information contained in the authorization confirmation form – including that the provider identifying information is correct and that the authorization reflects the specific service(s) they will be providing. If an error is detected, contact Concordia immediately to rectify the information. Failure to do so may render a denial of payment. When submitting claims, providers need to include the authorization number(s) issued for the respective services. Concordia will not grant retrospective authorizations for non-emergency, routine care.

G. NOTICE OF DENIAL OF SERVICES

- ❖ All utilization management reviews consistently apply Concordia's standardized medical necessity criteria, Concordia's Care and Coverage Guidelines, and level of care (LOC) criteria to ensure fairness and equity.

- In accordance with 42 CFR 438.210(b)(3), all decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease. Only Concordia's Medical Director may authorize a denial for an initial or concurrent authorization of any request for behavioral health services. The psychiatrist's review shall be part of the UM process and not part of the clinical review, which may be requested by a provider or the enrollee, after the issuance of a denial.

- In accordance with 42 CFR 438.210(c), Concordia shall provide written confirmation of all denials of authorization to providers.

VII. UTILIZATION MANAGEMENT PROGRAM (UMP): Clinical Criteria & UR Processes

A full written description of Concordia Behavioral Health Utilization Management Program (UMP) is available upon request. For all UM related issues, please contact Concordia at:

Main Numbers:	Local (Miami-Dade): 305-514-5300 Toll Free: 855-541-5300 TTY: 305-514-5399
Fax Number::	Local (Miami-Dade): 305-514-5301
Email:	Care Coordination and Advocacy: advocacy@concordiabh.com
Mailing address:	Concordia Behavioral Health Attn: Care Coordination and Care Advocacy Department 7190 SW 87th Avenue, Suite 204 Miami, FL 33173

A. UM PROGRAM OVERVIEW

Concordia's Utilization Management Program (UMP) is a part of the Quality Improvement Program and overseen by the Medical Director in collaboration with the Director of Utilization Management, and the Director of Quality Improvement. The Programs main goals are to provide for care-decisions that are arrived at fairly and equitably. Its objectives include assuring care is:

1. Medically necessary and clinically appropriate,
2. Provided in a safe, timely manner, and
3. Cost effective (of value)

These goals and objectives are accomplished through two (2) key avenues:

1. By developing and adopting clinical standards and medical necessity criteria to inform and guide the care utilization decision-making process, promote their consistent use (within the organization and among network providers/facilities), identifying patterns of under-/overutilization and ensuring enrollees have equitable access to needed care across the spectrum of network service programs, care facilities and practitioners;

2. By monitoring Network utilization and claims practices to identify patterns and trends that may be incongruent with Concordia's established utilization criteria and accepted national and community standards; assessing and intervening when these suggest provider activities outside the scope of ethical practices, and/or may be suggestive of improper / illegal activity – fraud, waste and abuse.

The UM Program and its respective policies and procedures are reviewed annually and revised as needed as an integral part of our Quality Improvement Program.

B. KEY UM MONITORING COMPONENTS

The Program's monitoring activities may include, but are not limited to the following processes:

- Outpatient & Inpatient utilization
- Patterns of over and under utilization
- Triage and Referral
- Care Coordination and Care Advocacy
- Intensive Care Advocacy: High Risk Cases
- After-Hours Coverage
- Emergency Behavioral Health Care Services
- Authorizations
- Concurrent Review
- Retrospective Review
- Denials
- Discharge Planning
- Inter-rater reliability
- Assessment of acuity and level of care
- Drug Utilization Review
- Satisfaction Surveys (re: UM Process)
- UM Program Evaluation
- Staff training
- Evaluation of new clinical technology and applications for existing clinical technologies

C. PROGRAM COMPLIANCE WITH FEDERAL & STATE REGULATIONS

The UM Program has the duty to monitor and evaluate the safety, timeliness, medical necessity, clinical appropriateness and integrity of services provided by Concordia and our Provider Network. The UM Program is consistent with 42 CFR 456. The manner in which it conforms includes, but is not limited to:

- Establishing procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses.
- Reporting fraud and abuse information identified through the UM program to AHCA's Program Integrity unit.
- Providing mechanisms and processes that include:
    a. Protocols for prior authorization and denial of services that includes consultation with the requesting provider, when appropriate and independent peer reviewer, as needed
    b. Service authorization systems that provide the authorization number and effective dates for authorization to providers and non-participating providers and written confirmation of all denials of authorization to providers
    c. A process for:

- Review of authorization requests that do not delay service authorization if written documentation is not available in a timely manner. (This does not, however, imply that Concordia is required to approve claims for which it has received no written documentation.)
- Evaluation of prior and concurrent authorizations
- Retrospective reviews of both inpatient and ambulatory claims
- Hospital discharge planning
- Assuring enrollees/enrollees are able to obtain a second medical opinion and payments of claims for such services are authorized (in accordance with s. 641.51, F.S)
- Physician profiling

d. Mechanisms that provide for assurance that:

- Review criteria for authorization decisions are consistently applied
- All decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee‘s condition or disease
- Only a licensed psychiatrist is authorized to issue a denial for an initial or concurrent authorization of any request for behavioral health services and that the psychiatrist's review be part of the UM process and ***not*** part of the clinical review (which may be requested by a provider or the enrollee, after the issuance of a denial)
- Compensation to individuals or entities that conduct UM activities is ***not*** structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

A. UM STAFF – AVAILABILITY AND QUALIFICATIONS:

- **Availability:**
  - During our business hours (Monday through Friday, 8:30 AM to 5:30 PM) enrollees and providers can reach our clinical staff via telephone, fax, or email.
  - After-hours access to our licensed Care Advocates for questions about our UM processes (inbound calls) is available 24 hours per day, 7 days per week via our main number. After-hours calls are responded to within **thirty (30) minutes** from receipt of the call. Non-urgent calls received after business hours are responded to by a licensed Care Advocate no later than **one (1) business** day from receipt of the call, unless otherwise agreed upon (outbound calls).

- **Qualified Reviewers:** All utilization reviews are conducted by qualified, licensed behavioral health professionals whose education, training and experience are commensurate with the UM reviews they conduct. Behavioral health professions who have a master’s level or higher degree (e.g., physician/psychiatrist, nurse, psychologist, clinical social worker, or MH counselor). Their overriding responsibility consists of ensuring that enrollee’s available behavioral health benefits are appropriately used and/or maximized. The final decision-maker on any adverse determination (denial) on the basis of medical or clinical necessity is our Medical Director (licensed board certified

psychiatrist). In some cases, when the clinical judgment needed is highly specialized, Concordia may call on an outside expert for consultation.

B. Medical Necessity and Level of Care Criteria:

Clinical care determinations are based on medical necessity criteria, adopted level of care (LOC) and evidence-based practice guidelines. Concordia actively involves practicing practitioners in the review, revision and adoption of medical necessity criteria, including procedures for applying the criteria.

- **Medical Necessity:** Concordia defines medical necessity as services provided by a qualified behavioral health practitioner or provider organization to identify or treat an illness that has been diagnosed, or is suspected, due to reported symptomatology. We adopt Medicaid's guidelines for determining medical necessity / medically necessary care [as per 59G-1.010 (166), F.A.C.].

  Medically necessary services must contain the following elements: The medical or allied care services/goods furnished or ordered must:

  (a) Meet the following conditions:

  1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
  2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the enrollee's needs;
  3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
  4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
  5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

  (b) "Medically necessary" or "medical necessity" for inpatient hospital or CSU services requires that those services furnished in a hospital could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

  (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Medical Necessity for Acute Inpatient:

In determinations for authorizing inpatient hospital services, additional considerations include, but are not limited by, evaluating the following:

- Is the service necessary to protect life, prevent significant illness and/or significant disability?
- Can the attending clinician provide sufficient clinical information for an adequate care-determination?

- Does clinical information provided indicate a history of inpatient admissions with failure to sustain gains on discharge?
- Is another inpatient admission likely to improve the enrollee's condition or symptomatology?

❖ **Level of Care Guidelines:** Appropriate level of care determinations are founded on the principle that care must be provided in the safest, least intrusive, least restrictive and least disruptive setting and manner that be reasonably expected to effectively treat the enrollees illness, intensity of acute symptoms and enrollee's functioning. At any level of care, Concordia emphasizes individualized treatment, where enrollees may enter treatment at any level and be moved to more or less-intensive levels of care. Treatment interventions must be evidence-based and not experimental in nature. Treatment must be short-term and solution-focused.

Concordia's UM Program has adopted Care and Coverage Guidelines, Level of Care Criteria (these include the ASAM) and treatment guidelines by nationally recognized sources (the American Psychiatric Association) for acute and chronic behavioral health and substance abuse conditions. The Quality Improvement Committee is responsible for the development, review and revision of these tools. The guideline selection process includes annual identification of high risk / high volume enrollee demographic data obtained from claims. At least every two (2) years, the Concordia Level of Care Criteria and the Care and Coverage and treatment guidelines are reviewed and when applicable, updated by the Committee. When new scientific evidence or nationally recognized standards are published before the two-year review date, the committee reviews the guidelines at the time the new scientific evidence and/or nationally recognized resource is published and revisions to the guidelines are made when indicated.

If you would like more information on the criteria, please contact us by phone. We always welcome your feedback. Both, our utilization and quality management mechanism are designed to inform and guide our internal care-decisions and aid providers in making decisions about the most appropriate course of treatment for enrollees under their care. They do not replace good, sound medical judgment

C. UM DECISIONS AND TIME FRAMES

❖ **Pre-service and Concurrent Reviews:** It is our goal to make timely care decisions that will promote ease of access to care and minimize disruptions to the delivery of services to enrollees. Our clock for care decisions starts at the time we receive a request for initial or continued authorization. The timeframes for UM decisions are dependent on and responsive to the nature of need and/or the type of service requested. These timeframes comply with the standards set by state and/or federal guidelines.

Care Decision Timeframes

REQUEST: (Verbal or Written notification/request)	**PRE-SERVICE:** Any care/service that Concordia must review to determine authorization, in whole or in part, in advance of the enrollee obtaining care.	**CONCURRENT:** Any care/service that Concordia must review to determine authorization, in whole or in part, during the course of the enrollee's treatment
Urgent Care	**Pre-service *urgent* care request**: The review is conducted and completed *as soon as possible* and no later than seventy **(72) hours** from the date and time of receipt of the request.	**Concurrent urgent care request:** The **r**eview is conducted and completed within twenty-four **(24) hours** of the date and time of the request
Non-Urgent Care	**Pre-service *non-urgent* care request:** The review is conducted and completed within fourteen **(14) calendar days** from the date of receipt of the request	**Concurrent non-urgent care request:** The review is conducted and completed are reviewed and completed within fourteen *(***14) calendar days** from the date of receipt of the request

Notifications of, both, urgent and non-urgent concurrent care decision include the new total days or services authorized, the date of admission or onset of services, the number of days or units of service approved and the next anticipated review point.

- **Post-service Reviews (a/k/a Retrospective Reviews):** These UM reviews are conducted after the completion of a course of treatment. The services were neither pre-authorized nor denied by Concordia. The Medical Director makes all post-service review determinations. Post-service review determinations and notifications are made within thirty ***(30) calendar days*** of receipt of the request and/or upon receiving all clinical information pertinent and necessary to make a medical necessity decision. Retrospective reviews require the complete treatment record for the dates of service under review. Providers have forty-five ***(45) calendar days*** from receipt of the notice requesting submission of the information.

- **Peer Reviews:** When an enrollee's needs fall beyond the definition and scope of the criteria, the case is referred to a Peer Reviewer. Peer Reviewers are expected to make a clinical determination by conducting a thorough, careful and independent/objective review of each case consistent with the standards of good medical practice and medical necessity criteria.

- **Consideration of the individual's Circumstances:** UM clinical determinations also take into account the individual clinical circumstances of the enrollee and the actual resources available. If the local delivery system cannot meet the needs of the enrollee, Concordia may authorizes a higher level of care to ensure that services will meet the enrollee's needs for safe and effective treatment.

- **Drug Utilization Review:** The Drug Utilization Review process is carried out in collaboration with the Health Plan and is designed to encourage coordination between an enrollee's primary care physician and a prescriber of a psychotropic or similar prescription drug for behavioral health problems. It aims to identify those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where there is a significant risk to the enrollee posed by potential drug

interactions between drugs for these conditions and behavioral-related drugs. When it identifies the potential for such problems, the DUR Program notifies all related prescribers that certain drugs may be contra-indicated due to the potential for drug interactions and shall encourage the prescribers to coordinate their care. Notice may be provided electronically or via mail, or by telephonic or direct consultation, as the deemed appropriate by Concordia's reviewer.

- **In making all UM decisions, Concordia enforces several important standards:**
  - We do not encourage decisions that result in under-utilization
  - We do not provide financial incentives for UM decision-makers
  - We do not reward practitioners contingent on their issuing of denials
  - Concordia's decision-making is based only on the appropriateness of care and available benefits

G. DENIALS AND APPEALS

Concordia makes every reasonable effort to avoid disagreements with enrollees and Network Providers regarding utilization management decisions. If attempts to negotiate a mutually acceptable outcome are not successful the enrollee, treating provider or practitioner acting on the enrollee's behalf or a designated enrollee representative (including a family enrollee) has the right to file a complaint or grievance with Concordia or with the Health Plan. Concordia's care management system is configured to maintain a detailed record of reviews and determinations so that the process is timely and sensitive to needs of those involved. Our process ensures timely follow-up, and peer reviews.

Providers can call our UM/Care Coordination Department for assistance on how to proceed with any formal complaint, grievance, or request for reconsideration/appeal of a UM determination. Grievances and Appeals are handled through the health plan and not delegated to Concordia.

H. SATISFACTION WITH THE UM PROCESS

Concordia measures enrollee and provider satisfaction with the Utilization Management Program (UMP) processes annually. Our Stakeholder and Enrollee Satisfaction Surveys include questions specific to the UM program. As another measure for assessing stakeholders' satisfaction, Concordia looks to reported provider and enrollee complaints with our UM processes. When these measures identify opportunities for improvement, the Utilization Review Committee presents the findings to the Quality Improvement Committee. Changes to UMP policies, procedures and processes may be recommended by the Committee and our Director of Clinical Operations is responsible for their implementation. Input from enrollees/health plan enrollees and our Network Providers are always appreciated.

VIII. QUALITY MANAGEMENT AND QUALITY IMPROVEMENT PROGRAM (QIP)

A full description of Concordia Behavioral Health (Concordia) Quality Improvement Program (QIP) and a progress report in meeting our goals is available upon request. We always

welcome your comments, suggestions and ideas on how we can improve care and services. You may contact us at:

Main Numbers:	Local (Miami-Dade): 305-514-5300 Toll Free: 855-541-5300 TTY: 305-514-5399
Fax Number::	Local (Miami-Dade): 305-514-5301
Email:	Quality Improvement Department: quality@concordiabh.com
Mailing address:	Concordia Behavioral Health Attn: Quality Improvement Department 7190 SW 87th Avenue, Suite 204 Miami, FL 33173

A. QI PROGRAM OVERVIEW

Concordia is committed to the continuous improvement of the quality of care that enrollees receive, as evidenced by the outcomes of their care. We aim to meet or exceed the needs and expectation of those who use our services. The organization continuously strives to ensure that:

- The treatment provided incorporates evidence based, effective practices;
- The treatment and services are appropriate to the needs of each individual served, and available when needed;
- Safety is priority – managing/reducing/eliminating risk to enrollees, providers and staff takes precedence, and preventing medical errors and complications are of primary importance;
- The enrollee's individual needs and expectations are respected – or those whom they designate as representative; they are given the opportunity to participate in treatment decisions. Services are provided with sensitivity, compassion, and cultural competence;
- Treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and service providers.

Our Quality Improvement Program (QIP) philosophy recognizes that quality management and improvement are key to success. The Program is guide by a *quality management philosophy* that believes all systems, processes and activities can be continuously improved through the application of systematic techniques and quality-building strategies. QI is a process that also contributes to enrollee satisfaction. We use three central QI functions:

1. *Discovery*: The formal process of systematically and objectively monitoring and reviewing care; actively collecting information, data, and feedback; analyzing findings and identifying trends, strengths and opportunities for improvement.
2. *Remediation:* The formal process of implementing corrective actions to overcome barriers to quality care, resolve specific problems and/or remedy deficiencies. Ensuring follow-up to assess the effectiveness of the corrective actions taken. Problems identified are resolved based on the prevailing community practices and professional standards of care.

3. *Continuous Improvement*: The formal process of utilizing the information obtained through QI monitoring processes in ways that lead to specific quality enhancements.

B. PROVIDER PARTICIPATION: We are certain of fulfilling our commitment to excellence with provider support of seven QI Principles.

1. *Enrollees come first:* We are enrollee-driven. Our services must be responsive and designed to meet the needs/requirements of enrollees. We place emphasis on identifying and understanding their needs, requirements, preferences, and expectations – and set out to meet or exceed them. Ultimately, those who use our service and receive care are best positioned to evaluate and determine their quality. The 'Voice' of enrollees is valuable in helping us drive quality improvement initiatives and the design and implementation of new services.
2. *Recovery Oriented Services:* We are committed to promoting recovery-focused, strength-based services that empower enrollees by focusing on their strengths and potentials. We encourage providers to teach enrollees the skills necessary to utilize their existing natural support systems and access supportive community services. We encourage the use of interventions that preserve wellness and expand choice and self-determination. [See Appendix D: *Core Treatment Principles & Values*]
3. *Data Informed Practice*. Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions. Tools and methods that turn data into information and foster knowledge and understanding are used to inform our quality-care decisions.
4. *Quality improvement is continuous:* It never ends. Processes must be continually reviewed and improved. Concordia, network providers, and enrollee's need to be accountable. In order to achieve the highest levels of quality and performance excellence, improvement needs to be a regular part of our daily work. Small incremental changes make an impact and service providers can almost always find an opportunity to make things better in how they deliver their services. A continual process of data-gathering, measuring, and analysis is essential to measuring our performance, identifying service 'gaps' and performance barriers, determining root causes, implementing improvement strategies and testing their outcome.
5. *Quality Improvement Involves Everyone:* Quality improvement spans across the full extent of our organization and has no boundaries. Our work is a process and part of an interrelated / interdependent system: Each department and staff enrollee fulfills an essential function and role in quality care. Everyone influences outcome and contributes to building and developing quality and producing the outcomes desired. When deficiencies or barriers are identified our QI Program focuses on *processes* rather than individuals.
6. *Leadership Involvement in QI is Instrumental:* Strong leadership, direction and support of quality improvement activities by the governing body (Board of Directors) and CEO are key to performance improvement. Their involvement assures that quality improvement initiatives are consistent with our mission, goals and strategic plan.
7. *Prevention over Correction:* We seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.

As a Concordia Network Provider, you have agreed to collaborate with Concordia's QI processes and activities, including, but not limited to:

- Participating and cooperating with all relevant aspects of our QIP
- Adhering to clinical practice guidelines, all applicable state and federal laws, regulations and accreditation care standards
- Protecting Enrollees' privacy and their Protected Health Information (PHI) by maintaining their records secured, their information private and confidential and appropriately using and disclosing Enrollee information according to HIPAA regulations
- Helping identify early on in treatment, at-risk Enrollees, complex cases and collaborating with Concordia's Care Advocates in planning appropriate services and safe and effective levels of care
- Providing Enrollees with prompt appointments, and rapid follow-up upon discharge from inpatient care, as per our established access to care standards and timeframes
- Promoting continuity and coordination of Enrollees' care by effectively communicating and collaborating with Enrollees' Primary Care Physicians (PCP) and other treating clinicians and/or facilities, with enrollee's written consent.
- Cooperating with on-site audits and chart review of enrollees' medical/ clinical records
- Cooperating with Concordia in addressing Enrollee complaints and helping to resolve them in a timely fashion.

Cultural competence allows for care that is sensitive and responsive to cultural differences. Providers should be aware of the impact of culture and possess skills to help provide services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation, language, family systems, or physical disability. The practice of continuous self-assessment and community awareness is strongly encouraged and expected. There are certain treatment approaches that have been identified as effective in providing culturally sensitive care. One in particular – with multiple other outcome related benefits - is the Person-Centered Approach. [See: Appendix: *Person-Centered Care*]

Concordia has a comprehensive Cultural Competency Plan (CCP) that is an integral part of QI and is in compliance with CFR 438.206 and AHCA (Medicaid) requirements designed to ensure that services and care are provided in a culturally competent manner to enrollees – including those with limited English proficiency (LEP). An LEP person cannot speak, read, or understand the English language at a level that permits effective interaction with clinical or nonclinical staff. We encourage our Providers to take a self-assessment test to determine their current level of cultural competence and avail themselves of some of the free web-based Cultural Competence training courses to enhance their skills. We provide a list of some web-based resources and a sample self-assessment tool at the end of this Manual [See Appendix F: *Promoting Cultural & Linguistic Competence – Self-Assessment Checklist for Providers, and* Appendix G*List of Web-based Training Resources*]

To overcome language barriers to care, Concordia provides language assistance services, including bilingual staff (English-Spanish) and a language interpreter service, at no cost to enrollees with limited English proficiency (LEP). Additionally, we also provide a TTY line for those with speech or hearing impairments.

To request a copy of our CCP, please contact our Quality Improvement Department.

B. PERFORMANCE IMPROVEMENT PROJECT

The QI Program implements at least one clinically-oriented Performance Improvement Project (PIP) that focuses on an area where a performance 'gap' has been indentified (i.e., where performance falls short of expected levels / when the care of service does not reach benchmarked targets). The selection of PIPs is informed and guided by the QI Committee and adheres to Health Plan / AHCA (Medicaid) contract guidelines. The standards call for all PIPs achieving, through on-going measurement and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on behavioral health outcomes and enrollee satisfaction. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following the application of an intervention. Change must be statistically significant at the 95% confidence level and must be sustained for a period of 2 additional re-measurements.

C. ENROLLEE FUNCTIONAL ASSESSMENT

It is expected that services provided to enrollees will result in positive outcomes. As part of the QI Program monitoring performance outcomes helps identify improvement opportunities. For all Health Plan-Medicaid enrollees – children, adolescents and adults – providers are required to administer an age appropriate functional assessment at onset of care and at time of termination or discharge. For all enrollees over the age of 18 you will need to use the *Functional Assessment Rating Scales* (FARS); for all enrollees age 18 and under you will need to use the *Children's Functional Assessment Rating Scales* (CFARS). Both instruments have been approved by the Joint Commission on Accreditation of Hospital (JCAHO).

You will need to maintain the results of the FARS and CFARS assessments in each enrollee's confidential clinical record, including a chart trending the results of the assessments and report FARS/CFARS data to us so we can submit it to the enrollee's Health Plan.

As clinical tools both instruments can help identify and document the enrollee's level of cognitive and behavioral (social or role) functioning and lead to helping develop the enrollee's individual care plan as well as monitor progress on achieving short-term and long-term goals. Most clinicians surveyed by the Institute that developed the tool (University of South Florida – Louis de la Parte Institute) reported that it took only 5-10 additional minutes to complete the assessment tools after conducting their mental status exam. You will need to receive DCF training that is provided free of charge on the web. You can get more information, including their web-based training at their website at: http://samh-fars.dcf.state.fl.us/fars/farshome.aspx

F. ACCESSIBILITY QUESTIONNAIRE/SURVEY

Annually Concordia will distribute a questionnaire surveying outpatient appointment accessibility based on the urgency of care need. Survey responses, along with enrollee complaints about inability to access a timely outpatient appointment, are analyzed collectively and findings are incorporated into a report that is presented to the Utilization Management Committee, the Credentialing Committee and the Quality Improvement Committee. Based on the report's findings, the committees identify and prioritize opportunities for improving access to care and will implement a corrective action plan (CAP) considered likely to have a positive impact on access performance.

Responses allow us to determine whether Provider Services/Contracting needs to recruit additional service providers to expand our network so hat we can effectively meet or exceed access to care standards. Additionally, based on responses we can modify our referral practices in the cases in which providers availability has changed. When the findings / When the analysis of findings identifies that an individual provider's rate of compliance with access to care standards falls below an established performance threshold, and/or when there's a trend in enrollee complaints about a provider's inaccessibility, a corrective action plan (CAP) is developed in Committee and implemented to target the area that the provider need to improve. The practitioner shall forward his/her planned remedies to Concordia QI Department within **thirty (30) days** of Concordia's notification. Concordia will subsequently review the outcome of the CAP for its effectiveness and either makes changes to the plan if further improvements are needed, or conclude the issue/problem has been satisfactorily resolved. Outcomes are reported to Utilization Management, Credentialing Committees and Quality Improvement Committees. Performance issues are considered at time of recredentialing. In situations in which enrollee safety may be jeopardized and immediate action is necessary to ensure their safety, it is swiftly taken and can include transferring the enrollee to another provider's care and placing restrictions on the provider pending further investigations and/or evidence indicating sufficient and satisfactory improvement/correction in the performance area so that we can reasonably assure enrollee safety.

G. SATISFACTION SURVEYS

Concordia is committed to achieving a high level of satisfaction among contracted providers. We value provider feedback and always welcome suggestions. On an annual basis, Concordia will conduct satisfaction surveys in both English and Spanish. The surveys are confidential and are distributed to Network Providers and Enrollees. Responses will help us assess our own service performance and indentify opportunities for improvement. The findings will be analyzed and submitted to the QI Committee for review and recommendations. A summary of the findings will be made available to enrollees and providers. We ask cooperation in promptly completing and returning the surveys.

H. COMPLAINTS AND GREIVANCES

QI monitors, trends and assesses provider and enrollee complaints and grievances. The categories for complaints and grievances include, but are not limited to:

- ♦ Access to care
- ♦ Benefit plan
- ♦ Claims
- ♦ Clinical care
- ♦ Provider
- ♦ Service provision
- ♦ Type of service
- ♦ Quality
- ♦ Quantity
- ♦ Timeliness

Concordia's IT system is configured to maintain a detailed record of complaints and grievances that is submitted to both the Health Plan client and AHCA as contractually stipulated. Our process ensures timely follow-up, corrective actions when necessary, and a reevaluation to ensure that the respective issue was properly addressed or resolved.

I. ENROLLEES' RIGHTS AND RESPONSIBILITIES (42 CFR 438.100);

Concordia is committed to maintaining quality care and service of the behavioral healthcare needs of its enrollees and ensuring that enrollees' rights and responsibilities be clearly outlined. We ask that you review the Enrollees' Rights and Responsibilities with your Concordia

enrollees. This information is also available in Spanish on our website at: www.concordiabh.com. A summary of enrollee rights and responsibilities follows:

- **Enrollees have the right to:**
  - Receive information about Concordia, our services, practitioners and providers and enrollees' rights and responsibilities
  - Be treated with respect and recognition of their dignity and right to privacy
  - Participate with practitioners in making decisions about their health care, including the right to refuse treatment
  - A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
  - Voice complaints or appeals about Concordia, or the care it provides
  - Make recommendations regarding Concordia's enrollees' rights and responsibilities policies
  - Receive information about Concordia's services in a language they can understand
  - Participate in the decision making process of Concordia's policies and quality improvement processes
  - Easily access care
  - Fair and equal treatment, regardless of race, religion, gender, ethnicity, age or disability
  - Receive information about advocacy, community groups and prevention services
  - Receive information on clinical guidelines used in providing and/or managing their care
- **Enrollees have the responsibility to***:*
  - Provide, to the extent possible, information that Concordia, its providers and facilities need in order to care for them
  - Follow the plans and instructions for care that they have agreed upon with their providers
  - Participate, to the highest degree possible, in the understanding of their behavioral health problems and developing mutually agreed upon treatment goals
  - Keep appointments or notify their provider as soon as possible regarding a missed appointment
  - Discuss any difficulty in regards to fee payment with their provider

J. ENROLLEE SAFETY

The safety of enrollees is an overriding priority. Concordia will thoroughly review all Critical Incidents to determine root cause(s). All Critical Incidents will be reported immediately to the Health Plan client and AHCA as contractually stipulated. A monthly summary will also be provided.

Incident Reporting: To help us indentify areas of improvement and minimize potential safety risks and hazards, Concordia requires Network Providers – practitioners and facilities – to report critical incidents. Network inpatient facilities are expected to report critical incidents *within 2-hours* of its occurrence / discovery; outpatient providers and practitioners are expected to report as soon a possible and not later than 24-hours of becoming aware of its occurrence.

- **Events / Incidents requiring report**
  - Enrollee Death – Suicide
  - Enrollee Death – Homicide
  - Enrollee Death – Abuse/Neglect
  - Enrollee Death – Other
  - Enrollee Injury or Illness
  - Sexual Battery
  - Medication Errors – Acute Care
  - Medication Errors – Children
  - Enrollee Suicide Attempt
  - Altercations Requiring Medical Interventions
  - Enrollee Escape
  - Enrollee Elopement
  - Other reportable incidents

K. HIPPA

Concordia complies with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

IX. CLAIMS

For all questions related to claims, please contact the Concordia Claims Department at:

Main Numbers:	Local (Miami-Dade): 305-514-5300 TTY: 305-514-5399	Toll Free: 855-541-5300
Fax Number::	Local (Miami-Dade): 305-514-5301	
Email:	Claims:	claims@concordiabh.com
Mailing address:	Concordia Behavioral Health Attn: Claims Department 7190 SW 87th Avenue, Suite 204 Miami, FL 33173	

Concordia is committed to ensuring the accuracy, timeliness and completeness of claims processing, payment and reporting. We abide by all applicable state and federal regulations, reporting requirements, accreditation standards and the guidelines of our organizational clients.

A. CLAIMS SUBMISSION

- Clean Claims**:** When a claim form is properly and thoroughly completed – when all the required fields contain the information needed – you have successfully submitted what we

call a “clean claim”. “Clean claims” place us in an excellent position to fulfill our stated commitment – timely and accurate processing and reimbursement. When a claim is submitted incomplete or is improperly filled out, it is referred to as an “unclean” or “contested claim”. Anytime our Claim’s Department needs additional information from any party external to Concordia to process a claim, delays occur.

- Timely Claims Submission**:** Providers have up to **one hundred and eighty (180) days** from the date service is rendered to submit their claims to Concordia. Claims may be submitted in two (2) ways: *electronically* through Concordia’s website Provider Portal or through U.S. Mail as a *‘paper claim’*.

- Electronic Submissions**:** Concordia is able to accept electronically-transmitted claims from outpatient providers (in HIPAA compliant formats). You can submit electronic claims through Concordia’s website Provider Portal at: www.concordiabh.com. You’ll find the system simple, user-friendly and time-saving.

- Paper Claims**:** Paper claims submission require the of the correct standard form, depending on whether you the provider delivering the service is a facility or an outpatient practitioner:

    a. Outpatient Practitioners: submit claims on a CMS-1500 Claim Form.

    b. Inpatient Services / Facilities Charges: submit claims on a UB-04 Claim Form via US Mail.

  Paper claims should be mailed to our office address, noting on the envelope: ATTN: Claims Department:

  We recommend that you stamp *“Confidential”* on the outside of the envelop – the information contained on the claim form is the enrollee’s Personal Health Information (PHI) protected under federal legislation

- Claim Filing Tips: For prompt processing and payment of claims:

    a. *Complete All Fields*: Include all the required itemized information requested in each of the required field. Concordia’s Notice of Authorization emailed, faxed or mailed to you on the day after the authorization was issued has much of the information the claim form requires. What you need to provide on the claim form includes:

        - The enrollee’s identifying information, include: name, date of birth, subscriber ID number (use the applicable health plan enrollee ID, not the Medicaid ID or the provider’s internal ID), address, phone
        - The diagnosis (codified: DSM-IV, ICD-9. ICD-9-CM), include all digits
        - The date(s) of service, and duration
        - The place of service(s)
        - The type of service(s)/ procedure(s) provided – use CPT code(s) / revenue code(s) for each service and/or procedure
        - The authorization number issued by Concordia for the service(s)
        - The Provider/Practitioner name, credentials, tax ID, and NPI numbers, mailing/billing address, and address where service was rendered

    b. *Check for Accuracy* – Ensure that

- date(s) of service correspond to the authorization effective date(s) or date range found on the authorization
- the service codes/type of service correspond to those detailed on the authorization
- you print/type the information clearly, legibly
- you sign and date the form

B. CLAIMS PROCESSING & PAYMENT:

❖ Electronic Claims - For all electronically submitted claims Concordia will:

a. Within twenty-four **(24) hours** after the beginning of the next business day after receipt of the claim, provide an electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.

b. Within twenty **(20) calendar days** after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim. Notice of the Concordia's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

c. Pay or deny the claim within one hundred and twenty **(120) calendar days** after receipt of the claim. Failure to pay or deny the claim within one hundred and forty **(140) calendar days** after receipt of the claim creates an uncontestable obligation for the Health Plan to pay the claim.

❖ Non-Electronic/"Paper" Claims Non-Electronic/"Paper" Claims

a. Within fifteen **(15) calendar days** after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.

b. Within forty (**40) calendar days** after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim. Notice of the Concordia's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

c. Pay or deny the claim within one hundred and twenty **(120) calendar days** after receipt of the claim. Failure to pay or deny the claim within one hundred and forty (**140) calendar days** after receipt of the claim creates an uncontestable obligation for the Health Plan to pay the claim.

Although you may on occasion receive a Remittance Advice along with a check, routinely these two documents are sent separately.

❖ Reimbursement Amount

Concordia reimburses providers for the delivery of authorized services at the negotiated fee/rate agreements contained in the provider's contract.

❖ Appeals - Providers have **(30) days** from notice of claim denial to appeal the denied claim – call us for assistance with the process.

- ❖ Claim Correction - Providers have **thirty-five** (**35) days** to resubmit a corrected claim
- ❖ Contact Us If a payment or denial is not received at your office within the time allotted per applicable state and/or federal law, we ask that you contact us immediately so that we may resolve the issue in a timely manner.

C. CLAIMS FOR EMERGENCY SERVICES:

It is Concordia Behavioral Health's policy that claims for emergency treatment and/or urgently needed services do not require prior authorization and should be paid on a timely basis. Under our Health Plan/Agency Contract, Concordia will not deny claims, based on lack of notification before or within a certain period of time after emergency services are rendered.

Out of Area Emergency Behavioral Health Service Claims: Concordia will process all out of plan Emergency Behavioral Health Service claims within the time frames specified for emergency claims payment in the Florida Medicaid Contract: Emergency Care Requirements. When Concordia identifies an emergency services/urgent care claim, the claim will be processed within the established federal and state guidelines. As the service was delivered by an out-of-network provider, the claim will be 'pended' to allow time for review. The claim will be paid according to Medicaid guidelines and approved rates.

D. ADDITIONAL BILLING PRACTICE INFORMATION:

Engaging in any of the following practices is considered improper and may be ground for terminating your contract:

- ❖ Billing for Missed Appointments: Medicaid prohibits providers from billing their enrollees for "missed" appointments– this includes charging 'late cancelation fees'. Medicaid considers a missed appointment to be part of the provider's overall cost of doing business.
- ❖ Balance Billing: Balance billing enrollees is strictly prohibited. Balance-billing is defined as the practice of requesting payment from the enrollee for the difference between Concordia's contracted rate and the provider's usual/customary fees for the service. The contracted rates listed in the schedule of your Concordia contract include any applicable co-payment. Concordia will reimburse you at your contracted rate minus the enrollee's co-payment amount and/or deductible. You may collect only applicable co-payments and/or deductibles directly from the enrollee but never engage in the following billing practices that are strictly prohibited by Concordia.
- ❖ Billing for Charges Denied / Unauthorized Services: Under no circumstances is a Concordia Enrollee to be charged for failure to have a service pre-authorized or a claim paid by our organization.

E. FRAUD, WASTE AND ABUSE PREVENTION

Concordia complies with all applicable state and federal billing requirements for all government sponsored and commercial plans including State False Claim laws, Federal False Claims Act, applicable "whistleblower" protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009 and with s. 409.91212, F.S.

Claims submitted for processing are monitored. Processors identify practitioners and/or providers who:

- Have on more than **two (2) occasions** demonstrated a pattern of filing claims

encounter data that did not occur

- Have on more than **two (2) occasions** demonstrated a pattern of overstated claims reports or up-coded levels of service
- Network Practitioners and Providers who have on more than **one occasion** charged beneficiaries for covered services

❖ Medicaid Definitions

Provider Abuse	
Abuse	Abuse means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary, coded incorrectly on the claim, or that fail to meet professionally recognized standards for health care. Abuse includes recipient activities that result in unnecessary cost to the Medicaid program. Abuse may also include a violation of state or federal law, rule or regulation. Note: See the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook for information regarding recipient overutilization or fraud of prescription drugs.
Overpayment	Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake.
Provider Fraud	
Fraud	Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. AHCA may require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.
Person	Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care. under whose supervision they were furnished, or the person causing them to be furnished

X. PROVIDER SERVICES DEPARTMENT

Please use the contact information below if you have any questions related to Provider Services.

Main Numbers: Local (Miami-Dade): 305-514-5300 Toll Free: 855-541-5300

TTY: 305-514-5399

Fax Numbers: Local (Miami-Dade): 305-514-5301 Toll Free: 855-698-5301

Email: Provider Services: providerservice@concordiabh.com

Mailing address: Concordia Behavioral Health
Attn: Provider Services Department
7190 SW 87th Avenue
Suite 204
Miami, FL 33173

Concordia's Provider Service Department serves as a liaison between our company and its network of contracted providers. The Department is committed to building and maintaining our Behavioral Health Network contingent on the behavioral health needs of our clients. We offer a comprehensive range of services and an ample number, mix and geographic distribution of providers to enhance timely and appropriate care access for Medicaid enrollees.

We contract with independent behavioral health practitioners, group practices, agencies, community mental health centers, hospitals and other behavioral health care facilities to provide a full range of services for adults, children and adolescents. The services include, but are not limited to acute Inpatient care, crisis intervention, partial hospitalization programs, residential treatment, intensive outpatient programs, and a full spectrum of substance abuse treatment services and outpatient treatment that includes services for the dually diagnosed.

Our Network of practitioners is comprised of multiple professional disciplines including psychiatrists, psychologists, nurse practitioners, clinical social workers, mental health counselors, and addictions specialists. All behavioral health professionals with whom we contract must be at the Master's degree level or above. Concordia does not discriminate against any practitioner based on any characteristic protected under State or Federal discrimination laws. In fact, we hold diversity as an asset and nurture awareness of the global community by being open to people of differing races, nationalities, cultures, languages, ages, genders, abilities, economic and social backgrounds, political beliefs and religions, family styles and sexual orientation. Concordia strives to be an accepting and respectful environment for all. Our provider network reflects the racial, ethnic, cultural and linguistic diversity found in our South Florida communities. Furthermore, all credentialing and re-credentialing decisions are based on objective criteria.

A. NETWORK ADEQUACY

The adequacy of our network is essential to ensuring enrollees are able to access the care they need in a timely manner that meets our access to care standards. Network adequacy includes:

1. A sufficient number of behavioral health care practitioners and providers so that Enrollees seeking care and/or services can do so in a timely manner
2. An adequate geographic distribution of practice and service locations to provide enrollees with care that is convenient and easy to access
3. An adequate number and variety of clinical professional levels, disciplines, specialties and types of services to meet the Enrollee's continuum of behavioral care needs, and

4. An adequate mix of expressed ethnicity, cultures and languages in our Network to meet the related needs and preferences of Enrollees and promote culturally sensitive and competent behavioral health care.

B. APPLICATION AND CREDENTIALING

❖ **The Application Process:** Practitioners interested in being credentialed by Concordia must complete and submit the Practitioner Credentialing Application or the CAQH application and accompanying forms and attestation. Applications can be obtained by calling our Provider Service Department at our main phone number. Once the application is completed, you may mail it accompanied by all the required supporting documentation to our main address.

a. *Required Information from Practitioners* We are required to obtain the following information from applicants seeking to join our Network of credentialed Practitioners:

- Practice locations, specialty areas, cultural and ethnic backgrounds, and languages spoken
- Five year malpractice history and proof of current professional liability insurance (coverage face sheet for the minimum amounts of $250,000/$750,000 or Malpractice Insurance Statement)
- A copy of current state professional license
- Medicare, Medicaid and NPI numbers
- DEA (Drug Enforcement Agency) and CDS (Controlled Dangerous Substances) certificates (physicians only)
- Board Certification (physicians only)
- Two (2) Peer References
- Controlling Interest Form
- Executed Business Associate Agreement
- Education and professional training
- An updated resume or curriculum vitae, with five (5) year work history and explanation of gaps longer than 6 months
- Reasons for an inability to perform any functions of your profession
- History of sanctions, disciplinary actions and loss of privileges
- History of loss of license and any felony convictions
- Commitment to no illegal drug use
- Your signature on the application confirming that the information you provided is true and correct
- W-9

b. *Required Information from Facilities* In addition to credentialing and contracting behavioral health practitioners, Concordia also contracts with facilities that provide inpatient and outpatient mental health and substance abuse services. We are required to obtain the following information from these entities:

- A current and valid state license
- Proof of accreditation
- General and Professional Liability insurance certificates
- W-9 forms
- Disclosure Ownership Form
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program descriptions
- Facility billing information form

❖ **The Credentialing Process:**

a. *Verification:* When you complete and submit your Credentialing Application to us, along with all the required supporting documentation, the credentialing process begins. While Concordia strives to make a credentialing determination in **less than ninety (90) days**, it may take longer since the process involves obtaining information from third parties. Your application will be reviewed and critical information will be validated. Prior to the initial credentialing process, the Provider Service Department shall conduct primary source verification of applicant's credentials, including a query using the cumulative Medicare and Medicaid Sanctions and Reinstatement Report, or by individual queries using the List of Excluded Individuals and Entities (LEIE). If the applicant practitioner and/or provider appear on the LEIE they shall not be credentialed as a Concordia network practitioner and/or provider.

b. *Credentialing Criteria:* Our credentialing process is based on the criteria set forth in Concordia's Credentialing Policies and Procedures and derived from the standards and requirements established by our Quality Improvement Program (QIP) and Quality Improvement Committee (QIC). These requirements include standards as indicated by: Centers for Medicare and Medicaid Services (CMS), the Agency for Health Care Administration (AHCA), and are in accordance to State and Federal Accreditation Organizations.

Primarily, provider selection decisions are made based on the needs of the enrollee populations and the provider's qualifications. Annually, if not more frequently, we use mapping software to conduct network analyses, however, availability and proximity standards are analyzed on an ongoing basis throughout the year. This process includes determining Network needs based on scope of practice and the cultural and language needs of the enrollees. Secondarily, we make determinations based on enrollee complaints, peer reviews, site visits and record reviews. The enrollees of the Credentialing Committee, which includes representation by network practitioners, arrive at a consensus on credentialing and re-credentialing decisions to ensure that the process is fair and non-discriminatory.

c. *Your Rights*: You have the right to review the information we obtain about you through the credentialing process unless it is peer review protected. We also cannot share information obtained from the National Practitioner's Data Bank (NPDB) or other databanks. You must query the databanks yourself. You have the right to correct erroneous information by submitting written corrections to Concordia within ten **(10) days** of our notification of any discrepancy. All credentialing information is kept in a confidential credentialing file that does not leave our facility and is stored in a locked cabinet.

d. *The Credentialing Committee*: The Credentialing Committee meets at least 6 times per year to review applications but ad hoc meetings are held as needed. Within fifteen **(15) days** of a credentialing decision, providers will receive a letter detailing the outcome.

❖ **Provider Trainings:** Your contract with Concordia becomes effective the day you are approved by our Credentialing Committee. All Medicaid providers will receive training within 30 days of network approval. Concordia will also offer weekly webinars for new providers. Providers may also access the Provider Handbook and the Provider Training Module online via the Provider Portal at our website: www.concordiabh.com. The trainings include elements such as:

- Using the Provider Manual
- Provider responsibilities
- Maintaining credentialing files current
- Practitioner/Provider change in status procedures
- The Authorization Process
- Medical Necessity
- Verifying enrollee eligibility
- Case management processes and forms
- HIPAA information
- Claims submission and electronic billing
- Concordia contact information for specific questions

C. RE-CREDENTIALING

a. Practitioner Recredentialing: Re-credentialing of our Network Practitioners occurs every 3 years. We will notify you ahead of time and provide you with a Re-credentialing Application for you to complete and return to us with the supportive documents required. You must respond within thirty **(30) days** of receipt of the packet or Concordia is required to terminate its contract with you in order to maintain its credentialing standards. All information and verification cannot be older than one hundred and eighty **(180) days** at the time of review by the credentialing committee.

The following documentation is required for re-credentialing:

- A completed Re-credentialing Application
- Proof of current professional liability insurance and/or a Malpractice Insurance Statement
- A copy of current state license

- DEA and/or CDS Certificate (physicians only)
- An updated resume or curriculum vitae

During credentialing and re-credentialing cycles, and as needed between cycles, Concordia queries the web-based Council for Affordable Quality Healthcare (CAQH), the National Provider Data Bank (NPDB) and other databanks. We also monitor network practitioner sanctioning using the cumulative Medicare and Medicaid Sanctions and Reinstatement Report, or by means of individual queries using the List of Excluded Individuals and Entities (LEIE). If a network provider appears on the LEIE they shall be terminated for breach of contract.

Our use of CAQH's Universal Provider Data Source to obtain the data needed for provider credentialing and re-credentialing streamlines the processes by allowing you to complete your applications online. This service is free to practitioners and is available **twenty-four (24) hours per day, seven (7) days-a-week**. You can work on your application on your own schedule and save your work as needed. Once completed, CAQH stores the application online and enables you to make updates to your information. By keeping your information current, future re-credentialing is quick and easy.

At the end of the application, you will be asked to sign an attestation and release of information granting Concordia access to information pertaining to your professional standing. This is required for primary verification and/or review of your records.

b. Facility Recredentialing: Recredentialing of our Network facilities, agencies and clinics occurs once every three years when we confirm that the accredited institution continues to be in good standing with state and federal regulatory bodies and accrediting agencies.

B. PROVIDER RESPONSIBILITIES

Concordia Network Providers are expected to adhere to the terms outlined on our Provider Agreement. Listed below is an overview of these commitments. You must:

- ❖ Adhere to all applicable state and federal laws, professional regulations and standards
- ❖ Treat enrollees in a non-discriminatory and timely fashion
- ❖ Maintain treatment records on all Concordia enrollees: Please take a moment to review the Treatment Guidelines [Appendix H] – these are the standards we will be using to guide QI Chart Reviews.
- ❖ Protect and safeguard enrollees' rights to confidentiality (see 42 CFR 438.100);
- ❖ Coordinate care with the enrollee's primary care physician and document this in the enrollee's record (subject to applicable laws of confidentiality)
- ❖ Fully participate in credentialing, utilization management and quality improvement processes
- ❖ Allow, with reasonable notice, Concordia to review services provided to the enrollees to assure quality
- ❖ Make treatment records available to Concordia for concurrent review compliant with HIPAA federal regulations and state regulations

- ❖ Continue to meet credentialing standards

- ❖ Notify Concordia Behavioral Health immediately of any adverse incidents (Adverse incidents include: enrollees that have died from any cause, or who have suffered serious injury, or have committed suicide/homicide having caused serious injury to themselves or someone else.

- ❖ Notify Concordia of any change in your status, including:

  - Name change or merger
  - Change of address, or other demographic change
  - Change of Tax Id Number
  - Any lapse or change in professional malpractice liability coverage - new, renewed, or expired malpractice insurance (updates)
  - New, renewed, or expired licenses
  - DEA/controlled substance registrations (if applicable)
  - ABMS or AOA board certifications (if applicable)
  - Any condition resulting in temporary closure of a facility or office
  - Short-term hold on referrals
  - Leaves of absence
  - Any legal action pending for professional negligence
  - Any indictment, arrest, or conviction for a felony or for any criminal charge related to an individual's or a facility's practice
  - Revocation, suspension, restriction, termination, or voluntary relinquishment of any licenses, authorizations, accreditations, certifications, medical staff enrolleeship or clinical privileges

  When notifying us of any of these changes by phone you must follow-up with a formal written notification letter on your company letterhead.

- ❖ **Emergency Availability:** You must make provisions to be available for enrollees in emergency situations twenty-four (24) hours per day, seven (7) days per week. Enrollees should be informed on how to reach you or a covering physician credentialed by Concordia for the same services that you provide. Your answering service or machine should give instructions to enrollees about what to do in an emergency situation.

C. SUPPLEMENTAL PROVIDER INFORMATION

- ❖ **Leave of Absence***:* Individual clinicians may request to be made unavailable for new referrals for up to **one hundred and eighty** (180) calendar days. You are required to notify the Provider Services Department thirty **(30) calendar days** prior to your lack of availability. You will be sent a letter confirming that your request has been processed. It is imperative that enrollees be advised of the intended leave early enough to process the termination of care or be smoothly transitioned to another Concordia participating provider.

  When you have been unavailable for one hundred fifty ~~(~~**150) calendar days**, Concordia will send you a letter or notice reminding you that you will be returned to active status

within thirty (**30) calendar days**. You may request an extension. Group practices or facilities that wish to be made unavailable should contact the Provider Services Department.

- **Failure to meet Concordia's performance standards:** Concordia will notify you in writing in the event of failure to meet any performance standard. We will explain the reason for the action and together develop a corrective action plan (CAP) to be reviewed in **6 month intervals** until performance standards are met. If the performance threshold is not met, you may be suspended or terminated from the network. You have the right to a formal appeal within **forty-five (45) calendar days** of the decision.

- **Failure to comply with our contract:** First, a enrollee of our Provider Services Department will contact you to determine how we might be of assistance in helping you become compliant. If this does not work, you may be issued a written warning that explains further noncompliance will result in more severe sanctions. Alternatively, you may be suspended or terminated from the network.

- **Terminating the Agreement:** Both parties have the right to terminate the Agreement, upon written notice, pursuant to the terms of the Agreement.

  a) If Concordia initiates the termination of your Agreement, or places a restriction on your Network participation, you may be eligible to request an appeal. If you are eligible for an appeal, Concordia will notify you of this in writing within **ten (10) calendar days** of the adverse action. Your written request for an appeal must be received by Concordia within **thirty (30) calendar days** of the date on the notification letter advising you of the termination and/or restriction. Failure to request the appeal within this time frame constitutes a waiver of all rights to appeal and acceptance of the adverse action.

     The appeal process includes a formal hearing before at least three clinicians appointed by Concordia. The Committee enrollees are not in direct economic competition with you, and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice, including legal counsel, at the appeal hearing. At the conclusion of the hearing, you have **five (5) business days** to submit further documentation for consideration. The Committee's decision is reached by a majority vote of the enrollees. The decision of this Committee is final, and may uphold, overturn or modify the recommendation of Concordia. A certified letter with the specific reasons for the decision is sent to you within **thirty (30) calendar days** of your documentation submission deadline.

  b) If a Network practitioner, group practice and/or agency decides to terminate their Agreement and withdraw form the Concordia Network, they must notify us in writing **ninety (90) calendar days** prior to the effective date of termination, unless otherwise stated in your Agreement or required by State law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse or change in license status, clinicians are obligated to continue to provide treatment for all Concordia enrollees under their care and to inform the enrollee as soon as possible of their decision. The timeline for continued treatment is up to **six (6) months** from the effective date of the contract termination, as outlined in the Provider Agreement or until one of the following conditions is met, whichever occurs earliest:

- The enrollee is transitioned to another Concordia clinician
- The period of care has been completed
- The enrollee's Concordia benefit is no longer active To ensure continuity of care, Concordia will notify enrollees affected by the termination at least **thirty (30) calendar days** prior to the effective date of the termination whenever feasible. Concordia will assist these enrollees in selecting a new clinician, group or agency.

c) If a Network facility decides to terminate their Agreement with us and withdraw from our Network they must notify Concordia in writing **ninety (90) calendar days** prior to the date of termination, unless otherwise stated in the Agreement or required by State law. To ensure that there is no disruption in a enrollee's care, Concordia has established a **ninety (90) calendar day** transition period for voluntary terminations. The Care Advocate may continue to issue authorizations for treatment during the termination period at the Concordia contracted rate. In the event that a facility's participation is terminated due to quality-related issues, fraud or change in license status requiring immediate transfer of a enrollee to another facility, Concordia and the facility will coordinate to ensure a safe and effective transition of care.

In some cases, the treating practitioner at the facility and the Care Advocate may determine it is in the best interest of a enrollee to extend care beyond these timeframes. Concordia will arrange to continue authorization for such care at the contracted rate. You may continue to collect all applicable co-payments and deductible amounts. The facility continues under contract at the existing rates through the completion of the period of care at any level of care provided by the facility. Enrollees may not be balance billed.

If you need further clarification on how to terminate your Agreement with us, please contact our Provider Services Department.

❖ **Provider Complaints:** Your satisfaction is of paramount importance to us. Concordia monitors all provider complaints through our IT System and has a specific process for handling these issues. Direct complaints to the Provider Services Department so they can be properly addressed in a timely manner. If complaints are not satisfactorily resolved, you may consider filing a written grievance.

APPENDIX A: Covered Service Requirements

Inpatient hospital services:

Medically necessary behavioral health services provided in a hospital setting. The Inpatient care and treatment services that an enrollee receives must be under the direction of a licensed physician with the appropriate medical specialty requirements.

Crisis stabilization units (CSU):

May be used as a downward substitution for Inpatient psychiatric hospital care when determined medically appropriate. These bed days are calculated on a two-for-one basis. Beds funded by the DCF SAMH cannot be used for enrollees if there are non-funded clients in need of the beds.

Outpatient Hospital Services:

Outpatient hospital services are medically necessary behavioral health services provided in a hospital setting. The outpatient care and treatment services that an enrollee receives must be under the direction of a licensed physician with the appropriate specialty.

Emergency Services – Behavioral Health Services:

Crisis intervention services include intervention activities of less than twenty-four (24) hour duration (within a twenty-four (24) hour period) designed to stabilize an enrollee in a psychiatric emergency.

Post-stabilization care services include any of the mandatory services that a treating physician views as medically necessary, that are provided after an enrollee is stabilized from an emergency mental health condition in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee‘s condition.

Physicians Services

Physician services are those services rendered by a licensed physician who possesses the appropriate medical specialty requirements, when applicable. A psychiatrist must be Florida licensed and certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.

Physician services include specialty consultations for evaluations. A physician consultation shall include an examination and evaluation of the enrollee with information from family enrollee(s) or significant others as appropriate. The consultation shall include written documentation on an exchange of information with the attending provider. The components of the evaluation and management procedure code and diagnosis code must be documented in the enrollee‘s medical record. A hospital visit to an enrollee in an acute care hospital for a behavioral health diagnosis shall be documented with a behavioral health procedure code and behavioral health diagnosis code. All procedures with a minimum time requirement shall be documented in the enrollee‘s medical record to show the time spent providing the service to the enrollee. The Health Plan shall be responsive to requests for consultations made by the PCP.

Physicians are required to coordinate medically necessary behavioral health services with the PCP and other providers involved with the enrollee‘s care.

Community Mental Health Services

General Provisions

- Community mental health services include behavioral health services that are provided for the maximum reduction of the enrollee‘s behavioral health disability and restoration to the best

possible functional level. Such services can reasonably be expected to improve the enrollee's condition or prevent further regression. Concordia will provide *medically necessary* community mental health services rendered or *recommended by a physician or psychiatrist and included in a treatment plan.* (See General Medical Necessity Criteria) – admission, continuing stay, and discharge, for all mandatory and optional services); Specific age and services level criteria are in process of development; they will be made available upon completion to all Providers)

- Services must be provided to enrollees of all ages
- Services should emphasize the value of early intervention, be age appropriate and be sensitive to the enrollee's developmental level. The term — community‖ is not intended to suggest that the services must be provided by state-funded facilities or to preclude state-funded centers from providing these services.
- Services shall meet the intent of those covered in the Florida Medicaid Community Mental Health Services Coverage and Limitations Handbook.

Treatment Plan Development and Modification: Treatment planning includes working with the enrollee, the enrollee's natural support system, and all involved treating providers to develop an individualized plan for addressing identified clinical needs. A behavioral health care provider must complete a face-to-face interview with the enrollee during the development of the plan. In addition to the Handbook requirements, the individualized treatment plan shall:

- Be recovery-oriented and promote resiliency;
- Be enrollee-directed;
- Accurately reflect the presenting problems of the enrollee;
- Be based on the strengths of the enrollee, family, and other natural support systems;
- Provide outcome-oriented objectives for the enrollee;
- Include an outcome-oriented schedule of services that will be provided to meet the enrollee's needs;
- Include the coordination of services not covered by the Health Plan such as school-based services, vocational rehabilitation, housing supports, Medicaid fee-for-service substance abuse treatment, and physical health care; and
- For enrollees in the child welfare system the individual treatment plans shall be coordinated with and complement the goals of the child welfare case plan.

Individualized treatment plan reviews shall be conducted at six (6) month intervals to assure that the services being provided are effective and remain appropriate for addressing individual enrollee needs. Additionally, a review is expected whenever clinically significant events occur or when treatment is not meeting the enrollee's needs. The provider is expected to use the individualized treatment plan review process in the utilization management of medically necessary services. For further guidance see the most recent Community Behavioral Health Services and Coverage Handbook.

Evaluation and Assessment Services

- Evaluation and testing services include psychological testing (standardized tests) and evaluations that assess the enrollee's functioning in all areas. Evaluations completed prior to provision of treatment shall include a holistic view of factors that underlie or may have contributed to the need for behavioral health services. Diagnostic evaluations are included in this category. Diagnostic evaluations shall be comprehensive and must be used in the development of an individualized treatment plan. All evaluations shall be appropriate to the age, developmental level and functioning of the enrollee. All evaluations shall include a clinical summary that integrates all the information gathered and identifies the enrollee's needs. The evaluation shall prioritize the clinical needs, evaluate the effectiveness of any prior treatment,

and include recommendations for interventions and mental health services to be provided. All new enrollees who appear for treatment services shall receive an evaluation unless there is sufficient collateral information that a new evaluation would not be necessary.

- Evaluation services, when determined medically necessary, shall include assessment of mutual status, functional capacity, strengths and service needs by trained mental health staff.
- Before receiving any community mental health services, children ages 0-5 shall have a current assessment (within one (1) year) of presenting symptoms and behaviors; developmental and medical history; family psychosocial and medical history; assessment of family functioning; a clinical interview with the primary caretaker and an observation of the child's interaction with the caretaker; and an observation of the child's language, cognitive, sensory, motor, self-care, and social functioning.

Medical and Psychiatric Services

- These services include medically necessary interventions that require the skills and expertise of a psychiatrist, psychiatric ARNP, or physician.
- Medical psychiatric interventions include the prescribing and management of medications, monitoring side effects associated with prescribed medications, individual or group medical psychotherapy, psychiatric evaluation (for diagnostic purposes and for initiating treatment), psychiatric review of treatment records for diagnostic purposes, and psychiatric consultation with an enrollee's family or significant others, PCPs, and other treatment providers.
- Interventions related to specimen collections, taking vital signs and administering injections are also a covered service.
- Treatment services are distinguished from the physician services outlined above in that they are provided through a community mental health provider. Psychiatric or physician services must be at sites where substantial amounts of community mental health services are provided.

Behavioral Health Therapy Services

- Therapy services include individual and family therapy, group therapy and behavioral health day services. These services may include psychotherapy or supportive counseling focused on assisting enrollees with the problems or symptoms identified in an assessment. The focus should be on identifying and utilizing the strengths of the enrollee, family, and other natural support systems. Therapy services shall be geared to the individual needs of the enrollee and shall be sensitive to the age, developmental level, and functional level of the enrollee.
- Family and marital therapy are also included in this category. Examples of interventions include those that focus on resolution of a life crisis or an adjustment reaction to an external stressor or developmental challenge.
- Behavioral health day services are designed to enable enrollees to function successfully in the community in the least restrictive environment and to restore or enhance ability for social and pre-vocational life management services. The primary functions of behavioral health day services are stabilization of the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care, to provide transitional treatment after an acute episode, or to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

Community Support and Rehabilitative Services

- These services include psychosocial rehabilitation services and clubhouse services. Clubhouse services are excluded from the Health Plan's coverage but are covered under fee-for-service Medicaid. Psychosocial rehabilitation services may be provided in a facility, home, or community setting. These services assist enrollees in functioning within the limits of a disability or disabilities resulting from a mental illness. Services focus on restoration of a previous level of functioning or improving the level of functioning. Services must be individualized and directly related to goals for improving functioning within a major life domain.

- The coverage must include a range of social, educational, vocational, behavioral, and cognitive interventions to improve enrollees' potential for social relationships, occupational/educational achievement and living skills development. Skills training development is also included in this category and includes activities aimed toward restoration of enrollees' skills/abilities that are essential for managing their illness, actively participating in treatment, and conducting the requirements of daily independent living. Providers must offer the services in a setting best suited for desired outcomes, i.e., home or community-based settings.
- Psychosocial rehabilitative services may also be provided to assist enrollees in finding or maintaining appropriate housing arrangements or to maintain employment. Interventions should focus on the restoration of skills/abilities that are adversely affected by the mental illness and supports required to manage the enrollee's housing or employment needs. The provider must be knowledgeable about TANF and is responsible for medically necessary mental health services that will assist the individual in finding and maintaining employment.

Therapeutic Behavioral On-Site Services (TBOS) for Children and Adolescents

- TBOS services are community services and natural supports for children/adolescents with serious emotional disturbances. Clinical services include provision of a professional level therapeutic service that may include teaching problem solving skills, behavioral strategies, normalization activities and other treatment modalities that are determined to be medically necessary. These services shall be designed to maximize strengths and reduce behavior problems or functional deficits stemming from the existence of a mental health disorder. Social services include interventions designed for the restoration, modification, and maintenance of social, personal adjustment and basic living skills.
- TBOS services are intended to maintain the child/adolescent in the home and to prevent reliance upon a more intensive, restrictive, and costly mental health placement. They are also focused on helping the child/adolescent possess the physical, emotional, and intellectual skills to live, learn and work in the home community. Coverage shall include the provision of these services outside of the traditional office setting. The services shall be provided where they are needed, in the home, school, childcare centers or other community sites.

Day Treatment Services

- *Adult day treatment services* include therapy, rehabilitation, social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for enrollees to function in the community. The provider must have an array of available services designed to meet the individualized needs of the enrollee, and which address the following primary functions:
    - Stabilize symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care;
    - Provide a level of therapeutic intensity between traditional outpatient and an Inpatient or partial hospital setting;
    - Provide a level of treatment that will assist enrollees in transitioning from an acute care or institutional settings;
    - Assist enrollees in redeveloping the skills required to maintain a living environment, use community resources, and conduct activities of daily living and/or live independently in the community.
- *Children/adolescent day treatment services* include therapy, rehabilitation and social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for children/adolescents to function in their community. The approach shall take into consideration developmental levels and delays in development due to emotional disorders. If the child/adolescent is school age, the services shall be coordinated with the school system. All therapeutic day treatment interventions for children/adolescents

shall have a component that addresses caregiver participation and involvement. Services for all children/adolescents should be coordinated with home care to the greatest extent possible. Day treatment services shall include an array of programs with the following functions:

- Stabilize the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care;
- Provide transitional treatment after an acute episode, admission to an Inpatient program, or discharge from a residential treatment setting;
- Provide a therapeutic intensity not possible in a traditional outpatient setting; and
- Assist the child/adolescent in redeveloping age-appropriate skills required to conduct activities of everyday living in the community.

- Staff providing adult or children/adolescent day treatment services must have appropriate training and experience. Behavioral health care providers shall be available to provide clinical services when necessary.

Services for Children Ages 0 through 5 Years

- Services include behavioral health day services and therapeutic behavioral on-site services for children ages 0 through 5 years.
- Prior to receiving these services, the enrollees in this age group must have an assessment that meets the criteria in the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Behavioral Health Targeted Case Management:

T*argeted case management services* will be provider to children/adolescents with serious emotional disturbances and adults with a severe and persistent mental illness as defined below. TCMs go through the TCM certification program. (Medical criteria and clinical are in the process of being developed and will be disseminated upon completion.) At a minimum, case management services are to incorporate the principles of *a strengths-based approach*. Strengths-based case management services are an alternative service modality for working with individuals and families. This method stresses building on the strengths of individuals that can be used to resolve current problems and issues, countering more traditional approaches that focus almost exclusively on individual's deficits or needs.

Target Populations: Behavioral health targeted case management services shall be available to all enrollees:

- Who require numerous services from different providers and also require advocacy and coordination to implement or access services;
- Who would be unable to access or maintain consistent care within the service delivery system without case management services;
- Who do not possess the strengths, skills, or support system to allow them to access or coordinate services;
- Who may benefit from case management but lack the skills or knowledge necessary to access services; or
- Who do not meet these criteria but may still be eligible for limited targeted case management services by meeting exception criteria contained in the Medicaid Targeted Case Management Coverage and Limitations Handbook.

Concordia will ensure case management services are available to children/adolescents who have a serious emotional disturbance, which is: a defined mental disorder; a level of functioning which requires two or more coordinated behavioral health services to be able to live in the community; and at imminent risk of out-of-home behavioral health treatment placement.

Concordia will also coordinate case management services for adults with a severe and persistent mental illness or who have been denied admission to a long-term mental health institution or

residential treatment facility or have been discharged from a long-term mental health institution or residential treatment facility.

Concordia is not required to seek approval from the SAMH Program Office for client eligibility or behavioral health targeted case management agency or individual provider certification.

Required Services

- Behavioral health targeted case management services include working with the enrollee and the enrollee's natural support system to develop and promote a service plan. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used shall identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the enrollee, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with providers and the enrollee to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of the services provided.
- When targeted case management recipients enrolled in the Health Plan are hospitalized in an acute care setting or held in a county jail or juvenile detention facility, Concordia shall document efforts to ensure that contact is maintained with the enrollee and shall participate actively in the discharge planning processes.
- Case managers are also responsible for coordination and collaboration with the parents or guardians of children/adolescents who receive mental health targeted case management services. The Health Plan shall monitor case management activities to assure that case managers routinely include the parents or guardians of enrollees in the process of providing targeted case management services. Integration of the parent's input and involvement with the case manager and other providers shall be reflected in medical record documentation and monitored through the Concordia/Health Plan's quality of care monitoring activities. Involvement with the child/adolescent's school and/or childcare center must also be a component of case management with children/adolescents.
- Concordia will coordinate behavioral health targeted case management services to children/adolescents in the care or custody of the state who need them. Concordia will document efforts to develop a cooperative agreement with DCF, or its provider of community-based services, to address how to minimize duplication of case management services and to promote the establishment of one case manager for the child/adolescent and family whenever possible.

Additional Requirements for Targeted Case Management:

- Caseloads set to achieve the desired results. Size limitations must clearly state the ratio of enrollees to each individual case manager. The limits shall be specified for children/adolescents and adults, with a description of the clinical rationale for determining each limitation. If the Health Plan permits ―mixed‖ caseloads, *i.e.*, children/adolescents and adults, a separate limitation is expected along with the rationale for the determination. Ratios must be no greater than the requirements set forth in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook;
- A system to manage caseloads when positions become vacant;
- A description of the modality of service provision and the location that services will be provided;
- The expected frequency, duration and intensity of the service with service limits and criteria no more restrictive than those in Medicaid policy;
- Issues related to recovery and self-care, including services to help enrollees gain independence from the behavioral health and case management system;

- Services based on individual needs of the enrollees receiving the service. The service system shall also address the changing needs and abilities of enrollees; and
- Case management staff with expertise and training necessary to competently and promptly assist enrollees in working with Social Security Administration or Disability Determination in maintaining benefits from SSI and SSDI. For enrollees who wish to work, case management staff must have the expertise and training necessary to help enrollees access Social Security Work Incentives.

Intensive Case Management

Intensive case management is intended for highly recidivistic adults who have a severe and persistent mental illness. The service is intended to help enrollees remain in the community and avoid institutional care. Care criteria for this level of case management shall address the same elements required above, as well as expanded elements related to access and twenty-four (24) hour coverage as described below. Additionally, the intensive case management team composition shall be expanded to include enrollees selected specifically to assist with the special needs of this population.

Concordia will coordinate this service for all enrollees for whom it is determined to be medically necessary, to include any enrollee who meets the following criteria:

- Has resided in a state mental health treatment facility for at least six (6) of the past thirty-six (36) months;
- Resides in the community and has had two (2) or more admissions to a state mental health treatment facility in the past thirty-six (36) months;
- Resides in the community and has had three (3) or more admissions to a crisis stabilization unit, short-term residential facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;

Community Treatment of Enrollees Discharged from State MH Treatment Facilities

Concordia will coordinate and authorize medically necessary behavioral health services to enrollees who have been discharged from any state mental health treatment facility, including, but not limited to, follow-up services and care. All enrollees who have previously received services at a state mental health treatment facility must receive follow-up care. The plan of care shall be aimed at encouraging enrollees to achieve a high quality of life while living in the community in the least restrictive environment that is medically appropriate and reducing the likelihood that the enrollees will be readmitted to a state mental health treatment facility.

Community Services for Medicaid Recipients Involved with the Justice System

Concordia will make every effort to coordinate and authorize medically necessary community-based services for Health Plan enrollees who have justice system involvement – Provide psychiatric services within twenty-four (24) hours of release from jail, juvenile detention facility, or other justice facility to assure that prescribed medications are available for all enrollees.

Treatment and Coordination of Care for Enrollees with Medically Complex Conditions

Concordia will ensure that appropriate resources are available to address the treatment of complex conditions that reflect both mental health and physical health involvement. The following conditions will be addressed:

- Mental health disorders due to or involving a general medical condition, specifically ICD-9-CM Diagnoses 293.0 through 294.1, 294.9, 307.89, and 310.1; and
- Eating disorders – ICD-9-CM Diagnoses 307.1, 307.50, 307.51, and 307.52.

Concordia will provide medically necessary community mental health services to enrollees who exhibit the above diagnoses and shall develop a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria shall address modalities of treatment that are effective for each diagnosis. Concordia's provider network will include appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods

Coordination of Children's Service:

- The delivery and coordination of child/adolescent mental health services will be provided for all who exhibit the symptoms and behaviors of an emotional disturbance. The delivery of services must address the needs of any child/adolescent served in an SED (severely emotionally disturbed) or EH (emotionally handicapped) school program. Developmentally appropriate early childhood mental health services must be available to children from birth to five (5) years and their families.
- Deliver services for all children/adolescents within a strengths-based, culturally competent service design and ensure that services are family-driven and include the participation of family, significant others, informal support systems, school personnel, and any state entities or other service providers involved in the child/adolescent's life.
- For all children/adolescents provider shall work with the parents, guardians, or other responsible parties to monitor the results of services and determine whether progress is occurring. Active monitoring of the child/adolescent's status shall occur to detect potential risk situations and emerging needs or problems.
- When the court mandates a parental behavioral health assessment, and the parent is an enrollee, the provider must complete an assessment of the parent's mental health status and the effects on the child. Time frames for completion of this service shall be determined by the mandates issued by the courts

Evaluation and Treatment Services for Enrolled Children/Adolescents:

Concordia will coordinate and authorize all medically necessary evaluations, psychological testing and treatment services for children/adolescents referred to the Health Plan by DCF, DJJ and by schools (elementary, middle, and secondary schools), will provide court-ordered evaluation and treatment required for children/adolescents who are enrollees. See specifications in the Medicaid Community Behavioral Health Services Coverage & Limitations Handbook, and will refer adolescents to DCF when residential treatment is medically necessary.

Psychiatric Evaluations for Enrollees Applying for Nursing Home Admission:

Concordia will, upon request from the SAMH offices, promptly arrange for and authorize psychiatric evaluations for enrollees who are applying for admission to a nursing facility pursuant to OBRA 1987, and who, on the basis of a screening conducted by Comprehensive Assessment and Review for Long term Care (CARES) workers, are thought to need mental health treatment. The examination shall be adequate to determine the need for —specialized treatment‖ under OBRA. Evaluations must be completed within five (5) working days from the time the request from the DCF SAMH office is received

Assessment and treatment of Mental Health Residents Who Reside in Assisted Living Facilities (ALF) that hold a Limited Mental Health License:

- The provider must develop and implement a plan to ensure compliance with s, 394.4574, F.S., related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. A cooperative agreement, as defined in s. 429.02, F.S., must be developed by the ALF with the enrollee's Health Plan if an enrollee is a resident of an ALF. The provider must ensure that appropriate assessment services are provided to enrollees and that medically

necessary behavioral health services are available to all enrollees who reside in this type of setting.

- A community living support plan, as per contract description will be developed for each enrollee who is a resident of an ALF, and it must be updated annually. The Health Plan or its designee's behavioral health care case manager is responsible for ensuring that the community living support plan is implemented as written

Individuals with Special Health Care Needs

- Concordia will implement mechanisms for identifying, assessing and ensuring the existence of an individualized treatment plan for individuals with special health care needs, as defined in Attachment II, Section I, Definitions and Acronyms. Mechanisms will include evaluation of risk assessments, claims data, and CPT/ICD-9 codes. Additionally, the Health Plan shall implement a process for receiving and considering provider and enrollee input.
- In accordance with this Contract and 42 CFR 438.208(c)(3), an individualized treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be:
    - Developed by the enrollee's direct service mental health care professional with enrollee participation and in consultation with any specialists caring for the enrollee;
    - Approved by the Health Plan in a timely manner if this approval is required; and
    - Developed in accordance with any applicable Agency quality assurance and utilization review standards.

Six Essential Components in Effective Discharge Planning:

1. **Timeliness:** Discharge planning begins at time of admission and continues throughout the duration of the hospitalization.
2. **Enrollee Engagement:** Promotes enrollee's participation in identifying their post-discharge needs, potential (non-clinical) barriers to discharge and selecting options for aftercare.
3. **Involvement of Support System:** Requires active input and participation from (as available):
   a. Family / significant other(s) / parents / custodian/ s legal guardian / caretaker, in the case of minors, or a person adjudicated incompetent, as applicable and appropriate
   b. Enrollees of the hospital treatment team
   c. Community case manager or forensic specialist/forensic case manager (when applicable)
4. **Comprehensive and Specific**: Addresses and specifies the supports and services a person will need and want when returning to their home and community. Depending on the needs identified it may include:
   a. Placement/Housing: Provides the enrollee with information regarding available residential/housing options – that allow for an informed choice.
   b. Social Support: Provides the enrollee with information regarding available options in the community for additional support/structure/socialization opportunities upon – that allows informed choice.
   c. Social Service Assistance: Provides the enrollee with information regarding available social service agencies that can provide assistance with needs such as meals, temporary financial aid, vocation training, employment assistance, devises/aid for physical handicaps – allowing for informed choices. Ensures the enrollee has sufficient identification (Drivers license, birth certificate, marriage certificate(s), drivers license, current passport, or U.S. Military issued photo-ID and/or State-issued ID Card) to support application for any needed social service benefit / assistance.
   d. Proper Preparation: Encourages the person to take as much responsibility as possible for addressing their medical and psychiatric needs upon discharge – provides information regarding diagnosis/illness and medications (including, possible side effects; the benefits/risks of compliance); strategies for symptom management, crisis/relapse prevention; signs of relapse/symptoms and/or condition worsening and steps to take;
5. **Follow-Up Appointment:** Ensures an aftercare / post-discharge appointment has been secured with their outpatient provider within the required timeframe (for Medicaid – 24-hours post discharge).
6. **Discharge Instruction:** Provides enrollee with written discharge instructions, recommendations, including discharge medications, follow-up appointment(s) with date, time, contact information.

SERVICE VISION:

Providing enrollees the necessary services and support to attain and maintain the most dignified life and highest level of functioning possible.

10 CORE TREATMENT PRINCIPLES &VALUES:

1. All individuals have a basic human right to be treated with dignity and respect
2. Quality is maintained by ethical and compassionate care
3. Professional relationships are founded on authenticity, honesty, and integrity
4. Sound, professional judgment guided by the enrollee's best interest
5. Treatment and placement must always be provided in the safest, least restrictive environment reasonably expected to lead to the best treatment outcome
6. Coordinating and communicating with the enrollee's Primary Care Provider (PCP) and other care providers is essential to ensuring safe, effective and efficient care
7. Providing clinically appropriate treatment requires meeting the enrollee's physical and emotional needs and taking into consideration their cultural preferences and linguistic needs
8. An empowering, enrollee-centered, strength-based, recovery-focused approach to care is the core of quality care
9. The inclusion of enrollee's family and natural/community support system in the treatment process is critical to positive, more enduring outcomes
10. Professionalism is enhanced with a commitment to increasing our knowledge and skill level through continued educational opportunities, including knowledge of the nature of social diversity (race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability)

APPENDIX D: ENROLLEE-CENTERED CARE: Overview & Educational Resources

The Institute of Medicine identifies *enrollee centeredness* as a core component of quality health care. The description of enrollee centeredness states that it

> *"encompasses qualities of* ***compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual enrollee."*** [1]

The Institute defines enrollee centeredness as:

> *[H]ealth care that establishes a partnership among practitioners, enrollees, and their families (when appropriate) to ensure that decisions respect enrollees' wants, needs, and preferences and that enrollees have the education and support they need to make decisions and participate in their own care.*[2]

The enrollee-centered approach includes:

- *Viewing the enrollee as a unique person, rather than focusing strictly on the illness,*
- *Building a therapeutic alliance based on the enrollee's and the provider's perspectives.*

Enrollee-centered care is supported by good provider-enrollee communication so that enrollees' needs and wants are understood and addressed and enrollees understand and participate in their own care. The approach to care has been shown to improve enrollees' health and health care. Unfortunately, many barriers exist to good communication. Providers also differ in communication proficiency, including varied listening skills and different views from their enrollees' of symptoms and treatment effectiveness.[9]

Additional factors influencing enrollee centeredness and provider-enrollee communication include:

- *Language barriers.*
- *Racial and ethnic concordance between the enrollee and provider.*
- *Effects of disabilities on enrollees' health care experiences.*
- *Providers' cultural competency.*

Efforts to remove these possible impediments to enrollee centeredness are underway within the Department of Health and Human Services (HHS). For example, the Office of Minority Health has developed a set of Cultural Competency Curriculum Modules that aim to equip providers with cultural and linguistic competencies to help promote enrollee-centered care.[10] [*Available at: www.thinkculturalhealth.hhs.gov*] These modules are based on the National Standards on Culturally and Linguistically Appropriate Services. The standards are directed at health care organizations and aim to improve the enrollee centeredness of care for people with limited English proficiency (LEP).

Another example, which is being administered by the Health Resources and Services Administration, is Unified Health Communication, a Web-based course for providers that integrates concepts related to health literacy with cultural competency and LEP.

The importance of translation and interpretation services has been noted as essential in facilitating communication between the healthcare provider and the enrollee.

References

1. Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press; 2001.
2. Institute of Medicine. Envisioning the National Health Care Quality Report. Washington, DC: National Academies Press; 2001.
3. Stewart M, Brown JB, Donner A, et al. The impact of enrollee-centered care on outcomes. J Fam Pract 2000 Sep;49(9):796-804.
4. Anderson EB. Enrollee-centeredness: a new approach. Nephrol News Issues 2002 Nov;16(12):80-82.
5. Michie S, Miles J, Weinman J. Enrollee-centeredness in chronic illness: what is it and does it matter? Enrollee Educ Couns 2003 Nov;51(3):197-206.
6. Little P, Everitt H, Williamson I, et al. Observational study of effect of enrollee centredness and positive approach on outcomes of general practice consultations. BMJ 2001 Oct 20;323(7318):908-11.
7. DiMatteo MR. The role of the physician in the emerging health care environment. West J Med 1998 May;168(5):328-33.
8. Beck RS, Daughtridge R, Sloane PD. Physician-enrollee communication in the primary care office: a systematic review. J Am Board Fam Pract 2002 Jan-Feb;15(1):25-38.
9. Rhoades DR, McFarland KF, Finch WH, et al. Speaking and interruptions during primary care office visits. Fam Med 2001 Jul-Aug;33(7):528-32.
10. U.S. Department of Health and Human Services, Office of Minority Health. Think Cultural Health: bridging the health care gap through cultural competency continuing education programs. Available at: www.thinkculturalhealth.hhs.gov. Accessed November 6, 2008.
11. U.S. Department of Health and Human Services, Office for Civil Rights. Guidance to Federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons. 68 Fed. Reg. 47311-02; August 2, 2008. Available at: www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/factsheetguidanceforlep.html.
12. Berry LL, Seiders K, Wilder SS. Innovations in access to care: a enrollee-centered approach. Ann Intern Med 2003 Oct 7;139(7):568-74.
13. Bechel DL, Myers WA, Smith DG. Does enrollee-centered care pay off? Jt Comm J Qual Improv 2000 Jul;26(7):400-9.
14. Hargraves JL, Hays RD, Cleary PD. Psychometric properties of the Consumer Assessment of Health Plans Study (CAHPS) 2.0 adult core survey. Health Serv Res 2003 Dec;38(6 Pt 1):1509-27.

Source:: Agency for Healthcare Research and Quality (AHRQ), “National Healthcare Disparities Report” (2010); At: http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf

APPENDIX E: PROMOTING CULTURAL& LINGUISTIC COMPETENCE: Self-Assessment Checklist for Providers

DEVELOPED BY: T. Goode, National Center for Cultural Competence, Georgetown University
National Center for Cultural Competence, 3307 M Street, NW, Suite 401, Washington, DC 20007
Voice: 800-788-2066 or 202-687-5387 **Fax:** 202-687-8899 **E-mail:** Cultural@Gunet.Georgetown.Edu

TARGET GROUP: Healthcare workers **LENGTH OF SURVEY:** 30-item list

PURPOSE:

- To increase individual awareness of practices, beliefs, attitudes and values that promotes and hinders cultural and linguistic competence in the delivery of health care.
- To identify training needs.

DISTINGUISHING CHARACTERISTICS: Divided into 3 categories:

1. Physical Environment, Materials, and Resources
2. Communication Styles
3. Values and Attitudes

RATING SCALE: Each item is rated on a 3-point scale

SELF-ASSESSMENT CHECKLIST:

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices, which foster cultural and linguistic competence at the individual or practitioner level.

DIRECTIONS: Select A, B, or C for each item listed below.

A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

I. PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

	1. I display pictures, posters, artwork and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
	2. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.
	3. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

	4. I insure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

II. COMMUNICATION STYLES

	1. When interacting with individuals and families who have limited English proficiency I always keep in mind that: *a. limitations in English proficiency is in no way a reflection of their level of intellectual functioning* *b. their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin* *c. they may or may not be literate in their language of origin or English.*
	2. I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.
	3. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.
	4. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.
	5. When possible, I insure that all notices and communiqués to individuals and families are written in their language of origin.
	6. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method.

III. CULTURAL COMPETENCY – VALUES & ATTITUDES

	1. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
	2. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.
	3. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases and prejudice
	4. I recognize and accept that individuals from culturally diverse backgrounds may desire

	varying degrees of acculturation into the dominant culture.
	5. I understand and accept that family is defined differently by different cultures (e.g. extended family enrollees, fictive kin, godparents).
	6. I accept and respect that male-female roles may vary significantly among different cultures and ethic groups (e.g. who makes major decisions for the family).
	7. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
	8. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
	9. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
	10. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
	11. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.
	12. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
	13. I understand that grief and bereavement are influenced by culture
	14. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.
	15. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.
	16. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
	17. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.
	18. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.
	19. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups

There is no answer key with correct responses. However, if you frequently responded "C", you may ***not*** necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

Web links to Cultural Competence Resources

- *The U.S. Department of Health and Human Services, Office of Minority Health* (includes access to the 14 CLAS standards; http://minorityhealth.hhs.gov
- *The Agency for Healthcare & Human Services – Cultural and Linguistic* Competency site at: http://www.ahrq.gov/path/compath.htm
- *The National Center for Cultural Competence (NCCC), Georgetown University Center for Child and Human Development* at: http://nccc.georgetown.edu/
- *NAMI STAR Center and The University of Illinois at Chicago, National Research and Training Center at:* http://www.consumerstar.org/pubs/SC-Cultural_Competency_in_Mental_Health_Tool.pdf
- *CLAS Institute (Culturally & Linguistically Appropriate Services)* at**:** clas.uiuc.edu/
- *Department of Human Services(DHS) Oregon, "Cultural Competence & Diversity", at DHS – Toolkit for Managers)*at*:* http://www.dhs.state.or.us/tools/diversity/tools/cctools-managers.pdf
- *UCLA, "Cultural Diversity and Health Care" – a PowerPoint presentation (with specific communication examples, tips on working with translators* at: healthcare.ucla.edu/

Consistent, current and complete documentation in the treatment record is an essential

Identification and Legibility:

- Each page of the medical record should have the enrollee name and/or some enrollee ID number and all entries are dated and legible to someone other than the writer.
- The record includes:
    a. Biographical information, including date of birth, gender, marital/civil status, and legal guardianship, if applicable.
    b. Demographic information: including home address and telephone and/or cell numbers, employer and work phone, if applicable, emergency contact name and phone number.
    c. Appropriate signed dated and witnessed authorization and consent forms.

The clinician and his/her credentials are identified on each entry.

- All entries in the treatment record include the responsible clinician's name, and licensure. Name or first initial and last name should follow each entry in the record. First and last initials can be used if they are referenced and explained somewhere in the record. Relevant provider identification number may also be included, if applicable.

Advance Directives-Documentation (MD services; Applicable to Adults 18 and over)

- Documentation that the Enrollee was provided written information concerning advance directives and documentation as to whether or not the enrollee has executed an advance directive *(as per Florida Statute 765.110 and Medicaid contract 20.13 Medical record requirements; Michigan Medicaid CHCP Contract requiring compliance with 42 C.F.R. 434.28 & Public Act 386 recognizing the Durable Power of Attorney for Healthcare (DPAHC);* (Applies to).

Enrollee Rights/Responsibilities are available.

- Enrollee rights and responsibilities are available in the facility or practitioner site for receipt, posted for viewing, and/or reviewed with the enrollee.

Presenting Problems:

- The presenting problems, along with relevant psychological and social conditions affecting the enrollee's medical and psychiatric status and the results of the mental status exam, are documented.
- The documentation of presenting problem shows evidence of screening for domestic violence, abuse and/or neglect (in the case of minors, elderly and the disabled), and abuse of substance.
- If abuse and/or neglect have been identified, there is documentation of report to / contact with Florida Abuse (DCF).

Special Status / Safety Risk factors are prominently noted, documented, and revised

- Special situations may include imminent risk of harm, suicidal ideation, elopement potential, etc. This may be addressed in the notes or in the treatment plan.
- Danger to self or others is acted upon by the practitioner/provider with the appropriate level of urgency.

Medical and psychiatric histories are documented. (Applies to both Inpatient and outpatient records)

- The record includes a documented medical and psychiatric history, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information, history of alcohol use/abuse and evidence of impact daily functioning and mental status exam.

A DSM IV diagnosis is documented.

- The diagnoses address all five Axes and reflect significant clinical findings or the evaluation / assessment processes are identified in initial psychiatric history and evaluation.
- The record shows a minimum of symptoms to support the diagnoses.
- The GAF score positively increases as a result of treatment (for outpatient services, over a period of 3 months of treatment).

Prescribed Medications are listed

- The listing of medications includes: drug names, dosages, frequency, prescribing provider (and their contact information) and dates of initiation for each; refills are clearly documented;
- A history of adverse drug reactions, significant side effects, and/or sensitivities is documented and adverse reactions / side effects identified are posted in a prominent place in the chart. If the enrollee is allergic to a medication we would expect this to be *on the front of the chart* (applies to MD's and ARNP's) and if the record is Inpatient it is expected that the information be noted, also, on the medication sheet.
- Medication information is recorded on the initial evaluation/assessment and updated in the progress notes / Rx order sheet / special medication record sheet, as changes occur
- History of compliance with medication is documented; Issues of irregular and/or non-compliance with Rx is included in the treatment plan.

Health Issues and Allergies:

- The medical history is documented; any medical condition indentified is included under Axis III diagnosis; the information is updated when changes occur
- Relevant medical issues identified are appropriately addressed as part of the care plan.
- The history includes allergies and/or lack of known allergies and their presence / absence is clearly documented; (Inpatient records) recorded outside of the chart (NKA, sticker)

Developmental History (Children. & Adolescents)

- A developmental history is documented. including prenatal events, milestones, psychological, social, intellectual, and academic achievements and/or challenges
- (For enrollees 12 and over) the history includes past and present use (or non-use) of cigarettes and alcohol, prescribed, and over-the-counter medications, and illicit

Appropriate Treatment Planning

- The treatment plan is consistent with diagnosis and has measurable goals and estimated time frames for attainment.
- Treatment interventions are consistent with the diagnosis and treatment plan goals.
- The enrollee has signed the treatment plan; there is supporting documentation that the enrollee participated in the development of the treatment plan, was given education regarding interventions and options, and gave informed consent.
- The enrollee's strengths and limitations are identified (if not included in the care plan, found in the assessment and reflected in progress notes.

- Enrollees who become homicidal, suicidal, or unable to conduct activities of daily living are promptly are referred to the appropriate level of care. (For instance an agitated enrollee may need to be secluded. A suicidal enrollee in outpatient treatment may need to be transferred to an Inpatient facility based on results of a risk assessment).
- The treatment record documents supportive and preventive services, such as AA/NA, relapse prevention, case management services, job placement, stress management, wellness programs, housing, food banks, etc.
- The treatment record reflects continuity and coordination of care among behavioral health clinicians, consultants, ancillary providers, and health care institutions.
    - This refers to communication between behavioral health providers and practitioners, exchange of information regarding medication, management of co-existing behavioral/medical disorders; i.e., obesity, pain, and/or exchange of information following a referral to behavioral health from medical, with written consent from the enrollee
    - For example: the enrollee may be seeing a therapist and an MD and we would expect communication between them. Release of information should be offered to the enrollee to allow the exchange of information to appropriate practitioners.
    - Another example includes lack of psychiatrist feedback documented in treatment records of non-psychiatrist behavioral health practitioners.
    - There is a signed release obtaining consent for the exchange of information between providers outside of the facility, in the case of hospital stay; Enrollee may refuse to sign and, if so, there should be documentation that the enrollee refused.
- Appropriate Discharge (D/C) Planning
    - The treatment plan documents an ongoing D/C planning process form onset of services through termination.
    - Upon D/C or termination of services the enrollee receives D/C instructions and /or and aftercare recommendations consistent with the level care / treatment needs.
    - The dates of follow-up appointments for continued treatment after hospitalization meet the timeframe standards **(OP appointment offered within 7 days following d/c from inpatient).**
- CFARS/FARS: (For all Medicaid enrollees)
    - An age appropriate functional assessment rating scale has been performed at required phases / time intervals. This data is reported for all Medicaid recipients.
    - FMHI guidelines must be followed.
- The PCP was notified of hospitalization/treatment/medications/discharge plan/termination and follow-up recommendations.
    - Release of information should be offered to the enrollee to allow the exchange of information to appropriate practitioners. Credit is given if there is a signed release obtaining consent and is documented in the record. Enrollee may refuse to sign and, if so, there should be documentation that the enrollee refused.
    - If enrollee claims no PCP or treating professional, no credit is given as provider should be proactive in obtaining a PCP for enrollee unless enrollee is a PPO enrollee.