Central Wisconsin Health Partnership (CWHP) Comprehensive Community Services (CCS)
Provider Contract Addendum

The CWHP is a consortium that includes Adams, Green Lake, Juneau, Marquette, Waupaca, and Waushara Counties. An essential component of the partnership is the CCS program. This addendum outlines regional expectations for individuals and agencies contracted to provide CCS services in a county or counties in the CWHP region.

Comprehensive Community Services (CCS)

Comprehensive Community Services (CCS) is certified per the requirements of Wisconsin Administrative Code DHS 36 and provides a flexible array of individual community-based psychosocial rehabilitation services authorized by a licensed mental health professional under DHS 36.15. CCS Services are provided to clients with mental health and/or substance use issues across the life span who qualify based on medical necessity and level of need as measured by a functional screen. The intent of the services and supports is to provide maximum reduction of the effects of the individual's mental health and substance use disorders and restoration to the highest level of possible functioning. The goal is to facilitate recovery and resilience.

Providers are expected to:

- Be recovery-focused
- Use evidence-based practices
- Participate in the wraparound team process, including attendance at recovery team meetings for the consumer they are providing services to a minimum of every six months or more often as dictated by the needs of the consumer.
- Have and implement written personnel policies and procedures that do not discriminate against any staff member or application for employment based on the individual's age, race, religion, color, sexual orientation, national origin, disability, ancestry, marital status, pregnancy or childbirth, or arrest or conviction record.
- Possess the appropriate professional certification, education, training, experience, and abilities to carry out their prescribed duties.
- Maintain required staff records and provide the information to the appropriate CCS staff person in the county or counties in which services are being provided.

Staff References, Background Checks and Misconduct Reporting and Investigation

For each staff person who will be providing CCS services, a resume and references obtained from at least two (2) people must be submitted. References must be documented in writing either by letter or by written documentation of the verbal contact with the reference, dates of contact, person making the contact, individuals contacted, and the nature and the content of the contact. This is in compliance with DHS 36.10(2)(d)1.

Contracting agencies must comply with the caregiver background check and misconduct reporting requirements in s. 50.065, Stats., and ch. DHS 12, and the caregiver misconduct reporting and investigation requirements in ch. DHS 13. Forms for conducting a caregiver background check including the background information disclosure form may be obtained from the Department's website at http://www.dhs.wisconsin.gov/forms/DQAnum.asp or by writing or telephoning the Department at Office of Caregiver Quality, P.O. Box 2969, Madison, WI 53701-2969, (608) 261-8319.

Qualified agency personnel of the individual(s) providing CCS services are responsible for closely examining the results of the CBC for criminal convictions or findings of misconduct by a governmental agency; and to make employment decisions in accordance with the requirements and prohibitions in the law.

A copy of the Background Check for each staff who will be providing CCS services must be provided to each county in which services are provided, every four years, and upon hire for new staff. Service providers shall not assign any staff to provide CCS services who do not meet the requirements of this section. CCS contracts will not be established with individuals/agencies until resume, two references, current background check, and applicable license/certification for each CCS staff are submitted to the contracting county(ies).

Supervision and Clinical Collaboration

In accordance with DHS 36.11, all CCS staff are required to be supervised and provided with the consultation needed to perform assigned functions to ensure effective service delivery.

Provision of supervision is the responsibility of the provider agency and may be accomplished by:

- Individual sessions with the staff member to review cases, assess performance, and provide feedback.
- Individual side-by-side sessions in which the supervisor is present while the staff member conducts assessments, service planning meetings, or services where the supervisor assesses, teaches, and gives advice regarding the staff member’s performance.
- Group meetings to review and assess staff performance and provide advice or direction regarding specific situations or strategies.

For Psychiatrists, Psychologists, physicians, psychiatric residents, LCSW, LPC, LMFT, adult psychiatric and mental health nurse practitioners, and advanced nurse prescribers this involves a minimum of at least one hour of either supervision or clinical collaboration per month or for every 120-clock hours of face-to-face psychosocial rehabilitation services they provide.

For all other staff, supervision involves day-to-day supervision and consultation, *and* at least one hour of supervision per week or for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation they provide.

Clinical supervision and clinical collaboration records may be kept in the form of a master log, a supervisory record, in staff record for each staff person who attends the session or review, or in the consumer record. Individual case staffing notes are kept when specific cases are being staffed. Notes are included in the consumer’s record to reflect discussion, outcome, and any treatment recommendations that may have been discussed. The note is dated and signed off by the staff member conducting supervision. Examples of individuals qualified to provide supervision include psychiatrists, physicians, psychologists, licensed independent clinical social workers, and professional marriage and family therapists (see s. DHS 36.10 (2) (g) 1-8 for a complete list of qualified supervisors). Supervision logs shall be submitted to the counties in which services are being provided. Monthly supervision logs, including dates and times of supervision provided, and supervisor signature must be submitted along with invoices to the counties in which services are being provided. Payment will be withheld until monthly supervision log(s) are received.

Orientation and Training

Required orientation and training are the responsibility of the provider to complete within the first three months prior to starting employment with the CCS program. Documentation of completed orientation training requirements must be submitted to the counties in which services are to be provided prior to the implementation of this contract and prior to any new staff providing CCS services.

Orientation Training Requirements:

- At least 40 hours of documented orientation training within 3 months of beginning employment for each staff member who has less than 6 months experience providing psychosocial rehabilitation services to children or adults with mental disorders or substance-use disorders.
- At least 20 hours of documented orientation training within 3 months of beginning employment with the CCS for each staff member who has 6 months or more experience providing psychosocial rehabilitation services to children or adults with mental disorders or substance-use disorders.
- At least 40 hours of documented orientation training for each regularly scheduled volunteer before allowing the volunteer to work independently with consumers or family members.
- In addition to the 40 or 20 hours of documented orientation training referenced above, **peer specialists and rehabilitation workers** must receive 30 hours of training during the past two years (prior to beginning employment with the CCS) on the following topics: recovery concepts, consumer rights, consumer-centered individual treatment planning, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, and consumer confidentiality (DHS 36.10(2)(g) 20 and 21).

For more information regarding orientation training requirements, including a log/checklist and resources to fulfil the requirements, please visit the regional training orientation webpage: http://www.cwhpartnership.org/ccs-orientation.html.

Ongoing Training Requirements:

Each staff member shall receive at least eight hours of training each year that is designed to increase their knowledge and skills. For current CCS providers, documentation of completed ongoing training requirements from the past year must accompany this signed contract. In addition to completion of a training log, attendance certificates should be included (if available).

For more information regarding ongoing training requirements, including an "ongoing training log" sample, please visit the regional CCS ongoing training page: http://www.cwhpartnership.org/ongoing-training.html.

Additional Training Requirements Specific to the CWHP

The following online training must be completed prior to providing services in the CWHP, regardless of the number of training hours previously completed, and can be found at: http://www.cwhpartnership.org/ccs-orientation.html. The time invested in these trainings can be applied toward orientation or ongoing training hours:

- Overview of CCS Essentials for Providers (20 minutes)
- Quality Progress Notes Using TARP (20 minutes)
- Ethics and Boundaries in Community Behavioral Health (60 minutes)

Authorization of Services

The services provided must be individualized to each person's needs and recovery goals as identified through a comprehensive assessment. The services must fall within the federal definition of "rehabilitative services" under 42 CFS s. 440. 130(d) in order for the services to be reimbursed by Medicaid.

In order to qualify as psychosocial rehabilitation, a service must:

- Have been determined through the assessment process to be needed by an individual consumer
- Involve provision of a direct, authorized, and in-person service to the identified consumer
- Address the consumer's mental health and substance use disorders to maximize functioning and minimize symptoms

- Be consistent with the individual consumer's diagnosis and symptoms
- Safely and effectively match the individual's need for support and motivational level
- Be provided in the least restrictive most natural setting to be effective for the consumer
- Not be solely for the convenience of the individual consumer, family, or provider
- Be of proven values and usefulness
- Be the most economic option consistent with the consumer's needs

Services and supportive activities are selected based on the needs, goals, and preferences of the consumer identified in during the assessment process. Services and supports must be determined to be medically necessary and authorized by the county's Mental Health Professional and/or Substance Abuse Professional as defined in DHS 36.

Services to be provided will be detailed in the consumer's recovery plan. Service providers must obtain an authorization prior to providing any services. Service providers may contact the Service Facilitator to verify whether a service has been authorized. Services provided without authorization will not be paid.

Services may only be provided in the frequency and intensity detailed in the consumer's recovery plan. Services not provided during the time period in which they were authorized may not be carried over to the next authorization time period. Services would need to be re-authorized for the new time period of service.

It is understood that the final authority for determining client eligibility for service and the amount of services to be provided to individual clients rest with Purchaser and that Provider will not be reimbursed for unauthorized services provided to clients or provided in amounts that exceed those authorized for individual clients. Provider will only be reimbursed for approved direct client contacts and documentation of such contacts. No collateral contacted will be reimbursed by Purchaser on an interim basis; the costs of these contacts should be built into Provider's rates.

The Purchaser reserves the right to withdraw any client from the program, service, institution or facility of the Provider at any time when in the judgment of Purchaser it is in the best interest of Purchaser or the client to do so.

Billing and Documentation

Activities that can be directly billed to a county:

Per Medicaid rule (see ForwardHealth Update No. 2014-42), Providers can only submit interim (e.g. monthly) claims for reimbursement for the following types of direct costs:

- **Service delivery time.** Allowable types of direct service are described in the CCS Service Array, which can be found in Attachment 1 of the ForwardHealth Update. In order to be considered a direct service, the consumer must be present. Collateral contacts are not billable via interim claims and should be captured into Providers' rates. *The type and amount of service provided and invoiced must match what is stated in an individual consumer's Recovery Plan.*

  Direct services may be provided in-person or (if authorized) via telehealth.

- **Provider Travel Time** – defined as time for a service provider to travel to provide a CCS service to a consumer.

  If the provider does not have contact with the consumer, then the travel time is not billable on an interim basis. For example, if a provider goes to a consumer's home and the consumer is not there, then the time invested is not billable as a service. Costs associated with this time can, however, be accounted for during a provider's rate setting process.

- **Documentation time** – defined as time after service delivery for a service provider to complete the CCS progress note required by the Purchaser. If a provider does not have direct, face-to-face,

or approved telehealth contact with the consumer, then the documentation time is not billable on an interim basis. Costs associated with this time can, however, be accounted for during a provider's rate setting process.

Costs not directly billable to a county:

Direct to service costs that are necessary to support the CCS services an individual or agency provides (e.g. time providing supervision, in person or phone contact with collateral contacts, phone calls with consumers, orientation and training, etc.), and allocable general overhead costs (e.g. utility costs, accounting, financial, agency administration, etc.) are reimbursable, *but* ***cannot*** *be billed/invoiced on a monthly basis*. Rather, these costs can and should be built into the provider's hourly rate(s).

Providers will be asked to provide documentation of actual costs / justification of rates to the county(ies) they are providing services in. Technical assistance is available to assist providers in the rate setting process from the county they are providing service in.

Documentation:

Providers are required to document the services provided, and to submit claims for service delivery time, documentation, and provider travel time. The standard documentation format used by the CWHP is the typed TARP Progress Note. Alternative formats may be considered but must be reviewed and approved by the Coordinator(s) of the CCS programs for which you are providing services. During contract development, specific guidelines will address how to turn in documentation and when it will be due.

Rate Setting - Expectations for Providers

- Compliance with ForwardHealth Update 2014-42, specifically:

  Providers are required to indicate their usual and customary charge on claim details when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits through Medicaid or BadgerCare Plus. For providers using a sliding scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid or BadgerCare program patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

  The usual and customary charge should represent the expected actual costs of providing the service regardless if it is greater than or less than the interim rate. Comprehensive Community Services providers should not simply bill the interim rate. The difference between the actual costs and the interim payments will be accounted for during the cost reporting and cost reconciliation process and may result in either a payment or recoupment to the county.

- Compliance with Wisconsin Department of Health Services Allowable Cost Policy Manual: https://www.dhs.wisconsin.gov/business/allow-cost-manual.htm
- Compliance with Federal regulations. Federal regulations (2 C.F.R. §200.403) require that costs must be necessary and reasonable for the performance of the work, that costs are consistent with policies and procedures that apply uniformly to both CCS and non-CCS funds, and be adequately documented.

  A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Federal regulations provide specific guidelines on reasonable compensation for personal services (2 C.F.R.§200.430) and fringe benefits (2 C.F.R. §200.431). Compensation for employees engaged in work on CCS will be considered reasonable to the extent that it is consistent with that paid for similar work in other activities of the provider. In cases where the kinds of employees required for CCS are not found in the other activities of the provider, compensation will be considered reasonable

to the extent that it is comparable to that paid for similar work in the labor market in which the provider competes for the kind of employees involved.

Fringe benefits are allowances and services provided by employers to their employees as compensation in addition to regular salaries and wages. Fringe benefits include, but are not limited to, the costs of leave (vacation, family-related, sick or military), employee insurance, pensions, and unemployment benefit plans. The costs of fringe benefits are allowable provided that the benefits are reasonable and are required by law, employer-employee agreement, or an established policy of the provider.

- Completion and approval of the CWHP Rate Setting Tool: [http://www.cwhpartnership.org/rate-tool.html,](http://www.cwhpartnership.org/rate-tool.html) or similar rate setting tool approved by Purchaser, is required prior to signature and implementation of contracts. The Purchaser reserves the right to review and negotiate rates with individual providers.