ADDENDUM B
CONGREGATE CARE AND RESIDENTIAL SERVICES AGREEMENT

This Addendum amends, modifies, and supplements that certain Agreement for Purchase of Services (Agreement) between the Fairfax-Falls Church Community Policy and Management Team (CPMT) or the Fairfax County Department of Family Services, as the case may be, hereinafter referred to as the "Buyer", and hereinafter referred to as the "Provider." Where there exists any inconsistency between the Agreement and Addendum B, the provisions of Addendum B will control. This Addendum B reflects those services which the Provider agrees to make available to the Buyer. The provision of youth mental health residential treatment services will be consistent with Department of Medical Assistance Services (DMAS) regulations set forth in the Virginia Medicaid Provider Manual for Residential Treatment Services, as revised, found at https://www.dmas.virginia.gov/, including the regulations that establish practices promoting comprehensive services and supports that are family-driven, youth-guided, strengths-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. Services will be in accordance with the youth's Initial Plan of Care (IPOC), Comprehensive Individual Plan of Care (CIPOC), Individualized Family Service Plan (IFSP) and the Provider's treatment plan, or, as the case may be, the Individual Education Program (IEP), with a review of the applicable document within 30 days after placement. Any related services provided as part of the youth's IEP shall be for the purpose of providing benefit from the educational program. When not otherwise specified, the IPOC, CIPOC, IFSP and IEP will hereafter be referred to as the "treatment plan." Terms not otherwise defined herein shall have the same meanings ascribed to them in the Agreement.

I. FACILITY DESCRIPTIONS

1. GROUP HOMES: A congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents. Therapeutic Group Homes (TGH) (formerly Level B) must meet all licensing requirements of the Virginia Department of Behavioral Health and Developmental Services (DBHDS) https://dbhds.virginia.gov/clinical-and-quality-management/licensing-childrens-residential-providers/. Children's Residential Facilities (CRF) (formerly Level A) are licensed by the Virginia Department of Social Services https://www.dss.virginia.gov/facility/crf.cgi.
2. PRIVATE RESIDENTIAL SCHOOLS: Residential education services provided to students with disabilities who are placed into a residential program through an IEP in which the "least restrictive environment" is identified as an accredited private residential school. Includes all services identified in the IEP as necessary to provide special education and related services, including non-medical care and room and board.
3. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF): 24-hour, supervised, clinically and medically necessary, out-of-home program designed to provide necessary

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support and address mental health, behavioral, substance use, cognitive, or other treatment needs of a youth in order to prevent or minimize the need for more intensive inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. PRTF therapeutic services provided under the direction of a physician shall include assessment and re-assessment; room and board; daily supervision; treatment planning; family engagement; therapeutic passes; crisis management; individual, family and group therapy; care coordination; interventions; general or special education (not covered by the Medicaid program); medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing availability); specialty services; and discharge planning that meets the medical and clinical needs of the youth.

4. RESPITE CARE FACILITY: a facility that is specifically approved to provide short-term, periodic residential care to children accepted into its program in order to give the parents or legal guardians temporary relief from responsibility for their direct care.
5. QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP): a designation of non family based placements by the Administration for Children and Families (ACF). QRTPs serve children with specific treatment needs who need short term placement out of their home. Upon implementation of Family First in Virginia, Title IV-E funds can only be used for non family-based placements which are designated as QRTPs. Family First Virginia.

II. RESIDENTIAL TREATMENT SERVICES

Residential Treatment Services include benefits available to youth who meet the service specific medical necessity criteria based on diagnoses made by licensed mental health providers acting within their scope of practice. Noted below are two concepts that should be reflected in all providers' service delivery practices:

1. RECOVERY AND RESILIENCY: Integrate individualized, recovery based behavioral health services into their practices and service delivery operations. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
2. CULTURAL AND LINGUISTIC COMPENTENCY: Demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

   Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order

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to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over time as cultures change. Facilities must provide interpretation and translation services to ensure vital information concerning the youth's safety, well-being and treatment goals/progress are effectively communicated to guardians. This includes provision of translated written notification to guardians of vital information concerning the youth and interpretation services to allow for guardian participation in treatment planning and family engagement meetings.

III. RESIDENTIAL AND CLINICAL SERVICES:

All clinical services may not be provided by all providers. If applicable, the following services should be provided:

1. RESIDENTIAL ROOM & BOARD includes:
   - A. A component of the total daily cost for placement in a licensed congregate care facility. Residential Room and Board costs are maintenance costs associated with the residential placement and include a semi-private room, three meals and two snacks per day, and personal care items.
   - B. Payment to cover the cost of (and the cost of providing) food, shelter, daily basic supervision, school supplies, personal incidentals, liability insurance with respect to a youth, clothing, and costs related to administration and operation of a facility necessary to provide the items listed above.
     1) Food: Costs associated with providing food for the youth (net of USDA revenues), costs may include:
        a) The food itself
        b) Meal preparation; operation and maintenance of the kitchen facility
        c) Dietary supplies
        d) Salaries and fringe benefits associated with staff involved in food preparation and assuring appropriate dietary/nutritional standards are met
     2) Shelter: Costs associated with providing and maintaining living quarters for the youth, costs may include:
        a) Cost of a lease or rental agreement
        b) Utilities, furniture, and equipment
        c) Costs of housekeeping; linen and bedding
        d) Maintenance of the building and grounds
        e) Routine recreation
        f) Insurance related to the living quarters
        g) Taxes related to the shelter of the youth

SAMPLE

h) Costs may not include construction costs, but may include depreciation of capital assets, interest, and property taxes

3) Daily basic supervision (normal supervision duties): Costs associated with normal 24-hour supervision of the youth. Costs may include:
   a) The salaries and fringe benefits of staff (including house parents) involved in supervising the youth
   b) Recreation supervision
4) School supplies: Costs associated with books, materials, and supplies necessary for a youth's education
5) Personal incidentals: Incidental costs associated with the personal care of a youth such as: items related to personal hygiene; cosmetics; over-the-counter medications and special dietary foods; infant and toddler supplies, including highchairs and diapers; and fees for participation in activities outlined in Section 9, Socialization/Recreation, below
6) Clothing: Costs associated with providing and maintaining the clothing for the youth. These costs may include costs of the clothing itself, laundry, and dry cleaning.

C. The Provider shall provide each youth with sufficient space, safe board, sanitary conditions, and the level of supervision necessary to comply with the residential service description in the State Service Fee Directory. Special dietary needs shall be assessed and provided on an individual basis.

D. The rates for services will be paid for the first day services are provided to the placed youth. The rates for services will not be paid for the day of discharge from the services of the Provider.

E. In the event the youth leaves the facility without authorization for more than seven (7) consecutive calendar days, the Provider must obtain written authorization from the Buyer's case manager to continue to bill for the placement. In any event, the Buyer will discontinue payment for room and board and other services as of the 14th calendar day of the unauthorized absence.

F. If a youth in a residential placement is authorized for a service in an acute care setting, the bed in the residential placement will be held for the youth for no more than 14 calendar days with written approval of the Buyer's case manager. Longer holds will be negotiated on a case-by-case basis and must be authorized by the Family Assessment Planning Team (FAPT).

2. RESIDENTIAL DAILY SUPERVISION:

A. A component of the total daily cost for placement in a licensed congregate care facility. Activity includes around the clock supervision, through a resident-to-staff ratio approved by the Department of Behavioral Health and Developmental Services

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(DBHDS), with documented supervision checks every 15 minutes throughout the 24-hour period.

B. The youth's needs must be documented and must be billed as separate line items, clearly identifiable as separate from Therapeutic Behavioral Services/Residential Supplemental Therapies.

C. Is also referred to as Additional Daily Supervision and must be billed separately to permit IV-E reimbursement from a Therapeutic Group Home with QRTP designation.

3. RESIDENTIAL SUPPLEMENTAL THERAPIES:

A. A component of the total daily cost for placement in a licensed Psychiatric Residential Treatment Facility (PRTF) (formerly Level C residential treatment facility). Activity includes interventions that are goal-based with clear documentation/notes regarding the goal addressed, the intervention used, the resident's response/input, and plan for follow-up. Three non-psychotherapy interventions, including family engagement activities, shall be provided per 24-hour period including nights and weekends in addition to individual, group and family therapies specified in the treatment plan. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the youth's deviations from the treatment plan.

B. Therapeutic services rendered in a residential setting that provide structure for daily activities, psychoeducation, therapeutic supervision and activities, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the treatment plan. Therapeutic services engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members.

4. RESIDENTIAL MEDICAL COUNSELING:

A. A component of the total daily cost for placement in licensed PRTF. Activities include around the clock nursing and medical care through on-campus nurses and on-campus/on-call physician. Activities also include the doctor and nurse at every treatment planning meeting for resident.

B. Overall medical treatment of the youth is coordinated by the nursing staff or other medically trained staff. Such staff shall provide the scheduling, coordinating, monitoring of, and transportation to, medical treatments, physical examinations, and dental checks. In addition, trained staff shall coordinate and monitor the administration of medications and provide first aid to injured youth. The nursing staff or trained staff person shall conduct regularly scheduled meetings with each youth for the purpose of monitoring the onset of symptoms and reviewing nutritional, hygienic, and other regimens which may affect physical health. The services shall be supervised by a medical doctor.

SAMPLE

5. COUNSELING/THERAPY: All efforts should be made to use Evidence Based Practices such as Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), and Trauma-Focused Cognitive Behavior Therapy (TF-CBT)) when possible, as well as provision of trauma-informed care by trained clinicians.
   A. INDIVIDUAL THERAPY: Individual counseling/therapy shall be provided in accordance with the youth's treatment plan by a licensed clinician or license-eligible clinician under supervision. The frequency of such counseling/therapy shall be determined on a youth-specific basis and shall be approved by the Buyer's case manager prior to its initiation. Occurrence of therapy shall be a minimum of three sessions per week and shall be documented in the treatment plan and progress notes.
   B. GROUP THERAPY: Group counseling/therapy shall be provided in accordance with the youth's treatment plan by a licensed clinician or license-eligible clinician under supervision. The frequency of such counseling/therapy shall be determined on a youth-specific basis and shall be approved by the Buyer's case manager prior to its initiation. The therapy shall be documented in the treatment plan and progress notes.
   C. FAMILY THERAPY: Family counseling/therapy shall be provided in accordance with the youth's treatment plan by a licensed clinician or license-eligible clinician under supervision. The family counseling/therapy with the family member and significant others is for the direct benefit of the youth and is not aimed at addressing treatment needs of the youth's family or significant others. The youth shall be present at all sessions except when it is clinically appropriate for the youth to be absent in order to advance the youth's treatment goals. This can include sessions prior to the youth's readiness for psychoeducation and to begin to prepare the family for eventual discharge when appropriate. Family therapy shall be collaboratively scheduled to accommodate the families' schedules and ability to travel to the facility. Telemedicine services may be utilized. Counseling with family is to include techniques that will assist the family in the return of the youth to the family when appropriate. The frequency of such counseling/therapy shall be determined on a youth-specific basis and shall be approved by the Buyer's case manager prior to its initiation. Occurrence of therapy shall be a minimum of one face to face session per month. If telehealth services are utilized, family sessions should be available to the family weekly. Family sessions should begin once the child has completed the initial orientation to begin treatment. Family sessions shall be documented in the treatment plan and progress notes.

6. FAMILY VISITATION: Ongoing contact, therapy, and visitation are a critical component of an individual's clinical services and basic human rights. The Provider shall plan and schedule regular and ongoing visits for the youth with the family, relatives, and/or others

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(e.g., foster parents, adoptive parents, and fictive kin) in accordance with the youth's treatment plan.

A. Family visitation shall not be withheld as a behavioral consequence.
B. Any reduction or change in visitation must have clinical justification and the approval of the Buyer's case manager prior to the reduction or change.
C. Family visitation shall be flexible to accommodate the family's schedule and ability to travel to the facility.
D. Home passes shall begin as soon as it is safe and feasible to do so. Achievement of specific goals or levels shall not preclude a youth from beginning home passes. The decision as to when to begin home passes shall be a collaborative process with the family/community, treatment teams, and the facility. Home passes cancelled due to behavioral incidents shall only occur when the incident increases the likelihood of safety concerns on the home pass.be considered prior to discharge.

7. FAMILY ENGAGEMENT: A family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency and well-being for youth and families. Family engagement requires ongoing opportunities for a youth to build and maintain meaningful relationships with family members, e.g. frequent, unscheduled, and non-contingent phone calls and visits between a youth and family members. Family engagement may also include enhancing or facilitating the development of the youth's relationship with other family members and supportive adults responsible for the youth's care and well-being upon discharge.

A family engagement activity is an intervention, which may be provided in person or on the phone, consisting of family psychoeducational training or coaching; transition planning with the family; family and independent living skills, and training on accessing community supports as identified by the treatment plan. Family engagement activity does not include and is not the same as family therapy/counseling.

Family engagement shall be provided at least weekly as outlined in the treatment plan and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the treatment plan. The PRTF must provide interpretation/translation services to remove a language communication barrier to family engagement. When family engagement is not possible, the PRTF shall identify and document the specific barriers to the youth's engagement with the family or legal authorized representatives. The PRTF shall document on a weekly basis, the reason why family engagement is not occurring as required. The documentation shall specify alternative family engagement strategies to be used as part of the interventions in the treatment plan.

SAMPLE

In instances where the family or legal guardian has disengaged from treatment and routinely not participating in the weekly family engagement activities, the facility should document the communication and care coordination with the Buyer.

8. THERAPEUTIC PASS: Shall be provided as clinically indicated in the plan of care and as paired with community and facility-based interventions and therapeutic services to promote discharge planning, community integration and family engagement. Therapeutic passes should consist of collaboration with the family, legal guardian and/or supportive adults and involve consideration for what is clinically appropriate for the youth and family within the family's structure, culture and goals for engagement with the youth as they receive residential services.

   The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass.

9. SOCIALIZATION/RECREATION: Youth shall have regular, scheduled opportunities for socialization and recreation through individual and group activities designed to enhance learning, provide cultural enrichment, foster reintegration into the community, enhance leadership skills, and improve self-esteem. Goals to accomplish these specific outcomes will be identified in Individual Recreation Plans (IRPs) developed and documented by the Provider and the Buyer's case manager for each youth. The activities shall be designed to provide fun and pleasure and may include, but are not limited to, outdoor athletics, field trips, games, camping and crafts.

10. EDUCATION: Services that are provided to meet the educational needs of the youth in a group home setting as required by the educational requirements of the Virginia Code. Such services may include public school integration, on-site residential schooling, community based vocational training, vocational training, alternative education, or special education. See Addendum A regarding Education requirements.

11. RESIDENTIAL EDUCATION: A component of the total daily cost for placement in a licensed PRTF. These education services are provided in a licensed, privately-owned and operated PRTF to a child/youth with or without an individualized education program (IEP) who has been placed for non-educational reasons.

12. EMERGENCY SERVICES: Emergency services are programs and supports that are available 24 hours/day, 365 days/year that can be accessed immediately and may include

SAMPLE

crisis stabilization, pre-screening for mental health commitments, and emergency mental health assessments. Such services shall be time-limited, supportive, and clear as to purpose and goals.

For certain Providers emergency shelter may be purchased during the 72-hour emergency custody provision of the law as outlined in the Virginia State Social Services Manual. Provision of such service shall be provided on a temporary/emergency basis, up to 30 days and shall include, but is not limited to, room and board.

13. TRANSPORTATION: Transportation to support attainment of the goals in a child's service plan, either through contracted services or payment of mileage. Services may be designed to enable a child or family member to attend counseling, parenting classes, court, visitation with family members, or other appointments. Vehicles will be equipped with a first aid kit, a road safety kit, and seat belts will be utilized at all times youth are being transported. Maintenance checks will be performed on vehicles at regular intervals to ensure the safety of youth while being transported. The drivers shall be subject to a Department of Motor Vehicles check and all driving licensure requirements. Medicaid covers non-emergency medical transportation to and from residential treatment covered services and interventions including the provision of family engagement activities. This transportation must be pre-authorized by and billed to the Medicaid transportation broker or assigned MCO transportation contractor and is not included as part of the Residential Treatment Service.

14. ONE-ON-ONE CARE: One-on-one care is provided to youth whose medical, behavioral, or emotional condition necessitates close supervision and monitoring which cannot be provided through the regular staff-to-youth ratios. This supervision shall be designed to provide safety and support through acute periods. Except in emergencies, one-on-one care shall be provided only after approval from the Buyer's case manager. It shall be limited to the number of hours approved by the Buyer's case manager and the FAPT. One-on-one care is not to be charged to the Buyer during the sleeping hours of the youth, unless otherwise authorized by the Buyer.

15. INTERPRETATION: Services are provided when youth or youth's family's primary language is other than English and do not have English proficiency. The facility shall communicate with the youth and youth's guardians in their preferred language. If another language is identified, the facility will outline processes to be used for family sessions and communication of vital information, both written and verbal, prior to admission. If the facility needs additional funding, this shall be communicated with the Buyer's case

SAMPLE

manager prior to admission. This interpretation must be pre-authorized and is not included as part of the Residential Treatment Service.

16. SUBSTANCE USE/ADDICTION: Services are provided to assist youth and their families with recovery from substance use/addiction. Treatment of the actively substance-addicted population shall incorporate a structured program that addresses the addiction and the associated developmental, family, peer, and relationship issues. Treatment shall incorporate education and individual and group therapy dealing with substance use/addiction and concomitant problem areas, with a strong emphasis on family therapy and the twelve step programs for the development of coping and living skills to prevent relapse. Treatment shall also incorporate the provision of continuing care or referral to appropriate facilities for continuing care services.

17. URINE DRUG SCREEN (UDS): A UDS shall be considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

18. PROBLEMATIC SEXUAL BEHAVIOR/SEXUAL TRAUMA: Services are provided to assist youth who have demonstrated problematic sexual behavior or who have experienced sexual abuse. The program shall be designed to provide a professional evaluation and treatment by a licensed provider with specialized training and relevant expertise.

19. INDEPENDENT LIVING SKILLS TRAINING AND SERVICES: Services specifically designed to help adolescents make the transition to living independently as an adult. Services include training in daily living skills as well as vocational and job training.
    A. The Provider should provide or ensure training to youth ages 14 and older to help the youth gain life skills and transition successfully from foster care. The living skills training services are direct activities toward specific goals in accordance with the transition living plan. The training and services should include activities that fit into the domains of the Casey Life Skills Assessments, including daily living, self-care, housing and money management, career and education planning, permanency, and other domains.
    B. The Provider shall work collaboratively with the Buyer in providing independent living services mandated under the Foster Care Independence Act of 1999.
    C. Progress on independent living goals should be included in the monthly reports.

SAMPLE

D. The Provider will complete a Casey Life Skills Assessment for any youth ages 14 and older in their program within 30 days of placement or within 30 days of a youth turning 14 who is currently placed.
   1) The Casey Life Skills Assessments must be updated at least yearly. The youth may complete the plan on their own or it can be a collaborative effort with the youth and the Provider.
   2) The Casey Life Skills Assessment can be found at Casey Life Skills Toolkit - Casey Family Programs.
   3) Once completed the Provider should summit a copy to the Buyer's case manager within 10 days.

E. A transition living plan must be completed by the Provider within 30 days of completion of the Casey Life Skills Assessment.
   1) The transition living plan should be a collaborative effort with the youth and all treatment providers, including the Buyer's case manager. The transition living plan may be completed during an LCPA treatment meeting and other team-based planning meeting.
   2) A sample transition living plan can be received from the Buyer (DFS Life Skills Coordinator), upon request. In the event the Provider already has a transition living plan template, this plan must be approved by the Buyer's case manager prior to use.
   3) The transition living plan shall be updated at least yearly, or modified as needed, such as when the youth achieves the goals before the end of the year. Updates are done in collaboration with the Buyer's case manager, the youth, the youth's family, the provider, and any other members of the youth/family's team. Any significant changes proposed to the service/treatment plan will reflect the consensus of the youth, family, and team. An updated plan should be submitted to the Buyer's case manager within 10 days of the decision to make changes.
   4) The Buyer's case manager serves as the point of contact for the team-based planning process and is responsible for decisions about services rendered in a manner consistent with the FAPT authorization and team-based planning process.

F. The provider must complete a 90–day transition living plan for a youth 90 days before the youth turns 18, 19, 20 and 21.
   1) The 90–day transition living plan should be a collaborative effort with the youth and all treatment providers, including the Buyer's case manager. The transition plan may be completed during an LCPA Treatment meeting and other team-based planning meetings.
   2) A sample 90-day transition living plan can be received from the Buyer's case manager upon request. In the event the Provider already has a transition living plan template, this plan must be approved by the Buyer's case manager prior to use. The 90–day transition living plan must be updated at least yearly. Once completed, the

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Provider should submit a copy to Buyer's case manager within 90 days before the youth turns 18, 19, 20 and 21.

20. ASSESSMENT/EVALUATION: Service conducted by a qualified professional utilizing a tool or series of tools to provide a comprehensive review with the purpose to make recommendations, provide diagnosis, identify strengths and needs, risk level, and describe the severity of the symptoms. The service is a face-to-face interaction by a Licensed Mental Health Professional (LMHP) (including residents under supervision of licensed provider) that shall include a documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues. Additional diagnostic services may be requested by the Buyer from the Provider in addition to those psychological, educational, medical, and other diagnostic evaluations provided by the Buyer at the time of admission of the youth. The Provider may recommend approval of additional services from the Buyer's case manager.

21. APPEARANCES: It is understood that in the course of the provision of services, the Provider's staff may be called upon by the Buyer's case manager to appear for court hearings, Family Resource team meetings, Family Partnership Meetings, and FAPT meetings. Information to be provided at such hearings or meetings may include assessments, evaluations, recommended services, the services provided, and the progress resulting from the service interventions. The Buyer will make every attempt to notify the Provider well in advance of the Provider's requirement to appear at the court hearings and meetings. When possible, subpoenas will be provided for court.

22. ACCESS TO FACILITY: In addition to the language in Section 7A of the Agreement for Purchase of Services, the Provider will at all times provide the Buyer access to the child's living areas/residence/bedroom. At the Provider's request the Buyer's agents will sign a notice of confidentiality if there are Provider concerns about confidentiality of roommates or other children in the facility.

23. SECLUSION AND RESTRAINT: PRTF's must comply with federal requirements regarding restraint and seclusion. Providers should refer to 42 CFR Section 483.350 – 483.376 for detailed information regarding definitions, the protection of youth: orders for the use of restraint or seclusion; consultation with the treatment team physician; monitoring of the youth in and immediately after restraint or seclusion; notification of the youth's parent or legal guardian in the parent/guardian's preferred language.; application of time out; post emergency safety intervention debriefings; medical treatment for injuries resulting from an emergency safety intervention; facility reporting; and, education and training of staff.

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IV. TREATMENT PLANNING AND REPORTING:

1. INITIAL PLAN OF CARE (IPOC)
   A. The Provider will complete and submit to the Buyer the IPOC within 24 hours of admission by the treatment team.
   B. The IPOC shall include:
      1) Youth and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;
      2) Diagnoses, symptoms, complaints and complications indicating the need for admission;
      3) Description of the functional level of the youth;
      4) Treatment objectives with short-term and long-term goals;
      5) Any orders for medications, psychiatric, medical, dental, and any special healthcare needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the youth;
      6) Plans for continuing care, including review and modification to the plan of care;
      7) Plans for discharge; and
      8) Signature and date by the youth, parent, or legally authorized representative, a physician and treatment team members.

2. COMPREHENSIVE INDIVIDUAL PLAN OF CARE (CIPOC):
   A. The Provider will complete and submit to the Buyer the CIPOC within 14 days of admission by the treatment team.
   B. The CIPOC shall:
      1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and development aspects of the youth's situation and must reflect the need for residential care;
      2) Be developed by an interdisciplinary team of physicians and other licensed mental health professionals
      3) State treatment objectives that shall include measurable, evidence-based, short-term and long-term goals and objectives, family engagement activities, and the design of community-based aftercare with targeted dates for achievement;
      4) Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the youth and the family treatment needs; and
      5) Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the youth's family, school, and community.

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C. The CIPOC shall be reviewed every 30 calendar days by the team responsible for the CIPOC to determine that services being provided are or were required from the Provider and to recommend changes in the plan as indicated by the youth's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the youth, parent, or legally authorized representative, a physician and treatment team members.

D. The "treatment team" developing the CIPOC shall meet the following requirements:

1) At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child and adolescent psychiatry, the team must be capable of all of the following: assessing the youth's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the youth's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the CIPOC's objectives.

2) The team shall include either:

(i) A board-eligible or board-certified psychiatrist;

(ii) A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or

(iii) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a licensed clinical psychologist.

3. TREATMENT REVIEW MEETINGS: The legal guardian and the Buyer's case manager shall be invited to all scheduled/emergency treatment team meetings. For youth in the custody of the DFS, the youth/youth's family shall be invited when deemed appropriate by the Buyer's case manager.

4. PROGRESS NOTES: Individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress or lack of progress toward goals and objectives in the plan of care. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units required to deliver the service. The content of each progress note shall corroborate the time or units billed. Progress notes shall be documented for each service that is billed.

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5. MONTHLY PROGRESS REPORTING:
   A. The Provider will complete and submit a monthly report **by the 15th day of the month** after the end of the month services were delivered.
   B. Monthly reports shall be submitted to the Buyer's case manager. Electronic submission via a secure email transmission is strongly encouraged.
   C. The monthly report, submitted on the Provider's letterhead, shall include the following:
      1) Provider's legal name, email, and phone number (including clinician name and credentials)
      2) Identifying client information to include name of youth and birthdate
      3) Progress on goals; progress toward discharge
      4) Progress in family therapy; frequency type; type of visits, contacts, and off-site passes
      5) Significant incidents affecting the youth
      6) Change in therapist, medication, and/or agencies/service involvement with youth
      7) Current functioning in major life domains (e.g., school, home, community, legal)
      8) Date of reporting period
      9) DSM-V Diagnoses and medications

6. CRISIS SAFETY PLANNING: "Crisis" means a deteriorating or unstable situation that produces an acute, heightened emotional, mental, physical, medical, or behavioral event. "Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis. A crisis safety plan to include interventions to stabilize and prevent harm and higher level of acuity shall be part of discharge and therapeutic pass planning.

7. DISCHARGE PLANNING: Beginning at admission and continuing throughout the youth's residential placement, the Buyer, parent or legally authorized representative, FAPT case manager and if applicable, Medicaid case manager, shall be involved in treatment planning and shall identify the anticipated needs of the youth and family upon discharge and identify the available services in the community.

   Prior to discharge the Provider shall complete a comprehensive discharge plan in the CIPOC and if applicable, submit to Magellan of Virginia for review with its service authorization request. Upon approval of the discharge plan, the Provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for comprehensive needs assessments as needed. The Provider shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the youth has been enrolled in school, and shall provide IEP recommendations to the school if necessary.

SAMPLE

8. DISCHARGE SUMMARY REPORTING:
    A. The Provider will complete and submit a discharge summary report within ten (10) business days of the discharge/end of service. This report will include a crisis safety plan that has been developed within 10 days prior to discharge from the program. A written copy of the crisis safety plan will be provided to the family when developed and at discharge from the program.
    B. Discharge reports shall be submitted to the Buyer's case manager. Electronic submission via a secure email transmission is strongly encouraged.
    C. The discharge/termination report, submitted on Provider's letterhead, shall include the following:
        1) Provider's legal name, email, and phone number (including clinician name and credentials)
        2) Summary of progress on goals
        3) DSM-V diagnoses and medications at time of discharge
        4) Description of functioning in major life domains at end of service (e.g., school, home, community, legal)
        5) After-care plans, including recommendations for levels of service, will be based on clinical needs.
        6) Crisis Safety Plan to be included after being developed with the youth and family and provided to the family prior to discharge.
        7) Written recommendations provided to the parent/caregiver for after-care upon discharge that will foster the youth's continued recovery and stability. Written recommendations will build upon treatment objectives, strengths, successes, natural supports, and other resources as well as referencing appointments with after-care providers.

V. REIMBURSEMENT FOR SERVICES:

1. PAYMENT THROUGH INSURANCE: The Provider agrees to accept the family's insurance, or Virginia Medicaid or FAMIS for payment of services, provided that the Buyer obtains the permission and signature of the parent or legal guardian of the youth. CSA will not fund services covered by the above forms of insurance if that insurance is available to pay for services.

    When all or any portion of the services rendered by the Provider hereunder is covered by a policy of insurance, Medicaid, or FAMIS, the Provider shall submit claims for such service to the insurance company holding such policies, as the case may be. The Buyer shall pay the balance remaining due, if any, within 45 days after the Provider furnishes satisfactory evidence

SAMPLE

to the Buyer that the payment by the insurance company is the full amount. If the Provider receives Virginia Medicaid or FAMIS payments for services rendered under this Agreement, such payments shall constitute payment in full for those services.

2. PROVIDER MEDICAID SERVICES: The CPMT requires all providers whose services meet the Virginia Medicaid standards for Residential Treatment Services as outlined in the Community Mental Health Rehabilitative Services Manual, to enroll as a Therapeutic Group Home (TGH) provider (formerly Level B) or PRTF. Medicaid application information is available through:

Virginia Medicaid - PES PO Box 26803 Richmond, VA 23261-6803
1-800-829-5373 (in state toll-free) 1-804-270-5105 local
Fax: 1-804-270-7027
Home | Virginia Medicaid

If the Provider is already enrolled as a Medicaid provider, the Provider shall provide the Buyer with its Medicaid Provider number with the submission of contract documents. The Provider shall be responsible for timely and complete filing per the Department of Medical Assistance Services Community Mental Health Rehabilitative Services located at:
Home | Virginia Medicaid

A. All youth being considered for admission to a PRTF or TGH will be assessed by the Independent Assessment, Certification, and Coordination Team (IACCT) to determine the appropriate level of care. An IACCT Inquiry Form must be submitted within five days of the youth receiving Medicaid eligibility. This form may come from the child's parent/guardian, private provider, school, or agency. The IACCT process guide can be found at Acentra Health_IACCT Roadmap (hubspotusercontent-na1.net). A certificate of need shall be completed by the IACCT according to the DMAS regulations.
The Provider shall be responsible for:
   1) Completing and forwarding the Medicaid pre-authorization materials, including the Initial Review form, for each Medicaid eligible youth to the DMAS contractor within three business days after admission or after receipt of information from the Buyer.
   2) Notifying the Buyer when a youth is authorized for Medicaid reimbursement. Such notice is required by fax at (703) 803-7128 within five business days after the Provider receives notice from DMAS that the youth is approved or denied.
   3) Developing the CIPOC for the youth within 30 days of authorization for Medicaid reimbursement and reviewing every thirty 30 days.

SAMPLE

4) Completing the continued stay criteria and submitting it to the DMAS contractor prior to expiration of the authorization period.
5) Preparing and implementing DMAS billing.
6) Ensuring that its physicians and other professionals serving the Buyer's referred clients are also enrolled in Medicaid and providing the Buyer with the Medicaid number of those individuals on staff or under subcontract who provide services to the Buyer's clients.
7) Billing DMAS for other Medicaid covered services, e.g., therapy, pharmacy.
8) Invoicing the CPMT for the non-Medicaid eligible services according to Section 27 of the Agreement for Purchase of Services.
9) Notifying the Buyer when the youth no longer meets the Medicaid reimbursement criteria and DMAS no longer authorizes payment for the youth. Such notice is required by FAX to (703) 803-7128 within five business days after the Provider receives notice from DMAS that it will no longer make payment.

B. The Provider is responsible for submitting all Medicaid preauthorization documentation and continuing stay documentation within the time frames required by Medicaid. If a Provider fails to submit this information in a timely manner for Medicaid RTC reimbursement, the Provider is financially responsible and shall not be eligible for reimbursement from the Buyer.

C. The Buyer shall provide the Medicaid number of the youth referred, if applicable. When referring a youth for Medicaid residential treatment the Buyer's responsibilities are to:
1) Provide a complete copy of DSM-V diagnosis.
2) Complete the score sheets from the CANS form for the current CANS rating (both the Youth Functioning Profile and the Caregiver Functioning Profile) and submit to the Provider as part of the authorization process. The CANS rating shall be completed within 30 days prior to placement and shall be submitted to the Provider in a timely fashion. It shall indicate at least two areas of moderate impairment as defined in the eligibility criteria.
3) Submit a placement assessment signed by the Buyer's case manager which includes: a description of the youth's behavior during the 30 days immediately prior to admission, a description of alternative placements attempted or explored and the outcomes of each, a description of the level of family support available, and a description of the initial plan of care.

D. The Buyer is responsible for providing the CIPOC, a complete copy of the DSM-V diagnosis, a completed CANS rating, and a placement assessment in a timely manner to assist the Provider with submission of documentation within the time frames required by Medicaid. Providers should contact the Medicaid Analyst with the County's Federal Reimbursement Unit at (703) 324-7120 ***or*** ***Vickie.Grazioli@Fairfaxcounty.gov*** to

SAMPLE

request the above information. The Medicaid Case Analyst will send a signed Medicaid Rate Certificate to the provider for their submission to Magellan.

3. OUT OF STATE FACILITIES: If a youth requires residential level of service that is not available in Virginia, out of state providers must apply for Virginia Medicaid reimbursement for a specific youth by contacting Magellan of Virginia https://www.dmas.virginia.gov/.

VI. INVOICING:

1. The Provider will submit invoices in accordance with Section 27 of the APOS and Section 5 of this Addendum B within ten (10) business days of the end of the month. The Buyer reserves the right to reject any invoices with incomplete data elements. Time frames for payment begin when the invoice contains all required elements.

A. The invoice shall include the following:

1) Provider's legal name, email, and phone number
2) Separate invoice for each youth
3) Youth's name
4) Month service was provided
5) Purchase order/service request number
6) Buyer's case manager name
7) Services delivered as defined on the rate sheet
8) Contract unit price
9) Number of units
10) Dates of service

B. TITLE IV-E: The CPMT requires that all allowable costs for foster care youth must be structured in accordance with all Federal and State regulations to allow the Buyer to seek appropriate reimbursement for those services via Title IV-E of the Social Security Act. Whenever a service can be claimed to Title IV-E, Title IV-E must be the payer of first resort. The Provider shall be responsible for providing the Buyer with documentation that meets requirements for Title IV-E reimbursement, including a Financial Placement Agreement with appropriate itemization of services and fees where definitions agree with this document and the executed rate sheet.

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