CHAMPAIGN COUNTY BOARD
COMMITTEE OF THE WHOLE – Finance/Policy/Justice Addendum
County of Champaign, Urbana, Illinois
Tuesday, February 9, 2010 – 6:00 p.m.

Lyle Shields Meeting Room, Brookens Administrative Center
1776 East Washington Street, Urbana, Illinois

Page Number

VIII. Finance:

A. Budget Amendments & Transfers

5. Budget Amendment #10-00033 1-3
   Fund/Dept: 641 Access Initiative Grant – 053 Mental Health Board
   Increased Appropriations: $679,597
   Increased Revenue: $679,596
   Reason: To create account for subcontract from the Illinois Department of Human Services (DHS) for management of federal Substance Abuse and Mental Health Services Administration (SAMHSA) Cooperative Agreement.

G. Other Business

1. Closed Session pursuant to 5 ILCS 120/2(c)2 to consider collective negotiating matters between the County and its employees or their representatives

REQUEST FOR BUDGET AMENDMENT BA NO. 10-00033

FUND 641 ACCESS INITIATIVE GRANT **DEPARTMENT** 053 MENTAL HEALTH BOARD

INCREASED APPROPRIATIONS:

ACCT. NUMBER & TITLE	BEGINNING BUDGET AS OF 12/1	CURRENT BUDGET	BUDGET IF REQUEST IS APPROVED	INCREASE (DECREASE) REQUESTED
641-053-511.03 REG. FULL-TIME EMPLOYEES	0	0	225,000	225,000
641-053-513.01 SOCIAL SECURITY-EMPLOYER	0	0	17,719	17,719
641-053-513.02 IMRF - EMPLOYER COST	0	0	20,034	20,034
641-053-513.04 WORKERS' COMPENSATION INS	0	0	827	827
TOTALS	0	0	263,580	263,580

INCREASED REVENUE BUDGET:

ACCT. NUMBER & TITLE	BEGINNING BUDGET AS OF 12/1	CURRENT BUDGET	BUDGET IF REQUEST IS APPROVED	INCREASE (DECREASE) REQUESTED
641-053-331.94 HHS-MNT HTH SRV FOR CHLDN	0	0	679,596	679,596
TOTALS	0	0	679,596	679,596

EXPLANATION: TO CREATE ACCOUNT FOR SUBCONTRACT FROM THE ILLINOIS DEPT OF HUMAN SERVICES (DHS) FOR MANAGEMENT OF FEDERAL SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) COOPERATIVE AGREEMENT.

DATE SUBMITTED:	AUTHORIZED SIGNATURE ** PLEASE SIGN IN BLUE INK **
02-04-10	Kenny K. Lawyer

APPROVED BY BUDGET & FINANCE COMMITEE: DATE:

 REQUEST FOR BUDGET AMENDMENT BA NO. 10-00033

INCREASED APPROPRIATIONS:

ACCT. NUMBER & TITLE	BEGINNING BUDGET AS OF 12/1	CURRENT BUDGET	BUDGET IF REQUEST IS APPROVED	INCREASE (DECREASE) REQUESTED
641-053-511.03 REG. FULL-TIME EMPLOYEES	0	0	225,000	225,000
641-053-513.01 SOCIAL SECURITY-EMPLOYER	0	0	17,719	17,719
641-053-513.02 IMRF - EMPLOYER COST	0	0	20,034	20,034
641-053-513.04 WORKERS' COMPENSATION INS	0	0	827	827
641-053-513.05 UNEMPLOYMENT INSURANCE	0	0	1,353	1,353
641-053-513.06 EMPLOYEE HEALTH/LIFE INS	0	0	10,824	10,824
641-053-522.01 STATIONERY & PRINTING	0	0	5,100	5,100
641-053-522.02 OFFICE SUPPLIES	0	0	2,400	2,400
641-053-522.06 POSTAGE, UPS, FED EXPRESS	0	0	650	650
641-053-522.44 EQUIPMENT LESS THAN $1000	0	0	19,900	19,900
641-053-533.07 PROFESSIONAL SERVICES	0	0	141,797	141,797
641-053-533.12 JOB-REQUIRED TRAVEL EXP	0	0	2,653	2,653
641-053-533.29 COMPUTER SERVICES	0	0	3,000	3,000
641-053-533.33 TELEPHONE SERVICE	0	0	18,000	18,000
641-053-533.50 FACILITY/OFFICE RENTALS	0	0	25,000	25,000
641-053-533.70 LEGAL NOTICES,ADVERTISING	0	0	1,500	1,500
641-053-533.92 CONTRIBUTIONS & GRANTS	0	0	115,481	115,481
641-053-533.95 CONFERENCES & TRAINING	0	0	29,036	29,036
TOTALS	0	0	640,274	640,274

INCREASED REVENUE BUDGET:

ACCT. NUMBER & TITLE	BEGINNING BUDGET AS OF 12/1	CURRENT BUDGET	BUDGET IF REQUEST IS APPROVED	INCREASE (DECREASE) REQUESTED
641-053-331.94 HHS-MNT HTH SRV FOR CHLDN	0	0	679,596	679,596
TOTALS	0	0	679,596	679,596

REQUEST FOR BUDGET AMENDMENT

BA NO. 10-00033

INCREASED APPROPRIATIONS:

ACCT. NUMBER & TITLE	BEGINNING BUDGET AS OF 12/1	CURRENT BUDGET	BUDGET IF REQUEST IS APPROVED	INCREASE (DECREASE) REQUESTED
641-053-544.33 FURNISHINGS, OFFICE EQUIP	0	0	28,075	28,075
641-053-511.02 APPOINTED OFFICIAL SALARY	0	0	11,248	11,248
TOTALS	0	0	39,323	39,323

INCREASED REVENUE BUDGET:

ACCT. NUMBER & TITLE	BEGINNING BUDGET AS OF 12/1	CURRENT BUDGET	BUDGET IF REQUEST IS APPROVED	INCREASE (DECREASE) REQUESTED
TOTALS	0	0	0	0

Illinois Department of Human Services
Carol L. Adams, Ph.D., Secretary

Mental Health CSA Attachment B

I. Introduction
II. Applicable Rules and Definitions
III. Programs and Services
IV. Provider Database and Deliverables
V. Payment
VI. Eligibility Criteria
VII. Reporting Requirements
VIII. Special Conditions

I. Introduction

This document serves as an attachment to the Illinois Department of Human Services (DHS) Community Services Agreement and sets forth supplemental contractual obligations between the Provider and the Department. The Attachment provides contractual requirements beyond those in the Agreement and is intended to clarify programmatic areas of the Department of Human Services Division of Mental Health (DHS/DMH) programs.

DHS/DMH is transitioning from a grant based funding to a fee-for-service based system. The performance of certain administrative functions, services, and processes related to this transition have been contracted for through an Administrative Services Organization (ASO). The name of the DHS/DMH ASO agent is The Illinois Mental Health Collaborative for Access and Choice (Collaborative).

II. Applicable Rules and Definitions

The Provider must comply with all applicable federal, state and local rules and statutes, including, but not limited to, the following:

A. Federal

1. Block Grants for Community Mental Health Services, Subp. I & III, Part B, Title XIX, PHS Act/45 CFR Part 96;
2. Medicaid (42 U.S.C.A. 1396 (1996);
3. 42 CFR 440 (Services: General Provision) and 456 (Utilization Control) (1996);
4. Health Insurance Portability and Accountability Act (HIPAA) as specified in 45 CFR, Section 160.310.

   More information on Federal Rules and Codes may be obtained on the internet at the following address: http://www.gpoaccess.gov/cfr/index.html

B. State

1. Mental Health and Developmental Disabilities Code (405 ILCS 5);
2. Community Services Act (405 ILCS 30);
3. Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110);
4. 59 Ill. Admin. Code 50, Office of Inspector General Investigations of Alleged Abuse or Neglect in State-Operated Facilities and Community Agency;
5. 59 Ill. Admin. Code 51, Office of Inspector General Adults with Disabilities Project;
6. 59 Ill. Admin. Code 103, Grants;
7. 59 Ill. Admin. Code 115, Standards and Licensure Requirements for Community Integrated Living Arrangements;
8. 59 Ill. Admin Code 117, Family Assistance and Home-Based Support Programs for Persons with Mental Disabilities;

9. 59 Ill. Admin. Code 125, Recipient Discharge/ Linkage/Aftercare;
10. 59 Ill. Admin. Code 131, Children's Mental Health Screening, Assessment and Supportive Services program;
11. 59 Ill. Admin. Code 132, Medicaid Community Mental Health Services Program;
12. 59 Ill. Admin. Code 135, Individual Care Grants for Mentally Ill Children;
13. 89 Ill. Admin. Code 140, Medical Payment;
14. 89 Ill. Admin. Code 140.642, Screening Assessment for Nursing Facility and Alternative Residential Settings and Services;
15. 89 Ill. Admin. Code 507, Audit Requirements of Illinois Department of Human Services;
16. 89 Ill. Admin. Code 509, Fiscal/Administrative Record keeping and Requirements;
17. 89 Ill. Admin. Code 511, Grants and Grant Funds Recovery;
18. Campus Security Enhancement Act of 2008 (110 ILCS 12/1)

More information on State Statutes and Rules may be obtained on the internet at the following address:

http://www.ilga.gov (For Statutes select "Illinois Compiled Statutes" for Rules select "Administrative Rules")

C. Manuals and Handbooks

The Provider shall comply with all applicable requirements for services and service reporting as specified in the following Department manuals and/or handbooks:

1. DHS/DMH Provider Manual: http://www.dhs.state.il.us/page.aspx?item=33244
2. DHS Mental Health CSA Program Manual: http://www.dhs.state.il.us/page.aspx?item=41497
3. DHS/DMH PAS/MH Manual: http://www.dhs.state.il.us/OneNetLibrary/27896/documents/Contracts/PAS%20MH%20Contractor's%20Procedure%20Manual.pdf
4. Community Forensic Services Handbook: http://www.dhs.state.il.us/OneNetLibrary/27896/documents/Contracts/Forensic%20Training%20Manual%20%20(UST).pdf
5. Community Mental Health Service Definitions and Reimbursement Guide: http://www.hfs.illinois.gov/assets/070107_cmph_guide.pdf
6. DHS/DMH Collaborative Provider Manual: http://www.illinoismentalhealthcollaborative.com/
7. Handbook for Providers of Screening Assessment and Support Services, Chapter CMH-200 Policy and Procedures For Screening, Assessment and Support Services: http://www.hfs.illinois.gov/assets/0708sass.pdf

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B. Definitions for Terms Used in Attachment B

1. **Accepted Bill:** A bill a Provider submitted to the Department of Human Services or its agent, within twelve months from the date of service, that cleared all edits by the DHS or its agent and the Department of Healthcare and Family Services.
2. **Active Medicaid Individual:** An individual who has been determined by the Department to have an active status under Title XIX or Title XXI of the Social Security Act.
3. **Administrative Expense:** Administrative expense defined according to the instructions provided by the Department for the completion of the Consolidated Financial Report (CFR). This excludes any non-reimbursable expenses as defined in those instructions, but includes direct program administration costs plus management and general costs. Program administration costs are those expenses that are caused by activities not related to an

individual case, but related to administration of the overall program. Examples include, but are not limited to:

a. Accrued salaries and wages earned by all administrative, managerial, office, and clerical employees;
b. Administrative staff payroll, taxes, fringe benefits, and Worker's Compensation Insurance;
c. Other employee benefits for administrative and management staff;
d. Administrative consultants;
e. Telecommunications costs not assigned to program activities;
f. The costs of administrative office supplies and expensed equipment; and
g. Management and general expenses that are not part of any one program, but are caused by services to all programs run by an agency.

4. **Advanced Payments:** Payments made to a Provider prior to the delivery of services. Accepted billings will be credited against these advanced payments per the procedures described in this contract. Payments not earned by billings for services are subject to recovery by the Department.
5. **Allowable expense:** An expense by a provider associated with the provision of community mental health services as defined in 89 Ill. Admin. Code 509, Section 509.20a.
6. **Attachment:** That part of the Community Service Agreement that contains the contract provisions specific to the Division of Mental Health. The DHS/DMH attachment is referred to as "Attachment B".
7. **Bill:** A statement of charges for mental health services that conforms to the requirements for billing prescribed by a DHS/DMH agent for processing bills. A bill may apply to Medicaid or non-Medicaid services and to HFS eligible individuals, including Medicaid eligible, or to DHS/DMH eligible individuals.
8. **Billable Service:** A service described in either the 59 Ill. Admin. Code 132 or the current Community Mental Health Service Definitions and Reimbursement Guide.
9. **Capacity Grant:** Funding for certain mental health programs or portions thereof that are not reasonably reimbursed on a fee-for- service basis or otherwise sustained by consumer market demand. This funding is awarded as grants. The amounts of these grant awards are specified by program name on the accompanying FY 2010Attachment Cover Sheet and are expected to be reconciled by expenses as outlined in 89 Ill. Admin. Code 511.
10. **Community Support Team:** A service under the Mental Health Medicaid Rule, 59 Ill. Admin. Code 132, that requires a team of staff to coordinate and deliver the services to an individual.
11. **Consumer:** An individual who has received a DHS/DMH mental health treatment service or has participated in a DHS/DMH program.
12. **Coordination of Benefits:** A systematic process of determining all parties liable for payment for a service to an individual and the amount of each party's liability.
13. **Department:** Reference to the Department of Human Services (DHS) or the Division of Mental Health (DHS/DMH) acting on behalf of the Department of Human Services or reference to any agent representing the Department or the Division in the execution of the terms of this contract.
14. **Department Approved Rate:** The rate associated with each billable service as specified in the current Community Mental Health Service Definitions and Reimbursement Guide.
15. **DHS/DMH:** Department of Human Services, Division of Mental Health.
16. **DHS/DMH Eligible Individual:** An individual who meets the eligibility criteria for DHS/DMH, but who has not been determined to meet the eligibility requirement or be on active status for Programs administered by the Illinois Department of Healthcare and Family Services, including Title XIX or Title XXI, All Kids, and Veterans' Care. This includes

individuals who do not meet eligibility requirements under Title XIX or Title XXI, individuals who might meet those eligibility requirements but have not applied (or have not had their application approved), and individuals who may become active Medicaid individuals once they meet a Medicaid "spend-down" requirement.

17. **Evidence Based Practice:** The preferential use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatment for specific problems.
18. **Fee-for-Service:** Funding mechanisms by which the payments are made on the basis of a rate, unit cost, or allowable cost incurred and are based on a statement or bill as required by the Department. Payments made as a fee-for-service are not subject to the Illinois Grant Funds Recovery Act (30 ILCS 705). Payment is made contingent on the Provider's delivery of services, as documented in an accepted bill.
19. **Grant:** A funding mechanism by which a program of services and activities receives all or part of the funding in advance of the actual delivery of services. This includes prorated prospective payments and payments made by the Department on an estimated basis or any other basis when the Department does not know the actual amount earned by the Provider. This does not include advance payments made under the authority of Section 9.05 of the State Finance Act (30 ILCS 105/9.05). All funds paid as a grant are subject to the Illinois Grant Funds Recovery Act (30 ILCS 705) and subject to reconciliation under 89 Ill. Adm. Code 511, section 511.10.
20. **Grant Activity Report:** The report submitted to the Department of a program of services and activities funded as a capacity grant program. This report must conform to the requirements specified by DHS/DMH. A grant activity report is not a bill.
21. **Household:** A household includes all persons who occupy a housing unit. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy) as separate living quarters. Separate living quarters are those in which the occupants live and eat separately from any other persons in the building and which have direct access from the outside of the building or through a common hall. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated persons who share living arrangements. (People not living in households are classified as living in group quarters.)
22. **Household Income:** The gross amount of income a household receives evidenced by pay stubs, tax returns or other documents submitted to the provider or reported to the provider by the consumer, their guardian or family member. Should a consumer be unwilling or unable to provide this information, the provider may estimate the amount on the basis of available information, them provider may estimate this amount on the basis of available information through documentation of an attestation, a sample of which is in the DMH Provider Manual.
23. **Housing Coordinator:** The Division of Mental Health Housing Coordinator - Coordinates all matters related to Permanent Supportive Housing (PSH) development, as well as, all matters that relate to housing options that DMH currently funds. Relates to all public entities local, state, and federal, as well as private to facilitate the expansion of permanent supportive housing on a statewide level. Coordinates any necessary activities and forums with any and all stakeholders to further the development of permanent supportive housing options in Illinois.
24. **Illinois Mental Health Collaborative for Access and Choice (Collaborative):** The DHS/DMH name for the functions, services, and processes performed by the DHS/DMH Administrative Service Organization.
25. **HFS Eligible Individual:** An individual who meets the eligibility requirement and is on active status for Programs administered by the Illinois Department of Healthcare and Family Services, including Title XIX or Title XXI, All Kids, and Veterans' Care.
26. **Medicaid Contract Amount:** The portion of the Provider's Total Billable Contract Amount the Department estimates the Provider will bill for Medicaid services provided to Medicaid recipients. The Department has calculated this amount based upon the Provider's past

billing history.

27. **Medicaid Service:** Any service defined under the Medicaid Community Mental Health Services Program in 59 Ill. Admin. Code 132.
28. **Mental Health Service Site:** A physical location, designated by an address and linked to a particular DMH-contracted Mental Health Provider, from which this provider delivers a DMH funded Mental Health Service and has **all** of the following characteristics:
    - Each service site may have only one address;
    - Each service site must have a unique address (no two sites may share the same address);
    - The site must be owned, leased, or otherwise controlled by a DMH funded Mental Health Provider;
    - The site must have staff employed by or under contract with the DMH funded Mental Health Provider;
    - A DMH funded Mental Health Provider may have multiple service sites.

    Certified Mental Health Service Site - A Mental Health Service Site as defined above that has been certified as defined by 59 IL Adm. 132 ("Rule 132") as determined by the Department of Human Services (DHS) or the Department of Children and Family Services (DCFS) or their respective agents designated for this purpose. A Mental Health Service Site may be certified only if the DMH Mental Health Provider with which the site is associated is also certified. A DMH provider may provide both Medicaid and non-Medicaid services for which they are certified/approved at a certified site.
29. **Monthly FY10 Total Billable Contract Amount:** One-twelfth of the sum of a Provider's annual Medicaid contract amount and annual non-Medicaid contract amount for FY 2010.
30. **Non-Medicaid Contract Amount:** The portion of the Provider's Total Billable Contract Amount the Department estimates the Provider will bill for non-Medicaid services or for Medicaid services provided to non- Medicaid recipients.
31. **Non-Medicaid Service:** Any service defined in the Community Mental Health Service Definitions and Reimbursement Guide as Non-Medicaid (DHS only) service.
32. **Permanent Supportive Housing (PSH):** Integrated permanent housing (typically rental apartments or units with a self-contained bathroom and kitchenette) linked with flexible community-based mental health services that are available to the tenant/consumer as needed, but not mandated as a condition of occupancy. The PSH model is based on a philosophy that supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible and available support services.
33. **Program:** A defined set of one or more mental health activities or services that are grouped to achieve objectives for a particular population or mental health system need. The distinction of a program is not in the individual activities or services, which are not exclusive and may be included in more than one program, but in the combination of the activities.
34. **Program Manual:** A resource manual that by reference is part of the Community Service Agreement. It contains further explanation of the DMH specific guidelines, requirements, and contract provisions in Attachment B when warranted.
35. **Provider:** A community-based agency or entity, including community hospitals, delivering direct mental health services to individuals through a Community Services Agreement with DHS/DMH.
36. **Provider Database:** A collection by DHS/DMH or its agent containing key pieces of information to describe aspects of the Provider's organization and its operations.
37. **Provider Manual:** A policy and procedure document produced by DHS/DMH and the Collaborative providing a source of readily available information regarding administration of Collaborative functions, services and process including consumer enrollment, service delivery requirements, service authorizations, monitoring, billing administration, forms and

other valuable information in executing the provider's business arrangement with DHS/DMH.

38. **Purchase of Service:** See "Fee-for-Service"
39. **Reconciliation of Grant Payments:** The process by which DHS grant payments to Providers for the fiscal year are compared to the Provider's expenses for the year or the number or amount of services and activities delivered during the fiscal year. This process is described in 89 Ill. Admin. Code 511.
40. **Resident:** A individual with a home address in the State of Illinois, including individuals who are considered "homeless" but spending their nights in Illinois.
41. **SASS:** The Screening Assessment and Support Services program of intensive mental health services delivered by an agency to provide pre-admission, crisis stabilization, and follow-up services to children with mental illness or emotional disorder who are at risk for psychiatric hospitalization.
42. **Service:** Treatment events or products as contracted for through this agreement.
43. **Third Party Payments:** Payments from Medicare, other government entities, private insurance and other payers liable for payment for services for an individual (excluding payments from the individual or their family) for specific services for an identified individual. Not included are payments (such as grants) to the Provider that are not designated for services to a specific individual.
44. **Total Billable Contract Amount:** The sum of the Provider's Medicaid contract amount and the non-Medicaid contract amount payable within the contractual fiscal year obligations.
45. **Unearned Medicaid and non-Medicaid Contract Amount:** The difference between the Provider's total billable contract amount and the sum of the Provider's total accepted bills for services with dates of service within the current fiscal year.

III. Programs and Services

Through this agreement with the Provider and as reflected on the Provider's Contract Attachment Cover Sheet, the Department purchases one or more mental health programs or services, which are to be provided and then reported or billed to the Department under the following broad categories.

A. **Services Purchased by Fee-for-Service**

1. Medicaid Services

   These services are defined in 59 Ill. Admin. Code 132. These services shall be delivered in compliance with the service's standards and requirements 59 Ill. Admin. Code 132 for all individuals receiving the services.

2. Non-Medicaid Service

   These services are defined in the "Community Mental Health Service Definitions and Reimbursement Guide."

3. Pre-admission Screening and Resident Review for Persons with Mental Illness (PAS/MH; Cost Center 790)

   These services will be provided by agencies designated by DHS/DMH Central Office as "PAS Agent". Pre-Admission Screening, Resident Review and Targeted Case Management will be provided to individuals who have been referred for long term care nursing home admission (PAS) or are residing in Nursing Facilities who require, by policy, additional screening, resident review, or Targeted Case Management. Services will be provided irrespective of payee status. The State of Illinois is required to purchase these activities under 89 Ill. Admin. Code, Chapter I, Part 140.642. Details concerning the services are presented in the DHS/DMH PAS/MH manual.

4. Individual Care Grant (ICG) Services

   Highly specialized residential or intensive in-home rehabilitative and habilitative services for children and adolescents with serious mental illness. The residential services shall include, at a minimum, intensive individual, group, and family therapy within a twenty-four hour

treatment continuum. In addition, the intensive in-home services shall include, at a minimum, therapeutic stabilization, child support services, behavior management interventions, and case coordination services. Services details are available in 59 Ill. Admin Code 135. SASS-ICG providers are required to screen for Medicaid eligibility and initiate applications for Medicaid for all new ICG referrals.

5. Community Hospital Inpatient Psychiatric Services (CHIPS; Cost Center 550)

   CHIPS consists of inpatient psychiatric treatment services contracted for by DHS/DMH to be provided through a community hospital.

B. **Capacity Grant Programs**

This contract may include grant funding for programs or portions thereof that involve some services and activities that have not been converted to a fee-for-service basis. DHS/DMH has calculated the amount and type of these services and activities and the associated funding, which is awarded as grants and is not expected to be reimbursed as fee-for-service.

The Provider's obligation in receiving these grant funds is to expend the funding for allowable expenses required to meet the program's objectives and to report to the Department on appropriate deliverables. As it meets the program objectives, a Provider may determine that some program activities supported by these grant funds are billable services. However, when a Provider bills for an activity under a capacity grant program, the Provider is not to report the activity or the expenses as part of the grant funded deliverable, as this would result in counting the activity more than once in meeting the Provider's obligation.

Because the Department must track capacity grant awards through its accounting system, the Provider's FY 2010 Attachment Cover Sheet may display portions of the total award for a program among several lines. In the reconciliation of allowable expenses the Department expects the provider to demonstrate allowable expenses for the total of these lines for each program, not portions of the award that may be associated with specific accounting service codes or Provider service sites.

The programs that comprise capacity grants vary among Providers, and not all Providers are currently funded for each of these programs.

The capacity grant services listed below must meet the following guidelines:

1. At least 80% of the grant award shall be applied to allowable expenses necessary to deliver services and related activities for consumers participating in this program.
2. The specific services, activities, staffing, subsidies and per diems of care to be supported by each capacity grant programs are to be reported to DHS/DMH as prescribed in the DHS/DMH Provider Manual.
3. Not more than 20% of the grant award for any service may be applied to administrative expenses.

These guidelines apply to the following services.

a. Mental Health Juvenile Justice (Cost Center 121)
b. Urban Systems of Care (Cost Center 140)
c. Consumer Centered Recovery Support (Cost Center 213)
d. Geropsyhiatric Services (Cost Center 540)
e. PATH Grant (Cost Center 575)
f. Co-location Project (Cost Center 576)
g. Crisis Services (Cost Center 580)

Additional capacity grant services and their associated requirements, in addition to the reporting requirements and 20% cap on administrative expenditures are:

1. SASS Flex (Cost Center 131)
   a. At least 80% of the grant award shall be applied to allowable expenses necessary to deliver services and related activities for consumers participating in this program.

b. Services purchased are to be reported as directed by the DHS/DMH Children & Adolescent Office

2. Psychiatric Leadership (Cost Center 350)
   a. At least 80% of the grant award shall be applied to allowable expenses necessary to deliver services and related activities for consumers participating in this program. At least 80% of the grant award shall be applied to salaries and benefits or contractual costs for psychiatrists and support staff, such as nursing and clerical staff, involved in the delivery of psychiatric services, including supervision and other leadership functions.
   b. Psychiatric services delivered under this program that are not billed as a DHS/DMH Medicaid or non-Medicaid service are to be submitted as a service report only to the Department or its agent.
3. Special Projects (Cost Center 510)
   a. At least 80% of the grant award shall be applied to support staff time and other costs necessary to fulfill the scope of the project.
   b. DHS/DMH will specify any additional reporting requirements.
4. Specialized Direct Clinical Services (Cost Center 515)
   a. At least 80% of the grant award shall be applied to support staff time and other costs necessary to fulfill the scope of the project.
   b. Instructions for reporting will be issued by DHS/DMH.
5. Client Transition Subsidies (Cost Center 572)
   a. At least 80% of the grant award shall be applied to allowable expenses for temporary assistance to meet the living needs of specific individuals.
   b. Services purchased are to be reported to the Department or its agent.
6. Adolescent Transition to Adult Services (Cost Center 573)
   a. At least 80% of the grant award shall be applied to the costs for special alternative or adjunctive therapeutic services and activities not offered by the Provider that are purchased from other service Providers to meet the needs of specific individuals transitioning into adulthood.
   b. Services purchased are to be reported as a service report only for specific individuals to the Department or its agent.
7. Psychiatric Medications (Cost Center 574)
   a. At least 80% of the grant award shall be applied to allowable expenses related to the psychiatric medication needs of specific individuals.
   b. Services purchased are to be reported as a service report only for specific individuals to Department or its agent.
8. Community Integrated Living Arrangement (CILA; Cost Center 620)
   a. At least 80% of the grant award shall be applied to other allowable expenses related to activities and services necessary to maintain this residential program, such as staff, rent, mortgage payments, utilities, maintenance costs, food and supplies. If the CILA is a supervised residential program, the Provider may request that these expenses be combined with those of other supervised residential programs operated by the agency and funded by DHS/DMH.
   b. Services provided under this program are to be reported as nights of care for specific consumers in a service report to the Department or its agent.
9. Supported Residential Services (Cost Center 820)
   a. At least 80% of the grant award shall be applied to other allowable expenses related to activities and services necessary to maintain this residential program, such as staff, rent, mortgage payments, utilities, maintenance costs, food and supplies.

b. Services provided under this program are to be reported as nights of care for specific consumers in a service report to the Department or its agent.

10. Supervised Residential (Cost Center 830)
    a. At least 80% of the grant award shall be applied to other allowable expenses related to activities and services necessary to maintain this residential program, such as staff, rent, mortgage payments, utilities, maintenance costs, food and supplies. The Provider may request that these expenses be combined with those in other supervised residential programs, included supervised residential CILA programs, operated by the agency and funded by DHS/DMH.
    b. Services provided under this program are to be reported as nights of care for specific consumers in a service report to the Department or its agent.
11. Crisis Residential (Cost Center 860)
    a. At least 80% of the grant award shall be applied to other allowable expenses related to activities and services necessary to maintain this residential program, such as staff, rent, mortgage payments, utilities, maintenance costs, food and supplies.
    b. Services provided under this program are to be reported as nights of care for specific consumers in a service report only through the Department or its agent.

    Further descriptions are located in the DHS/DMH Collaborative provider manual.

C. **DHS TANF Initiative**

The Temporary Assistance for Needy Families (TANF) program provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical expenses. Since the inception of this program in 1997, DHS has had agreements with various types of contractors who provide employment and training services to TANF customers in an effort to help them gain independence.

Pursuant to the Deficit Reduction Act, changes were made to federal TANF regulations that place greater restrictions on the types of activities that are countable and tighten record-keeping requirements. Failure to meet the new requirements would result in the potential loss of millions of dollars in federal funding. Consequently, DHS must increase the number of Work Experience and Community Service positions available for TANF customers. Accordingly, DHS has begun a new initiative to encourage additional providers to establish such positions.

Below is a description of this new initiative. Provider participation in this program is voluntary. If you choose to participate, DHS will provide you with a specific agreement detailing requirements of the program.

The Role of the Provider

The Provider will ensure it establishes work experience and/or community services positions for up to three individuals participating in the Temporary Assistance to Needy Families (TANF) employment and training program. These individuals are referred to herein as the "Participant" or "Participants".

The Participants will be referred to the Provider by the local Family Community Resource Center (FCRC) or by a TANF employment and training contractor. Participants will be assigned to either work experience or community service positions for no more than thirty hours per week.

The Provider will be required to provide daily supervision to the Participant(s) assigned, complete daily attendance records, provide comments on the Participant's progress, and transmit this information on a weekly basis to the person or entity that made the referral (i.e., the local office and/or Employment & Training contractor).

The attendance form must be signed by the Participant(s) and the site supervisor. The Provider's site supervisor must participate in monthly telephone conferences with the case manager assigned to the client/customer. These telephone conferences will be held at a time that is mutually agreeable to the site supervisor and the case manager.

For Community Service positions, the Provider must provide the following information: (1) a

description of the agency's mission, (2) how its services benefit the community, (3) the task(s) that will be performed by the Participant(s) at the agency, and (4) the job skills to be acquired by performing the task(s). It is preferred that all documents required are submitted to the agency prior to the client/customer being referred to the provider; however, such documents must be provided no later than (5) days after receiving the referral. Daily attendance of the client must be recorded and maintained.

Upon request, record of the attendance of each customer sent to the referring agency must be sent to the TANF caseworker.

For Work Experience, the Provider must identify the specific tasks/duties to which the Participant (s) will be assigned. It is preferred that all documents required are submitted to the agency prior to the client being referred to the provider; however, such documents must be provided no later than five days after receiving the referral. Daily attendance of the client must be recorded and maintained. Upon request, record of the attendance of each customer sent to the referring agency must be sent to the TANF caseworker.

Definitions of TANF Work and Training Activities

Work Experience - Provides a Participant with an opportunity to acquire the general skills, training, knowledge, and work habits necessary to obtain employment. The activity must be supervised daily by an employer, work site sponsor, or other responsible party. Participants may be placed in a supervised assignment with public, private or not-for-profit employers, organizations and governmental agencies. Pursuant to applicable law, the maximum number of hours each Participant may be assigned per week is thirty; the specific number of weekly hours a Participant may be assigned will be determined by DHS.

Community Service - A structured program in which Participants perform work for the direct benefit of the community under the auspices of a public or non-profit organization. Community service programs must be limited to projects that serve a useful community purpose in fields such as health, social services, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and childcare. Community service programs are designed to improve the employability of Participants not otherwise able to obtain employment; Participants in such programs must be supervised daily on an ongoing basis. Pursuant to applicable law, the maximum number of hours each Participant may be assigned per week is thirty; the specific number of weekly hours a Participant may be assigned will be determined by DHS.

If you have any questions or require further information, please contact DHS' Division of Human Capital Development at (312) 793-0683 or (217) 785-3300.

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IV. Provider Database and Deliverables

A. Provider Database

The Provider in consultation with the DHS/DMH Regional Office will cooperate in maintaining and updating the Provider Database. Data elements collected include but are not limited to the following:

1. General provider administrative identification information, such as addresses, telephone numbers and hours of operation.
2. Services and programs offered to individuals at each provider site.
3. Listing of other government and charitable organizations funding the Provider's mental health services listed in the Community Mental Health Services Definitions and Reimbursement Guide.
4. Listing of subcontracts that the Provider has entered into with private entities to deliver direct mental health services billable or reportable to DHS/DMH. These entities must be certified under Rule 132 to provide these services. Note: This requirement does not apply to subcontracted entities doing business as an individual or a sole proprietor.

B. Deliverables

1. Contract Deliverables for Medicaid and non-Medicaid Services

   The Provider will submit bills to the Department on at least a monthly basis for billable services funded by the Provider's Medicaid and non-Medicaid contract amounts.

2. Pre-Admission Screening and Resident Review for Persons with Mental Illnesses (PAS/MH Cost Center 790) Deliverables

   Providers designated to provide PAS/MH services are expected to complete pre-admission screening for any person with mental illnesses in the Provider's service area that is seeking admission to a nursing facility.

   The Provider is also expected to be available to perform resident reviews for persons in their service area who are already residents of nursing facilities under certain circumstances. The deliverables for any funding for these activities are bills submitted to the Department for screenings and reviews that have been completed according to the Department's requirements.

3. Individual Care Grant (ICG) Deliverables
   a. The deliverables for Providers that receive funding for individual care grants are bills submitted to the Department for services provided consistent with the Department's rules and regulations concerning this program. The Provider will submit bills to the Department on at least a monthly basis.
   b. ICG Providers are required to screen for Medicaid eligibility and initiate applications for Medicaid eligibility for all new ICG referrals.
   c. ICG Providers are required to submit quarterly progress reports to DHS/DMH or its agent.
   d. ICG Providers are required to comply with 59 Ill Admin Code 132.

4. Community Hospital Inpatient Psychiatric Services (CHIPS: Cost Center 550)

   The deliverables for Providers that receive funding for CHIPS are bills submitted to the Department for services provided consistent with the DHS/DMH Scope of Service for this program. The Provider will submit bills to the Department on at least a monthly basis.

5. Capacity Grant Contract Deliverables

   The Provider will submit grant activity reports to the Department generally on at least a monthly basis in a manner prescribed by the Department for each of the programs funded as part of the Provider's capacity grant contract amount. The Department will specify for the Provider what the grant activity reporting requirements are for each program (service units provided to individuals, staff hours, events, dollars expended, etc.). The Provider is not required to make these reports until the Department has specified what the reporting requirements are for each Capacity Grant program.

   The Department will review the Provider's grant activity reports during the fiscal year. If the Provider fails to submit these reports according to the Department's requirements, the Provider may not be in compliance with this contract, and the Department may require a plan of correction to ensure the timely submission of these reports; for serious and substantial non-compliance, the Department may reduce the Provider's contract amount in the current or succeeding fiscal year.

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V. Payment

A. Payment for Fee-for-Service

1. Payment for Medicaid and non-Medicaid Services.
   a. For billable services to be delivered, providers will receive Advanced Payments for the first six months of the Total Billable Contract Amount for FY 2010.
   b. For all subsequent months, (January through June), Provider will be eligible for an adjusted pre-payment using the following criteria:

i. Payments for the remainder of the year will be based on the year to date monthly average of Accepted Bills submitted for services delivered in FY10. Adjustments to the payment using this criteria will occur based on data available to the Department at the end of November and the end of February.

ii. The Department may establish service limits for the Medicaid and non-Medicaid services.

iii. The Department assumes no obligation to pay for non-Medicaid services in excess of the non-Medicaid portion of the FY10 Total Billable Contract Amount.

2. Payment for Pre-Admission Screening and Resident Review for Individuals with Mental Illnesses (PAS/MH: Cost Center 790)

   The Department shall make all payments for Pre-admission Screening for individuals with mental illnesses seeking admission to a nursing facility (PAS/MH) and for resident reviews of individuals in nursing facilities per policy as fee for service payments after delivery of the service and receipt by the DHS/DMH of a bill for those services. Details of these payments are available in the PAS/MH manual.

3. Payment for Individual Care Grants (ICG)

   The Provider will receive payment for services delivered under individual care grant on a fee for service basis.

4. Payment for Community Hospital Inpatient Psychiatric Services (CHIPS: Cost Center 550)

   The Provider will receive payment for services delivered under CHIPS on a fee for service basis.

B. Payment for Capacity Grants

In general, the Department will make monthly payments to the Provider for capacity grants equal to one-twelfth of the annual total capacity grant amount.

C. Payment for Special Projects

The Department may adopt a different payment schedule for special projects. The details of these special projects will be specified in an exhibit describing the scope of service for the special project or will be on file with the Department.

D. Safety Net

If the existing levels of consumer access to community mental health services are adversely impacted by an adjusted reduction in the payment of the Provider's Monthly FY10 Total Billable Contract Amount, the Provider shall petition their Regional Office for "safety net" assistance to sustain consumer access levels. Conditions that may warrant the issuance of a "safety net" payment are identified in Section VII B) 1-4 and C) of this document. Providers should contact their Regional Office to discuss their specific situation.

Payments made under the "safety net" provision of this contract will not increase the total contract amount, inclusive of fee-for-service, capacity grant and special projects. In addition any payments made as a safety net are subject to the recovery provisions of this contract as outlined in Section V, E) of this document.

E. Payment Recovery

1. Fee-for-Service

   a. Medicaid and non-Medicaid reconciliation and recovery will occur as follows::

      i. The Department will determine the total amount of accepted bills for Medicaid and non-Medicaid billable services with dates of service during fiscal year 2010 that have been processed by the Departments of Human Services and Healthcare and Family Services or DHS/DMH's agent before the end of September 2010.

      ii. This amount will be subtracted from the Provider's FY 2010 Medicaid and non-Medicaid payments for services delivered during FY 2010.

      iii. If the results of this subtraction result in a positive remainder amount, this

remainder amount is subject to recovery.

iv. Providers will be allowed twelve months from the date of service to submit a bill before the recovery process is initiated.

v. The Department will offset future payments to a provider to recover funds paid under the FY10 Total Billable Contract Amount that were not earned through service delivery

b. PAS/MH, ICG, and CHIPS services, will be reconciled by comparing billed services to actual services provided, with any positive difference subject to recovery.

2. Capacity Grants

Payment Reconciliation

All payments for funding in capacity grant contract amounts in this contract shall be reconciled by expenses as described in the Grants and Grant Funds Recovery Rule, 89 Ill. Adm. Code 511, section 511.10 a), subject to specific expenditure and other restrictions detailed in this contract. This reconciliation must be done by each individual program as specified on the cover sheet of the Provider's contract.

Service Reconciliation

Failure to demonstrate appropriate expenditures according to the conditions stated in "Section III. Programs and Services" for the full amount of each capacity grant program may result in grant fund recovery.

F. Coordination of Benefits

The Provider is responsible for determining whether the individual or family has private or public benefits that can pay for services. The Provider shall assist individuals and their families in applying for any benefits for which they may be eligible. This may include using a screening tool to evaluate the potential for any individual to become eligible for Medicaid or AllKids benefits. The Provider shall document in the individual's record the Provider's assessment for entitlement eligibility, their efforts to assist in the application process, and, if applicable, when an application for such benefits has been made to the Department of Human Services, the Department of Healthcare and Family Services, the Veteran's Administration, or the Social Security Administration.

When an individual is provided a billable service under this contract and the Provider determines that the individual has other resources for payment, the Provider is to follow these procedures for submitting a bill to the Department:

1. The Provider will determine if there are other liable third parties for payment, other than the individual or the individual's family, and will bill those third parties first
2. The Provide will bill DHS/DMH for the service at the DMH rate:
3. The Provider will report on the bill to DHS/DMH the amount of any third party payments received for the service or anticipated to be received (if the actual amount received differs, the Provider shall resubmit the bill with the correct amount actually received);
4. DHS/DMH will then price the bill and pay the lower of the following:
   a. The Provider's usual and customary charge for the service minus the sum of all third party payments, or
   b. The established DHS/DMH rate for the service minus the sum of all third party payments.

G. Other Payment Conditions

1. Informing consumers of DHS/DMH funded services

Under the Health Insurance Portability and Accountability Act (HIPAA) and the requirements in the DHS/DMH Provider Manual, the Provider shall inform all consumers receiving services funded by DHS/DMH that the name and demographics of the individual receiving the services and the services received are reported to DHS/DMH as the payer of the services and retained

in the DHS/DMH information database. This notification shall be entered in the individual's clinical record.

2. Special Projects

   For special projects (program codes 510 and 515) the method of payment will be specified in an exhibit to this attachment that may include the scope of services, activities or deliverables for the project and budget detail.

3. Debt Service Deduction

   a. If the Provider is approved by the Department for a debt service deduction contract to participate in a pooled loan program or other loan program, the Provider hereby authorizes the Department to deduct the Provider's debt service payments from the Provider's award and forward payment directly to the trustee bank or other designated party. If so participating, the Provider agrees to execute a debt service deduction contract in the form provided by the Department.

   b. If the Provider desires to participate in such a deduction contract, the Provider shall provide ninety days written notice to the Department of its intention to enter into pooled loan financing, or any other financing transaction which would require the use of a debt service deduction mechanism by the Department. If the Provider fails to provide such notice, the Department shall not execute any debt service deduction contracts until the Department has had ninety days for project review. The Department has the right of approval of all financed projects where the debt service deduction will be performed by the Department.

   c. The Provider shall supply to the Department an estimated debt service deduction payment schedule thirty days before closing of the loan transaction.

   d. Additionally, Providers specifically acknowledge that if they enter into a debt service deduction contract to secure a loan based upon fee-for-service funding, such funding is based upon individuals receiving services, each authorized for service or placement by the Department, at rates set by the Department. Accordingly, if and when funding for a particular individual receiving services terminates, the Department does not guarantee replacement of equivalent funds. Therefore, any such debt service deduction contract will be honored only to the extent of currently supported fee-for-service funding at the time of any debt service deduction.

4. Funding Reserves

   The Department maintains the right to reserve funds in this contract based on budgetary considerations. Providers subject to reserves will be notified in writing of the amount and duration of the funding reserve.

5. Payments for Services to Individuals Not Eligible for Medicaid

   For DHS/DMH eligible individuals who are not active recipients under either the Medicaid or AllKids programs, DHS/DMH will pay bills for services according to a payment table based on the individual's household income and household size. This payment table is available in the DHS/DMH Collaborative Provider Manual.

   http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/CompGuide/FinancialEligibilityMay2007. (pdf)

6. Billing Requirements

   Billings for the following services must meet the requirements under VI. below and require authorization by DHS/DMH or its agent:

   a. Assertive Community Treatment (ACT)

   b. Community Support Team (CST)

   c. Supervised Residential, including Community Integrated Living Arrangements (CILA)

   d. Crisis Residential

7. Change in Contract Amount

The Department may increase or decrease contract amounts during the year depending upon available funds and Provider accepted billings, grant activity reporting and contract compliance. However, total payments to the Provider for the services delivered during the fiscal year shall not exceed the total annual contract amount.

8. Full Year Service Delivery

   The funds obligated under this total annual award are intended by the Department to support programs and services for individuals for the entire twelve-month period of the State fiscal year referenced herein. The Provider shall ensure that all programs and services funded by this award, are available for the entire twelve-month period of the fiscal year regardless of when full disbursement of the award occurs (unless prior written authorization is obtained from DHS/DMH). The Department reserves the right to stop all payments to Providers who cease providing programs and services during the contract year without the prior written approval of the Department.

9. Payment Adjustments

   DHS/DMH is required to manage expenditures within the appropriation spending authority contained in the DHS/DMH annual budget. As such, in the absence of additional available funding and spending authority for DHS/DMH, providers submitting billings which vary significantly from their estimated contract amounts should expect to see adjustments in their contract and payments, during and in subsequent years.

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VI. Eligibility Criteria

A. Criteria for Individuals

Medicaid, non-Medicaid and Capacity Grants

1. Individuals Eligible for Services
   a. Crisis, outreach/engagement, mental health assessment, and stakeholder education services may be provided to any individual in need.
   b. Services defined in Rule 132 (Medicaid services) are to be limited to the following persons:
      i. Persons who are residents of Illinois, and
      ii. Are persons with a diagnosis, including Axis V of the Diagnostic and Statistics Manual IV (DSM-IV), listed as eligible in the DHS/DMH Collaborative Provider Manual, and
      iii. Persons who are HFS eligible individuals, including Medicaid eligible individuals, or
      iv. Persons who are DHS/DMH eligible individuals and for whom the Provider has reported the individual's household income and household size as part of the individual's registration information.
   c. All other services, activities and subsidies, including those supported by capacity grants, are limited to:
      i. Persons who are residents of Illinois, and
      ii. Are persons with a diagnosis, including Axis V of the Diagnostic and Statistical Manual IV (DSM IV), listed as eligible in the DHS/DMH Collaborative Provider Manual.
      iii. who are HFS or DHS/DMH eligible individuals for whom the Provider has reported the individual's household income and household size as part of the individual's registration information.
2. Target/Priority Populations
   a. The Provider shall prioritize the provision of services to individuals who are:
      i. In the DHS/DMH Target/Priority population as described in the DHS/DMH

Provider Manual;

ii. Referrals to or from state hospitals and community hospital admissions funded by DHS/DMH;

iii. Referrals from Temporary Assistance to Needy Families (TANF) for mental health services;

iv. Referrals from the Office of the Inspector General's Adults with Disabilities Abuse Project;

v. Individuals remanded to the Department and adjudicated as either unfit to stand trial (UST) or not guilty by reason of insanity (NGRI) and for whom state hospital inpatient services are unnecessarily restrictive;

vi. Referrals from SASS Program services.

vii. Individuals under the age of 21 referred for mental health services under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT).

viii. Individuals who are transitioning from Long Term Care facilities.

b. Should the Provider be unable to serve an individual in the above priority populations, the Providers shall refer the individual to another Provider and inform their DHS/DMH Region Office.

c. For all of the above populations, substance abuse as a co-occurring or secondary diagnosis is not a basis for exclusion from mental health services, but rather deserves special consideration in the delivery of services, including the integrated delivery of services when possible.

d. Consumers who meet the target/priority population criteria who are Limited English Proficient (LEP) will be offered services by bilingual staff or by interpreters

3. If, upon review by the Department or its agent, a billed service is found to have been provided to a person who did not meet the conditions specified in Section VI of this contract on the date of service, the Provider will receive an error code for the billed service and the billed service will not be accepted by the Department.

PAS/MH Services

PAS/MH services are to be provided only to those persons seeking admission to nursing facilities who are suspected to have mental illnesses or persons with mental illnesses residing in a nursing facility who have evidenced significant change in their clinical needs.

ICG Services

ICG services are to be provided only to those persons who have been screened and approved according to the conditions of 59 Ill. Admin Code 135.

B. Criteria for Providers

1. Accreditation

All Providers receiving $20,000 or more annually in funding from the Division of Mental Health for mental health services will have these services accredited by one or more of the following national accreditation entities: The Council; CARF, The Rehabilitation Commission; Joint Commission on Accreditation of Healthcare Organizations; or Council on Accreditation of Services for Families and Children; or American Osteopathic Association (AOA) Healthcare Facilities Accreditation Program (HFAP) unless another written agreement is provided by the Bureau of Accreditation, Licensure and Certification. As evidence of the accreditation, Providers will submit to the DHS Bureau of Accreditation, Licensure and Certification a copy of their current accreditation certificate, accreditation report, and all correspondence about any and all corrective actions required to maintain accreditation status.

2. Medicaid Certification

Providers receiving funding under this contract must be certified as an Illinois Medicaid provider

3. Forensic Services

   Providers delivering court-ordered forensic services must comply with 725 ILCS 725 5/104-16 and 730 ILCS 5/5-2-4 and the provisions of the DHS/DMH Community Forensic Handbook. Providers must also participate in DHS/DMH forensic-specific training prior to offering forensic services as well as ongoing training offered by DHS/DMH.

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VII. Reporting Requirements

Reporting requirements apply to Providers delivering any service funded in part or in whole by DHS/DMH.

A. The Provider will comply with the Department's reporting criteria for any of the deliverables (i.e., Sections III and IV) associated with the funding in this contract.

B. So that DHS/DMH can monitor significant changes in the service system, the Provider will notify in writing in advance and discuss with their DHS/DMH Region Staff the following:
   1. Plans and the rationale to close or reduce the capacity of a program or service funded by DHS/DMH at least thirty (30) days prior to the planned change;
   2. After August 1st and on a monthly basis thereafter, notice within ten (10) business days if the Provider's waiting lists for the services of crisis intervention, assessment, mental health case management, community support, or therapy/counseling exceed thirty (30) calendar days;
   3. After August 1st and on a monthly basis thereafter, notice within ten business days if the Provider's waiting lists for the service of medication monitoring exceed sixty (60) calendar days;
   4. The Provider's dis-enrollment from all services or the stopping of the provision of all services without the explicit request of the consumer, to one or more individuals who meet the DHS/DMH target/priority population definition and who have received services from the Provider within the previous thirty one (31) days;
   5. Plans to expand or relocate a program or service funded by DHS/DMH, including expansion to different geographical areas and/or service populations;
   6. The following communication from courts relative to persons adjudicated to receive forensic services: any Rule to Show Cause orders, Contempt orders or any notice of noncompliance with court orders.

C. Upon request by DHS/DMH or its agent, the Provider will report the following:
   1. Readily available measures of the Provider's current fiscal condition, or notice that such information is not readily available to the Provider, including:
      a. Number of days of the Provider's operation that can be supported by available liquid assets (cash on hand, with threshold of less than thirty (30) days as a key indicator);
      b. Ratio of assets to current liabilities ("current ratio", with threshold of less than 1.0 as a key indicator).

D. The provider agrees to comply with the Year End Financial Reporting Requirements as identified by the DHS Office of Contract Administration.

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VIII. Special Conditions

A. Central Registry and Background Checks
   1. Nurse Aid Registry

      The Provider shall not employ an individual in any capacity until the Provider has inquired of the Department of Public Health as to information in the Nurse Aide Registry concerning the individual. For new applicants for employment, if the Registry has information substantiating a finding of abuse or neglect against the applicant, the Provider shall not

employ him or her in any capacity. For currently employed staff, if the Registry has information substantiating findings of abuse or neglect, the Department will expect the Provider to act in accordance with its personnel policies and procedures, and take steps to ensure the protection of individuals served by the Provider as deemed appropriate.

2. Health Care Worker Background Check Act.

   The Provider certifies that it is in compliance with all requirements and regulations issued pursuant to the Health Care Worker Background Check Act (225 ILCS 46).

B. Reporting and Investigating Incidents and Allegations of Abuse and Neglect

1. Provider Requirements
   a. The Provider shall develop and implement a policy and procedure on Reporting Abuse and Neglect ensuring reporting incidents as required by Rule 50 including definitions of abuse and neglect, screening prohibition, time frames for reporting and preservation of evidence;
   b. The Provider shall ensure that all OIG liaisons successfully complete the DHS/OIG Basic Investigative Skills training and then every two years thereafter;
   c. The Provider shall ensure that the parent or guardian are notified regarding an individual's involvement when an allegation is under investigation by the Office of the Inspector General;
   d. The Provider shall have a formalized ongoing systemic review process at least quarterly for evaluating all injuries, including those not definable as abuse and neglect, including and not limited to deaths, suicide attempts, and other adverse events within the agency. The review processes shall include, but are not limited to:
      i. Examining the circumstances and data to determine how and why the injury or other adverse event occurred, including determining all related processes and systems;
      ii. Identifying risk points and their potential contribution to the event, such as evaluating the appropriateness of the individual's treatment plan and level of supervision;
      iii. Identifying, communicating, documenting, implementing, and evaluating improvements in processes, systems, or treatment to prevent future such injury or other adverse event, including specifying:
         - The staff responsible for implementation;
         - When the actions will be implemented; and
         - How the effectiveness of the action will be evaluated.
2. It is the policy of the Division of Mental Health that all requirements pertaining to the reporting of licensed health care practitioners to the Illinois Department of Financial and Professional Regulation (IDFPR) and the National Practitioners Data Bank be followed. The Provider shall make such reports when and to the extent required by law.
3. The Provider shall endeavor to reinforce the responsibility of health care practitioners to report appropriate matters to IDFPR by such actions, as it deems reasonably necessary, including posting notice that individual practitioners shall comply with applicable licensing and reporting requirements.

C. Representative Payee Support

For individuals receiving DMH services under this contract, the Provider shall, if clinically appropriate and as directed by a physician, serve as representative payee or arrange for representative payee for benefit payments under the Social Security Disability Insurance program and/or the Supplementary Security Income program.

For each individual receiving representative payee support, the Provider will ensure that the individual's treatment plan includes goals, objectives and rehabilitation interventions designed to build the skills needed for the individual to progress toward self-management of their own funds.

Where the Provider will function as the representative payee of record, the Provider may be compensated for administrative and clerical support activities related to the management of funds per the rules and procedures of the Representative Payee Program of the Social Security Administration. Information about the SSA Payee Program is available at: http://www.ssa.gov/payee/.

D. Monitoring

1. The Provider shall allow the Department or its agent access to its facilities, records and employees for the purposes of monitoring this Agreement. The Department or its agent will monitor compliance with the conditions specified herein. However, for conditions specifically covered by accreditation standards, the Provider's current accreditation status with full compliance on all relevant standards (as submitted per section VI. D. of this agreement) is accepted by the Division of Mental Health in lieu of administrative and program monitoring requirements (per 405 ILCS 30/3). (Licensure and certification reviews per rules 115 and 132 will continue to provide deemed status as currently included.)

   The Provider shall notify their Regional Director if a specific monitoring activity is believed to be redundant with specific accreditation standards for which the Provider has been previously determined to be currently in full compliance. If satisfactory resolution of the issue is not achieved at the Regional level the issue should be advanced to the Director of DHS/DMH for resolution.

   Monitoring will be conducted by Department staff and its agent or contractors within various offices of the Department, including but not limited to, the DHS/DMH; Accreditation, Licensure, and Certification; Contract Administration; and Inspector General.

   Preliminary monitoring reports will be verbally provided to appropriate provider staff at the monitoring exit interview. Written reports and findings of provider monitoring and review activities will be provided to the Provider by the monitoring entity for review and corrective action if directed. The Collaborative will provide Provider training and technical assistance regarding provider monitoring, timetables, review tools and processes, and Corrective Action Plan(s) (CAP) documentation as necessary.

   The Provider shall submit Corrective Actions Plan(s) to the Department as directed and shall comply with the approved CAP or a CAP imposed by the Department.

   Monitoring may consist of, but is not limited to, the following review activities:

   a. Reviews of all required licenses and certifications;
   b. Reviews of all Provider service and funding plans;
   c. Reviews of direct service provision;
   d. Reviews of substantiated cases of abuse and neglect;
   e. On-site reviews of individual clinical records, personnel files, Provider and program policies and procedures, and financial records;
   f. On-site observations and interviews of individuals receiving services, guardians, and Provider staff (including, but not limited to, program supervisory and direct care staff);
   g. Reviews of electronic data submissions and verification of data submissions or data accepted in lieu of electronic submission;
   h. Reviews of utilization patterns; and
   i. Reviews of training records;
   j. Key indicators of the fiscal viability of the Provider;
   k. Measures of the degree of individual access to services, such as waiting lists.

2. Performance Measures: The indicators listed below represent information that is already

being collected on an ongoing basis and that DHS/DMH will use to monitor community provider performance in FY 2010. DHS/DMH is currently focused primarily on monitoring consumer access to services. (In future contract cycles, key indicators on which DHS/DMH will focus will include additional measures on the quality of services delivered and consumer related outcomes.) All indicators relate to services provided during FY 2010:

a. Percentage of consumers receiving services who meet the criteria for the DMH Target/priority population;
b. Percentage of consumers receiving services who meet the criteria for the DMH Eligible population;
c. Percentage of consumers receiving services who are 200% or below of the Federal poverty level;
d. Percentage of consumers receiving services who are eligible for Medicaid;
e. Percentage of consumers receiving services who are eligible for DHS/DMH services;
f. Percentage of consumers receiving services within 24 hours of discharge from a state-operated or CHIPS hospital;
g. Percentage of Community Support (individual, group or team) services provided off-site (e.g. in the community with a standard: 60%);
h. Percentage of Assertive Community Treatment services provided off-site (e.g. in the community with a standard: 75%);
i. For Providers receiving a contract or whom are under another business agreement with DHS/DMH to provide evidence-based practices each evidence-based practice (EBP) the fidelity scale scores for the EBP(s) at 6 and 12 months;
j. Percentage of the following fields containing complete data (e.g. responses other than unknown or deferred in the case of diagnosis):
    i. Diagnosis
    ii. History of Disability
    iii. Level of Impairment
    iv. GAF/CGAS
    v. Income
    vi. Number in household
    vii. Residential arrangement
k. Employment status
l. Number of days from initiation of forensic services to either:
    i. Adjudication of Fitness or
    ii. Conditional Release.
m. Percentage of LEP consumers receiving services compared to the percentage of LEP individuals living in the geographic service area.

E. Data and Data Security

The Provider shall adhere to DHS policies and procedures for submitting data to the Department and for maintaining data security for all data submitted to, or received from, the Department.

F. Individual and Family Input and Participation

The Provider shall have policies and practices which reflect formal mechanisms, which ensure the outreach toward, and participation of individuals, their families, and/or other interested parties in the planning, development, delivery, and evaluation of and satisfaction with clinical services.

Providers are expected to educate individuals receiving services toward participation in developing their plan for care, treatment and services including a crisis plan. The individual's participation in developing his or her plan for care, treatment, services, and crisis plan is

documented on the individual treatment plan as well as a separate note in the individual's clinical record. The note includes the Provider's process for involving individuals in their care, treatment, and service decisions. The process shall consider and respect the individual's views All efforts to involve individuals in consumer-generated crisis planning are to be made and documented before employing a provider-generated crisis planning. Provider-generated crisis planning is to be replaced with consumer-generated crisis plan. A copy of the written treatment plan will be provided to the individual.

G. DHS/DMH Individual and Family Grievance Process

In addition to maintaining an internal process for receiving and responding to grievances from individuals, families or members of the community, to facilitate compliance with the DHS/DMH Grievance Process DHS/DMH Providers contracted to deliver community-based mental health services (i.e., excluding PAS/MH, ICG, CHIPS Providers) shall, upon an individual's enrollment in DHS/DMH grievance process, make available the Consumer and Family Handbook from the Collaborative and contact information upon enrollment in the DHS/DMH grievance process.

H. Requests for Information

The Provider shall respond to a request by the Department for general information (for example, a legislative inquiry) within ten (10) working days of the written request for information. For emergency forensic inquiries, the Provider shall respond within forty-eight (48) hours of receipt of the request.

I. Federal Mental Health Services Block Grant Funds

Federal Mental Health Services Block Grant funds (CFDA 93.958) allocated to a mental health grant provider shall not be used for the following:

1. To provide inpatient services;
2. To make cash payments to intended recipients of health services;
3. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment;
4. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or
5. To improve financial assistance to any entity other than a public or nonprofit public entity.

J. Federal Housing Development

The Provider agrees to notify the the DMH Housing Coordinator thirty (30) days in advance of making any application to the federal Department of Housing and Urban Development (HUD) for HUD Section 811 or Continuum of Care programs for community-based Permanent Supportive Housing development funding for persons with mental illnesses.

The Provider further agrees not to include the Department as a funding source on any application without the express written consent of the DMH Housing Coordinator.

K. Consumer Enrollment Information

The Provider shall ensure that consumer enrollment data on file with the Department or its agent are complete and are updated to accurately reflect for each consumer receiving services their current status and condition, including information on diagnosis and functional capacity, whenever the consumer's treatment plan is updated as defined in Rule 132 or the Provider discontinues serving the consumer.

L. Continuity of Care

The Provider, if receiving funding for mental health services or programs, is required to sign a Continuity of Care Agreement with the DHS/DMH Region Office which services the Provider's catchment area. This is on behalf of the Department for State-funded inpatient services. On behalf of the Department of Healthcare and Family Services (DHFS) Providers will execute and provide to the Regional Director the Coordination of Care agreement for those community hospitals having inpatient psychiatric units (programs) within the Provider's catchment area.

M. Disaster Response

In the event of a State Declared disaster, agencies funded through this contract for capacity grant program crisis services (cost center 580) shall participate in training for, and response to, a DHS/DMH activated emergency response plan.

N. Evidence-based Practices

Providers receiving a contract or who are under another business agreement with DHS/DMH to provide evidence-based practices must demonstrate fidelity to evidence-based practice models.

O. Distribution of Materials to HFS or DHS/DMH Eligible Individuals

DHS/DMH or its agent may develop and produce electronic and paper products designed to inform individuals about services, benefits, rights or the service delivery system such as updated copies of the Consumer and Family Handbook, notices for consumer and/or family telecalls. Providers shall assist DHS/DMH or its agent with distributing these materials by placing or posting copies of written material produced and provided by DHS/DMH or its agent in waiting areas, and by notifying individuals of available electronic information by providing and posting the website address for the information starting at the time of registration/enrollment and continuing throughout the consumer's service contract.

P. Advisements

1. The Provider is reminded that they continue to be qualified for possible post-payment reviews by the Illinois Department of Healthcare and Family Services and the federal Department of Health and Human Services that utilizes extrapolation in determining disallowed billings for services. DHS/DMH reserves the right to implement a similar methodology for providers who continue to exceed an established threshold of unsubstantiated billings for two consecutive post-payment reviews.
2. DHS/DMH continues to require the use of national standardized assessment instruments as outlined in the Provider Manual.

Q. Functional Standardized Assessments of Consumers

1. For all consumers over the age of 18 receiving ACT, CST, PAS/MH and residential services, the Provider shall ensure the completion of the Level of Care Utilization System (LOCUS) scale within 30 days of the first date of service, followed by annual re-assessments with this scale (i.e. within every 365 days) following each of these assessments, and at treatment completion or termination. Explanations for failure to complete these scales are to be documented in the consumer's clinical record.
2. For all youth consumers ages 5 to 17, the Provider shall ensure the completion of the Ohio Scale (worker version) and the Columbia Impairment Scale (parent and youth version) within 30 days of the first date of service, followed by quarterly re-assessments with these scales (i.e. within every 92 days) following each of these assessments, and at treatment completion or termination. The Provider will ensure that these assessment results and other required information are entered into the web-based outcomes analysis system maintained by DHS/DMH. Explanations for failure to complete these scales are to be documented in the consumer's clinical record.

R. Consumer Access

In order to preserve consumer access to services Providers may not close or relocate service sites where DHS/DMH funded services are provided without obtaining approval from DHS/DMH.

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