MEMORANDUM

Agenda Item No. 9(A)(1)

TO:	Honorable Chairman Oliver G. Gilbert, III and Members, Board of County Commissioners	**DATE:**	February 7, 2023
FROM:	Geri Bonzon-Keenan County Attorney	**SUBJECT:**	Resolution retroactively approving and authorizing the County Mayor's execution of Contract No. ME225-12-28 Amendment #2 between Miami-Dade County, through the Community Action and Human Services Department, and South Florida Behavioral Health Network, Inc., for grant funding in the approximate amount of $2,642,116.00, for the provision of substance abuse services, for a term ending on June 30, 2023; authorizing the County Mayor to execute other agreements and documents necessary for receipt and expenditure of such funds and to exercise termination and amendment provisions set forth therein including amendments that require match funding, provided that such other agreements and documents and any amendments thereto are consistent with the purpose described herein; and authorizing the County Mayor to apply for, receive and expend additional future funds, for up to five years should they become available for this purpose, and to execute termination and amendment provisions set forth therein including amendments that require match funding, provided that such amendments are consistent with the purpose described herein

The accompanying resolution was prepared by the Community Action and Human Services Department and placed on the agenda at the request of Prime Sponsor Community Safety and Security Committee.

Geri Bonzon-Keenan
County Attorney

GBK/gh

Memorandum

Date: February 7, 2023

To: Honorable Chairman Oliver G. Gilbert, III
and Members, Board of County Commissioners

From: Daniella Levine Cava
Mayor

Subject: Resolution Retroactively Approving and Authorizing the County Mayor's or County Mayor's Designee's Execution of Contract No. ME225-12-28 Amendment #2 between South Florida Behavioral Health Network, Inc. and Miami-Dade County for Provision of Services by the Community Action and Human Services Department

Executive Summary

This item seeks retroactive authority from the Board of County Commissioners (Board) for the County Mayor's or County Mayor's designee's execution of Contract No. ME225-12-28 Amendment #2 between Miami-Dade County, through the Community Action and Human Services Department and South Florida Behavioral Health Network, Inc., (SFBHN) for the provision of residential and outpatient treatment to adults struggling with substance use and co-occurring disorders. Amendment #2, attached to the resolution as Exhibit A, extends the contract end date to June 30, 2023, and allocates $2,642,116 for fiscal year 2022-2023.

Recommendation

It is recommended that the Board of County Commissioners (Board):

1. Approve the attached resolution retroactively approving and authorizing the County Mayor's or County Mayor's designee's execution of Contract No. ME225-12-28 Amendment #2, in the amount of $2,642,116, between the SFBHN and County through CAHSD. With the additional funding awarded pursuant to Contract No. ME225-12-28 Amendment #2, the total amount of funding under Contract No. ME225-12-28 and amendments thereto is $5,308,638.00. Said funding shall be used for the provision of substance abuse treatment services to residents of Miami Dade County. The grant period is from July 1, 2021 through June 30, 2023 and requires matching funds in the amount of $432,987.00, which have been allocated in the department's FY 2022-2023 adopted budget.
2. Authorize the County Mayor or County Mayor's designee to execute other agreements and documents necessary for receipt and expenditure of such funds and to exercise termination and amendment provisions set forth therein including amendments that require up to $432,987.00 in match funding, provided that such other agreements, documents, and any amendments are consistent with the purpose described herein.
3. Authorize the County Mayor or County Mayor's designee to apply for, receive and expend future funds, if they become available for this purpose, and to execute other documents necessary for receipt and expenditure of such funds including documents that require matching funds up to $432,987.00.

4. Authorize the County Mayor or the County Mayor's designee to exercise the termination and amendment provisions set forth therein including amendments that require additional matching funds in an amount up to $432,987.00, provided that such amendments do not alter the purpose of the agreement or extend the term of the agreement beyond five years from the effective date of this resolution.

Scope

The impact of this item is countywide.

Delegated Authority

The County Mayor or County Mayor's designee is retroactively authorized to execute Contract No. ME225-12-28, Amendment #2 between the County, by and through the CAHSD, and the SFBHN. The County Mayor or County Mayor's designee is authorized to execute agreements and documents necessary for the receipt and expenditure of such funds or that otherwise may be required by grant guidelines, as well as exercise the termination and amendment provisions set forth therein including amendments that require up to $432,987.00 in match funding, following approval by the County Attorney's Office. Further, the County Mayor or County Mayor's designee is authorized to apply for, receive, and expend future grant funds, should they become available for this purpose and to execute agreements or documents necessary for the receipt and expenditure of such funds or that otherwise may be required by grant guidelines, including agreements or documents that require up to $432,987.00 in match funding. The County Mayor or County Mayor's designee is also authorized to exercise the provisions set forth in such agreements and documents, including amendments that require up to $432,987.00 in match funding, provided that such exercise does not alter the purpose of the agreements or documents or extend the term thereof beyond five years from the effective date of this resolution and following approval by the County Attorney's Office. Local, in-kind match funding shall not be deemed a funding commitment for the purposes of this resolution. The County Mayor or County Mayor's designee's authority for future grant awards will be limited to the authority provided herein.

Fiscal Impact/Funding Source

Contract No. ME225-12-28, Amendment #2 requires matching funds in the approximate amount of $432,987.00, which have been allocated in the department's FY 2022-2023 adopted budget.

Track Record/Monitor

Ivon Mesa, CAHSD Assistant Director, or other supervisory personnel will monitor this grant.

Background

CAHSD has provided services to individuals struggling with substance use disorders for over 35 years. CAHSD uses grant funds to provide comprehensive behavioral health services,

inclusive of substance abuse assessment, residential and outpatient treatment, case management and referral to individuals diagnosed with substance use disorders and co-occurring mental health disorders. CAHSD provides services to approximately 1,500 individuals per year at various locations throughout Miami-Dade County.

The South Florida Behavioral Health Network, Inc.'s, total award to CAHSD under Contract No. ME225-12-28 and amendments thereto is $5,308,638.00 for the grant period of July 1, 2021, through June 30, 2023. These funds will provide substance abuse treatment, prevention, Medication Assisted Treatment, medical, psychiatric, and behavioral mental health, and referral services to residents of Miami Dade County.

Amendment #2 of the South Florida Behavioral Health Network, Inc.'s, Contract No. ME225-12-28 was executed on July 7, 2022.

Exhibit A

Morris Copeland
Chief Community Services Officer

MEMORANDUM
(Revised)

TO: Honorable Chairman Oliver G. Gilbert, III
and Members, Board of County Commissioners

DATE: February 7, 2023

FROM: Geri Bonzon-Keenan
County Attorney

SUBJECT: Agenda Item No. 9(A)(1)

Please note any items checked.

_____ **"3-Day Rule" for committees applicable if raised**

_____ **6 weeks required between first reading and public hearing**

_____ **4 weeks notification to municipal officials required prior to public hearing**

_____ **Decreases revenues or increases expenditures without balancing budget**

_____ **Budget required**

_____ **Statement of fiscal impact required**

_____ **Statement of social equity required**

_____ **Ordinance creating a new board requires detailed County Mayor's report for public hearing**

_____ **No committee review**

_____ **Applicable legislation requires more than a majority vote (i.e., 2/3's present ____, 2/3 membership ____, 3/5's ____, unanimous ____, CDMP 7 vote requirement per 2-116.1(3)(h) or (4)(c) ____, CDMP 2/3 vote requirement per 2-116.1(3)(h) or (4)(c) ____, or CDMP 9 vote requirement per 2-116.1(4)(c)(2) ____) to approve**

_____ **Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required**

Approved _____ Mayor
Veto _____
Override _____

Agenda Item No. 9(A)(1)
2-7-23

RESOLUTION NO. _____

RESOLUTION RETROACTIVELY APPROVING AND AUTHORIZING THE COUNTY MAYOR'S OR COUNTY MAYOR'S DESIGNEE'S EXECUTION OF CONTRACT NO. ME225-12-28 AMENDMENT #2 BETWEEN MIAMI-DADE COUNTY, THROUGH THE COMMUNITY ACTION AND HUMAN SERVICES DEPARTMENT, AND SOUTH FLORIDA BEHAVIORAL HEALTH NETWORK, INC., FOR GRANT FUNDING IN THE APPROXIMATE AMOUNT OF $2,642,116.00, FOR THE PROVISION OF SUBSTANCE ABUSE SERVICES, FOR A TERM ENDING ON JUNE 30, 2023; AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO EXECUTE OTHER AGREEMENTS AND DOCUMENTS NECESSARY FOR RECEIPT AND EXPENDITURE OF SUCH FUNDS AND TO EXERCISE TERMINATION AND AMENDMENT PROVISIONS SET FORTH THEREIN INCLUDING AMENDMENTS THAT REQUIRE MATCH FUNDING, PROVIDED THAT SUCH OTHER AGREEMENTS AND DOCUMENTS AND ANY AMENDMENTS THERETO ARE CONSISTENT WITH THE PURPOSE DESCRIBED HEREIN; AND AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO APPLY FOR, RECEIVE AND EXPEND ADDITIONAL FUTURE FUNDS, FOR UP TO FIVE YEARS SHOULD THEY BECOME AVAILABLE FOR THIS PURPOSE, AND TO EXECUTE TERMINATION AND AMENDMENT PROVISIONS SET FORTH THEREIN INCLUDING AMENDMENTS THAT REQUIRE MATCH FUNDING, PROVIDED THAT SUCH AMENDMENTS ARE CONSISTENT WITH THE PURPOSE DESCRIBED HEREIN

WHEREAS, this Board desires to accomplish the purposes outlined in the accompanying memorandum, a copy of which is incorporated herein by reference,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that this Board:

Section 1. Approves the foregoing recital, which is incorporated herein by reference.

Section 2. Retroactively approves Contract No. ME225-12-28 Amendment #2, attached hereto as Exhibit A and made a part hereof, between Miami-Dade County, through the Community Action and Human Services Department, and the South Florida Behavioral Health Network, Inc., for grant funding in the approximate amount of $2,642,116.00 for the term ending June 30, 2023. The grant requires approximately $432,987.00 in matching funds. The Miami-Dade County Community Action and Human Services Department will use such grant funding to support the provision of substance abuse services to Miami-Dade County residents.

Section 3. Retroactively authorizes the County Mayor or County Mayor's designee's execution of Contract No. ME225-12-28 Amendment #2.

Section 4. Authorizes the County Mayor or County Mayor's designee to execute other agreements and documents necessary for receipt and expenditure of such funds. This Board further authorizes the County Mayor or County Mayor's designee to exercise the termination and amendment provisions set forth in such agreements and documents including amendments that require up to $432,987.00 in match funding, provided that such other agreements and documents and any amendments thereto are consistent with the purpose described in section 2 above and following approval for legal form and sufficiency by the Miami-Dade County Attorney's Office. Local, in-kind match funding shall not be deemed a funding commitment for the purposes of this resolution.

Section 5. Authorizes the County Mayor or County Mayor's designee to apply for, receive, and expend additional future funds, for up to five years from the effective date of this resolution should they become available for this purpose, and to execute other agreements and documents necessary for receipt and expenditure of such funds. The County Mayor or County Mayor's designee is further authorized to exercise termination and amendment provisions set forth

therein including amendments that require up to $432,987.00 in match funding, provided that such amendments are consistent with the purpose described in section 2 above and following approval for legal form and sufficiency by the Miami-Dade County Attorney's Office.

The foregoing resolution was offered by Commissioner , who moved its adoption. The motion was seconded by Commissioner and upon being put to a vote, the vote was as follows:

Oliver G. Gilbert, III, Chairman
Anthony Rodríguez, Vice Chairman

Marleine Bastien	Juan Carlos Bermudez
Kevin Marino Cabrera	Sen. René García
Roberto J. Gonzalez	Keon Hardemon
Danielle Cohen Higgins	Eileen Higgins
Kionne L. McGhee	Raquel A. Regalado
Micky Steinberg	

The Chairperson thereupon declared this resolution duly passed and adopted this 7th day of February, 2023. This resolution shall become effective upon the earlier of (1) 10 days after the date of its adoption unless vetoed by the County Mayor, and if vetoed, shall become effective only upon an override by this Board, or (2) approval by the County Mayor of this resolution and the filing of this approval with the Clerk of the Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF
COUNTY COMMISSIONERS

LUIS G. MONTALDO, CLERK AD INTERIM

By:_____
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency.

Shanika A Graves

EXHIBIT A

THIS AMENDMENT, entered into between South Florida Behavioral Health Network, Inc. hereinafter referred to as the "**ME**" and **Miami-Dade County through its Community Action & Human Services Department,** hereinafter referred to as the "**Network Provider**," amends **Contract No. ME225-12-28.**

PREAMBLE: This amendment extends the contract end date to June 30, 2023, revises contract language, revises a number of contract exhibits and/or attachments, adds a number of contract exhibits and/or attachments, allocates funding for fiscal year 2022-2023, as detailed in the Exhibit G, Covered Service Funding by OCA and Exhibit H, Funding Detail.

A total of $2,642,116 has been added for FY 2022-2023 as follows:

Adult Substance Abuse Program (ASA): $2,642,116

In addition, revisions and insertions are made as detailed below.

All changes are effective **June 30, 2022.**

As a result, this amendment revises the Standard Contract; Attachment I; Exhibit B, Method of Payment; Exhibit C, Required Reports; Exhibit D, Substance Abuse & Mental Health Required Performance Outcomes and Outputs; Exhibit F, SAMH Programmatic State and Federal Laws, Rules and Regulations; Exhibit G, Covered Services Funding by OCA; Exhibit H, Funding Detail and **Local Match Plan; Exhibit K, Pre-Authorization Resource Management Roster for Substance Abuse & Mental Health Residential Level II Services Only; Exhibit R, Substance Abuse Residential Level II; Exhibit AC, Care Coordination; Exhibit AO, Peer Services; Exhibit AV, Transitional Voucher Program; and Exhibit BH, Recovery Management Practices.**

1. **Page 1 of 16, Standard Contract, Paragraph 3, Contract Amount,** is hereby amended to read:

   This contract shall begin on **July 1, 2021.** It shall end at midnight, local time in Miami-Dade County, Florida on **June 30, 2023**, subject to the survival of terms of Section 52.

2. **Page 2 of 16, Standard Contract, Paragraph 5, Contract Amount, as previously amended on Page 1 of 5 of Amendment # 1,** is hereby amended to read:

   5. Contract Amount

   The ME shall pay for contracted services according to the terms and conditions of this Contract in an amount not to exceed **$6,370,365.00**, subject to the availability of funds and satisfactory performance of all terms by the Network Provider. Of the total Contract amount, the ME will be required to pay **$5,308,638.00**, subject to the delivery and billing for services. The remaining amount of **$1,061,727.00** represents "Uncompensated Units Reimbursement Funds", which the ME, at its sole discretion and subject to the availability of funds, may pay to the Network Provider, in whole or in part, or not at all, for Exemplary Performance by the Network Provider. Exemplary Performance will be determined by the Network Provider delivering and billing for services in excess of those units of service the ME will be required to pay. Should the Network Provider receive any funding from the "Uncompensated Units Reimbursement Funds", then the amount of Local Match as it appears on **Exhibit B, Method of Payment** and in **Exhibit H, Funding Detail**, will automatically change, utilizing the formula prescribed in the Method of Payment section of this contract. The ME's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract between the ME and the Department. Any costs

or services eligible to be paid for under any other contract or from any other source are not eligible for payment under this Contract.

3. **Page 13 of 16, Standard Contract Section 42, Unauthorized Aliens and Employment Eligibility Verification (E-Verify), is hereby amended to read:**

42. Unauthorized Aliens and Employment Eligibility Verification (E-Verify) – Federal and State Requirements

a. Unauthorized aliens shall not be employed. Employment of unauthorized aliens shall be cause for unilateral cancellation of this Contract by the ME for violation of section 274A of the Immigration and Nationality Act (8 U.S.C. § 1324 a) and section 101 of the Immigration Reform and Control Act of 1986. The Network Provider and its subcontractors will enroll in and use the E-Verify system established by the U.S. Department of Homeland Security to verify the employment eligibility of its employees and its subcontractors' employees performing under this Contract. Employees assigned to the contract means all persons employed or assigned (including subcontractors) by the Network Provider or a subcontractor during the contract term to perform work pursuant to this contract within the United States and its territories.
b. Unauthorized aliens shall not be employed. Employment of unauthorized aliens shall be cause for unilateral cancellation of this Contract by the ME for violation of Section 448.095, Florida Statutes. The Network Provider must submit an affidavit by the date and to the individual identified in **Exhibit C, Required Reports**, attesting that it does not and shall not employ, contract with, or subcontract with an unauthorized alien, in accordance with section 448.095, Florida Statutes.

4. **Pages 1 - 55 Attachment I HC02 (a), dated 07/01/2021, as previously amended on Page 2 of 5 Amendment # 1,** are hereby deleted in their entirety and **Pages 1 – 56, Revised Attachment I, dated 07/01/2022,** are inserted in lieu thereof and attached hereto.

5. **Page 1 - 7, Exhibit B, Method of Payment for FY 2022-23,** are hereby inserted and attached hereto.

6. **Page 1 - 23, Exhibit C, Required Reports for FY 2022-23,** are hereby inserted and attached hereto.

7. **Page 1 - 3, Exhibit D, Substance Abuse & Mental Health Required Performance Outcomes and Outputs for FY 2022-23,** are hereby inserted and attached hereto.

8. **Pages 1- 4, Exhibit F, SAMH Programmatic State and Federal Laws, Rules and Regulations**, are hereby deleted in their entirety, and **Pages 1-4, Revised Exhibit F, SAMH Programmatic State and Federal Laws, Rules and Regulations,** are hereby inserted and attached hereto.

9. **Pages 1 - 4, Exhibit G, Covered Services Funding by OCA for FY 2022-23,** are hereby inserted and attached hereto.

10. **Page 1 of 1, Exhibit H, Funding Detail for FY 2022-23**, is hereby inserted and attached hereto.

11. **Page 1 of 1, Local Match Plan for FY 2022-23,** is hereby inserted and attached hereto.

12. **Page 1 of 1, Exhibit K, Pre-Authorization Resource Management Roster for Substance Abuse & Mental Health Residential Level II Services Only dated 07/01/2021**, is hereby deleted in its entirety

and **Page 1 of 1, Revised Exhibit K, Resource Management Roster for Substance abuse & Mental Health Residential Level II Services dated 07/01/2022**, is hereby inserted and attached hereto.

13. **Pages 1-8, Exhibit R, Substance Abuse Residential Level II dated 07/01/2021**, is hereby deleted in its entirety and **Pages 1-8, Revised Exhibit R, Substance Abuse Residential Level II Services dated 07/01/2022**, are hereby inserted and attached hereto.

14. **Pages 1-18, Exhibit AC, Care Coordination, dated 07/01/2021, as previously amended on Page 4 of 5 of Amendment # 1** are hereby deleted in their entirety and **Pages 1-18, Exhibit AC, Care Coordination, dated 07/01/2022,** are hereby inserted and attached hereto.

15. **Pages 1-4, Exhibit AO, Peer Services dated 07/01/2021,** are hereby deleted in their entirety and **Pages 1-4, Revised Exhibit AO, Peer Services dated 07/01/2022** are hereby inserted and attached hereto.

16. **Pages 1-10, Exhibit AV, Transitional Voucher Program dated 07/01/2021,** are hereby deleted in their entirety and **Pages 1-10, Revised Exhibit AV, Transitional Voucher Program dated 07/01/2022,** are hereby inserted and attached hereto.

17. **Pages 1-10, Exhibit BH, Recovery Management Practices dated 07/01/2021**, are hereby deleted in their entirety and **Pages 1-10, Revised Exhibit BH, Recovery Management Practices dated 07/01/2022**, are hereby inserted and attached hereto.

This amendment shall begin on **June 30, 2022**.

All provisions of the contract and any attachments thereto in conflict with this amendment shall be and are hereby changed to conform to this amendment.

All provisions of the contract not in conflict with this amendment are still in effect and are to be performed at the level specified in the contract.

This amendment is hereby made a part of the contract.

IN WITNESS THEREOF, the parties hereto have caused this **153** page amendment to be executed by their officials' thereunto duly authorized.

MIAMI-DADE COUNTY THROUGH ITS COMMUNITY ACTION & HUMAN SERVICES DEPARTMENT

SIGNED BY: _____

NAME: Morris Copeland

TITLE: Chief Community Services Officer

DATE: 7/7/2022

SOUTH FLORIDA BEHAVIORAL HEALTH NETWORK, INC.

SIGNED BY: _____

NAME: John W. Newcomer, M.D.

TITLE: CEO

DATE: _____

FEDERAL Tax ID # (or SSN): 59-6000573

REVISED ATTACHMENT I

A. Services to be Provided

1. Program/Service Specific Terms

(1) "Behavioral Health Services" are mental health services and substance abuse prevention and treatment services as defined by s. 394.9082(2)(a), F.S., and in Chapter 397. F.S.

(2) "Block Grants": The Community Mental Health Block Grant (CMHBG), pursuant to 42 U.S.C. s. 300x, et. seq., and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), pursuant to 42 U.S.C. s. 300x-21, et. seq.

(3) "Care Coordination" means the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage. Examples of care coordination activities include development of referral agreements, shared protocols, and information exchange procedures. The purpose of care coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among priority populations.

(4) "Child Welfare Integration and Support Team" (CWIST) Child Welfare Integration and Support Team (CWIST) assists families under the investigation of Department of Children and Families. The CWIST responds to the needs of families in Miami-Dade County while promoting the integration of behavioral health services, substance abuse services, and child welfare systems. The CWIST consists of a clinician and family navigator that will respond to requests by the Department of Children and Families (DCF) to assist in case consultation and care coordination for families under investigation. The CWIST approach is to facilitate the assessment of the family and determine needed interventions by providing immediate consultation through teamwork with Subject Matter Experts, individuals from specific professional disciplines, DCF, and other involved stakeholders.

(5) "Citrus Family Care Network" is the Southern Region's (Circuit 11 & 16) Lead Agency for Community Based Care provider under contract with the State of Florida Department of Children and Families for the child protection and child welfare system.

(6) "Collaborative Planning Group Systems, Inc." is the entity contracted with the Department of Children and Families that maintains the database called Performance Based Prevention System (PBPS) that Network Providers contracted to provide substance abuse prevention services must utilize to upload substance abuse prevention data required by this contract.

(7) "Continuous Quality Improvement" is an ongoing, systematic process of internal and external improvements in service provision and administrative functions, taking into account both in process and end of process indicators, in order to meet the valid requirements of Individuals Served.

(8) "Contract Manager" is the ME employee who is responsible for enforcing the compliance with administrative and programmatic terms and conditions of a contract. The Contract Manager is the primary point of contact through which all contracting information flows between the ME and the Network Provider. All actions related to the contract must be initiated by or coordinated with the Contract Manager.

(9) "Co-occurring Disorder" is any combination of mental health and substance use in any individual, whether or not they have been already diagnosed.

(10) "Co-occurring Disorder Service Capability" is the ability of any program to organize every aspect of its program infrastructure (policies, procedures, practices, documentation, and staff competencies), within its existing resources, to provide appropriately matched, integrated services to the individuals and families with co-occurring disorders that are routinely presenting for care in that program. Should services not be available at the Network Provider then then the individual served must be linked to an agency with the capability to meet the individual served needs.

(11) "Coordinated System of Care", as described in section 394.4573, F.S.is the full array of behavioral and related services in a region or community offered by all service providers, whether participating under contract with a Managing Entity or by another method of community partnership or mutual agreement.

(12) "Cost Analysis" is the review of the proposed cost elements to determine if they are necessary, allowable, appropriate and reasonable.

(13) "Cultural and Linguistic Competence" is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professional that enable effective work in cross-cultural situations that provides services that are respectful and/or responsive to cultural and linguistic needs.

(14) "Department" means the State of Florida Department of Children and Families.

(15) "Electronic Health Record (EHR)" is defined in s. 408.051(2)(a), F.S.

(16) "Evidenced-Based Practices (EBP) are programs, practices or strategies that are supported by research. EBP's are programs that have demonstrated effectiveness with established generalizability (replicated in different settings and with different populations over time) through research. The Department has established two option. For a list of approved registries used to identify, evaluate, and select EBP programs and strategies, refer to the Department's Guidance Document 1, Evidence Based Guidelines available at the following link:
https://www.myflfamilies.com/service-programs/samh/managing-entities/index.shtml

Note: Click on FY22-23 ME Templates and click on Guidance Document 1, Evidence Based Guidelines

(17) "FASAMS DCF Pamphlet 155-2" is the Department of Children & Families, Pamphlet 155-2 - Mental Health and Substance Abuse Measurement and Data means a document promulgated by the Department that contains required data-reporting elements for substance use and mental health services, and which can be found at: https://www.myflfamilies.com/service-programs/samh/fasams/index.shtml

(18) "Financial and Services Accountability Management System (FASAMS)" is the Department's information management and fiscal accounting system for providers of community substance use and mental health services.

(19) "Forensic Mental Health Services" are services provided to individuals with mental illness pursuant to Chapter 916, Florida Statutes.

(20) "HIPAA" is the acronym for Health Insurance Portability and Accountability Act and must mean the Privacy, Security, Breach Notification, and Enforcement Rules at 42 U.S.C. §1320d, and 45 C.F.R. Parts 160, 162, and 164.

(21) "Individual(s) Served" (synonymous with Client, Consumer, Participant) is an individual who receives substance use or mental health services, the cost of which is paid, either in part or whole, by Department appropriated funds or local match (matching).

(22) "Knight Information Software (KIS)"is the ME's online data system which Network Providers that do not have their own data system are required to use to collect and report data and performance outcomes on individual served whose services are paid for, in part or in whole, by the ME's contract, Medicaid, local match, Temporary Assistance for Needy Families (TANF), Purchase of Therapeutic Services (PTS) and Title 21. The KIS, or other system designated by the ME, must be utilized to upload individual served-related data as required by this contract.

(23) "Lead Agency for Community-Based Care (CBC)" is an agency under contract with the Florida Department of Children and Families that provides care for children in the child protection and child welfare system.

(24) "Local Match" means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts both individual and corporate, and bequests and funds received from community drives or any other sources.

See § 394.67, F.S. F.S. and 65E-14.005, F.A.C.

(25) "Managing Entity (ME)" as defined in section 394.9082(2)(e), F.S., is a corporation selected by and under contract with the Department to manage the daily operational delivery of behavioral health services through a coordinated system of care.

(26) "Mental Health Services" is defined pursuant to Chapter 394.67 (15), F.S.

(27) "Motivational Support Program" are services provided in Monroe County designed to reduce the incidence of child abuse and neglect resulting from parents' or caregivers' behavioral health and to improve outcomes for families in the child welfare system and/or community-based care.

(28) "Network Provider" is an entity that contracts with the ME and receives funding to provide services to eligible individuals; in this contract the Network Provider is synonymous with network service providers, provider or subcontractor.

(29) "Outcome for Individual Service Recipient" is a measure of the quantified result, impact, or benefit of services on the individual service recipient.

(30) "PBPS" is the Department's Performance Based Prevention System that collects data related to community assessments and plans and substance use prevention programs and activities.

(31) "Performance Measures" are quantitative indicators, outcomes and outputs that are used by the Department to objectively measure performance and are used by the ME and Network Providers to improve services.

(32) "Prevention" refers to the proactive approach to preclude, forestall, or impede the development of substance use or mental health related problems. These strategies focus on increasing public awareness and education, community-based processes, and incorporating evidence-based practices. Additional guidance regarding prevention services can be found in the Department's Guidance Document 10, Prevention Services and is available at the following link:

https://www.myflfamilies.com/service-programs/samh/managing-entities/index.shtml

Note: Click on FY22-23 ME Templates and click on Guidance Document 10, Prevention Services

(33) "Prime Contract" is the contract between the Department of Children and Families and the ME.

(34) "Program Descriptions" are the documents the Network Provider prepares and submits to the ME for approval prior to the start of the contract period, which provide detailed description of the services to be provided under the contract pursuant to Rule 65E-14, F.A.C. It includes but is not limited to the Network Provider's organizational profile, the service activity description, a detailed description of each program and covered service funded in the contract, the geographic service area, service capacity, staffing information, and target population to be served.

(35) "Projects for Assistance in Transition from Homelessness (PATH)" is a federal grant to support homeless individuals with mental illnesses, who may also have co-occurring

substance use and mental health treatment needs.

(36) "Protected Health Information" (PHI) relates to any information whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

(37) "Provider Network" (subcontractor or Network Provider) refers to the group of direct service providers, facilities, and organizations under contract with a ME to provide a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and support services including prevention services and any other services purchased by this contract. See section 394.9082, F.S.

(38) "Quality Assurance" is a process that measures performance in achieving pre-determined standards, validates internal practice, and uses sound principles of evaluation to ensure that data are collected accurately, analyzed appropriately, reported correctly and acted upon in a timely manner. The process may employ peer review, and outcomes assessment to assess quality of care.

(39) "Quality Improvement/Continuous Quality Improvement" is a management technique to assess and improve internal operations and network services. It focuses on organizational systems rather than individual performance and seeks to continuously improve quality. The process involves setting goals implementing systematic changes, measuring outcomes, and making subsequent appropriate improvements. Quality improvement activities will assess compliance with contract requirements, state and Federal law and associated administrative rules, regulations, and operating procedures and validate quality improvement systems and findings.

(40) "Representative Payee" refers to an entity/individual that is legally authorized to receive Supplemental Security Income, Social Security Income, Veterans Administration benefits, or other federal benefits on behalf of an individual who is unable to manage or direct the management of his or her benefits.

(41) "SAMH" stands for the Substance Abuse and Mental Health Programs within the Department.

(42) "Seclusion and Restraint Data System" referred to as SANDR, is the Department of Children and Families' web-based data system used to collect and report the frequency and types of seclusion and restraint events that involve persons served in state-contracted and non-state contracted community substance use and mental health programs, and state mental health treatment facilities. All facilities, as defined in section 394.455(10), F.S., are required to report each seclusion and restraint event to the Department of Children and Families in accordance with but not limited to Rule 65E-5.180, F.A.C.

(43) "SOAR" stands for Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access and Recovery and is a Substance Abuse and Mental Health Services Administration (SAMHSA) technical assistance initiative designed to help individuals increase earlier access to SSI and SSDI through improved approval rates on initial Social Security applications by providing training, technical assistance, and strategic planning to Network Providers.

(44) "Stakeholder(s)" are individuals/groups with an interest in the provision of treatment services for substance use, mental health services, co-occurring disorders and prevention services in the county(ies) outlined in Section A.2.c.(2), of this Contract.

(45) "Statewide Inpatient Psychiatric Programs (SIPP)"" are residential inpatient facilities under contract with the Agency for Health Care Administration (AHCA) under the Medicaid Institutes for Mental Disease (IMD) 1915B waiver for children under age 18 to provide diagnostic and active treatment services in a secure setting.

(46) "Substance abuse" as defined in Chapter 397, F.S., means the misuse or abuse of, or dependence on alcohol, illicit drugs, or prescription medications. As an individual progresses along this continuum of misuse, abuse, and dependence, there is an increased need for substance abuse intervention and treatment to help abate the problem.

(47) "Substance Abuse and Mental Health Information System (SAMHIS)" is the Department's web-based data system for reporting data such as but not limited to, Demographic, Temporary Assistance to Needing Families data, Seclusion and Restraint data and Incident reports by the Managing Entity and all Network Service Providers in accordance with this contract.

(48) TANF Participant" is a person or family member of that person defined in 45 C.F.R. Part 260.30 and section 414.1585 and subsection 414.0252(9), F.S.

(49) "Temporary Assistance to Needy Families (TANF)" as defined by 42 U.S.C. ss. 601, et. seq., and ch. 414, F.S., is a federal block grant component which provides funding to states to help move recipients into work. In the context of the Department, Office of Substance Abuse and Mental Health (SAMH), TANF is a funding stream for providing substance use disorder services or mental health services to families receiving TANF cash assistance benefits.

(50) "Third Party Payer" means commercial insurers such as workers' compensation, TRICARE, Medicare, Health Maintenance Organizations, Managed Care Organizations, or other payers liable, to the extent that they are required by contract or law, to participate in the cost of providing services to a specific individual.

(51) "Warm Hand-off" as defined by the U.S. Department of Health and Human Services is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving

them the opportunity to clarify or correct information or ask questions about their care. Warm handoffs engage the patient through structured communication and improve safety by helping prevent communication breakdowns.

2. General Description

a. General Statement

The services provided under this contract are community-based behavioral health services for an person-centered and family-focused recovery-oriented coordinated system of care (ROSC). A ROSC is a value-driven framework to guide transformation of a behavioral health system of care as described in Exhibit BH, Recovery Management Practices. The contract requires a qualified, direct service, community-based Network Provider who will provide services for children, adolescents, and adults as applicable, with behavioral health issues as authorized in section 394.9082, F.S., consistent with Chapters 394, 397, 916, section 985.03, F.S. (as applicable) and consistent with the Prime Contract (ME's contract with the Department), which is incorporated herein by reference.

The Network Provider must work in partnership with the ME to better meet the needs of individuals with co-occurring substance use and mental health disorders and expand its array of services to provide trauma informed care, as appropriate. The partnership process will be open, transparent, dynamic, fluid, and visible. The process must also serve as an opportunity for collaboration to continuously improve the quality of services. During the course of the contract period, the ME will require that the Network Provider participate in the process of improving co-occurring disorder service capability system wide, trauma informed care services and ensure the integration of behavioral health services and primary care services to all the individuals in care in coordination with a Federally Qualified Health Center or other medical facility as required by this Contract.

The Network Provider must work in collaboration and must assist, upon request of the ME, in fulfilling its contractual obligations pursuant to the Prime Contract with the Department of Children and Families including but not limited to the following functions:

(1) System of Care Development and Management;
(2) Quality Improvement;
(3) Data Collection, Reporting, and Analysis;
(4) Financial Management;
(5) Disaster Planning and Responsiveness

b. Authority

Section 394.9082, F.S., and the Prime Contract provides the ME with the authority to contract for these services.

c. Scope of Service

The following scope of service applies to the contract period and any renewal or extension:

(1) The Network Provider is responsible for the administration and provision of services to the target population(s) indicated in **Exhibit A, Individuals to be Served**, and in accordance with the tasks outlined in this contract. Services must also be delivered at the locations specified in, and in accordance with the Program Description, as required by Rule 65E-14, F.A.C., which is herein incorporated by reference, and maintained in the ME's Contract Manager's file.

(2) Unless otherwise authorized by the ME, services are to be delivered in the following county(ies):

X Miami-Dade County
_ Monroe County
_ Broward County

d. Major Contract Goals

The ME's goals for the SAMH Programs funded by this Contract are to improve access to care and promote service continuity and to support efficient and effective delivery of services, furthermore, the Florida Department of Children and Families is committed to partnering with stakeholders to transform Florida's substance use and mental health system into a recovery-oriented system of care (ROSC), and are as follows:

(1) Provide access to quality, recovery-oriented and community-based services and supports for persons with behavioral health disorders.

(2) Community-based health and prevention promotion by encouraging overall emotional health and wellness and preventing substance use, reduce the spread of infectious diseases, prevent and reduce attempted and completed suicides, and reduce opioid related overdose deaths.

(3) Integrate the Child Welfare and behavioral health systems.

(4) Improve co-occurring capability, trauma informed care, cultural and linguistic competence, ensure the integration of behavioral health and primary health care services and expertise in all programs.

(5) For funded substance use prevention services, the intent of substance use prevention is to promote and improve the behavioral health of Florida's Southern Region communities by strategically applying substance use prevention programs, and environmental strategies that are relevant to community needs as defined in a ME approved Comprehensive Community Action Plan (CCAP). The CCAP can be provided upon request to the ME's Director of Prevention Services Director.

e. Minimum Programmatic Requirements

The Network Provider must maintain the following minimum programmatic requirements:

(1) System of Care

The person -centered and family-focused system of care will:

(a) Be driven by the needs and choices of the individuals served;

(b) Promote family and personal self-determination and choice;

(c) Be ethically, socially, and culturally responsive; and

(d) Be dedicated to excellence and quality results.

There is a commitment to improve access to care, promote service continuity, support efficient and effective delivery of services that utilize evidence-based practices, recovery-oriented, and peer involved approaches in accordance with priorities established by the ME and the Department for substance use, mental health treatment and/or co-occurring disorders and, substance use prevention services.

(2) Guiding Principles

Guiding principles specify that services are as follows:

(a) Inclusive - involve and engage families and individuals served as full partners to participate in the planning and delivery of services;

(b) Comprehensive - incorporating a broad array of service and supports (e.g. physical, emotional, clinical, social, educational, community and spiritual);

(c) Individualized - meeting the individual's exceptional needs and strengths;

(d) Strengths based – focus on the strengths of the individual served, not their deficits;

(e) Community-based - provided in the least restrictive, clinically appropriate setting;

(f) Coordinated both at the system and service delivery levels to ensure that multiple services are provided and change as seamlessly as possible when warranted;

(g) Cultural and linguistic competent;

(h) Gender responsive;

(i) Sexual orientation; and

(j) Recovery-oriented and recovery-supported.

3. Individuals to be Served

See **Exhibit A, Individuals/Participants to be Served**

B. Manner of Service Provision

1) Service Tasks

The following tasks must be completed for each fiscal year covered in the contract period.

a. Task List

(1) Based on individual needs, the Network Provider agrees to provide appropriate services from the list of approved programs/activities described in **Exhibit G, Covered Service Funding by OCA** and the description of such services specified in the Program Description as required by Rule 65E-14, F.A.C. Any change in the array of services must be justified in writing and submitted to the ME's Contract Manager for review and approval.

(2) The Network Provider must serve the number of persons indicated in **Exhibit D, Substance Abuse and Mental Health Required Outcomes/Outputs.** Failure to meet the minimum numbers served may result in a corrective action and an imposed financial penalty as described in the Standard Contract.

(3) The Network Provider must assure the delivery of services is based on Evidence-Based Practices implemented with fidelity and in accordance with the approved Program Descriptions.

(4) The Network Provider must adhere to treatment group size limitations not to exceed fifteen (15) individuals per group for any clinical therapy service provided, with the exception of Outpatient Group services. For Outpatient Group services funded under this contract, the Network Provider must adhere to the group size limitations outlined in the current Medicaid Handbook.

In addition to other programmatic documentation requirements, service documentation to evidence group activities must include the following:

1. Data Elements:
   a) Service Documentation-Group Sign in Sheet
   b) Recipient name and identification number or, if non-recipient, participant's name, address, and relation to recipient;
   c) Staff name and identification number
   d) Service date;
   e) Start time
   f) Duration;
   g) Covered Service;
   h) Service (Brief description of type of group);
   i) Group Indicator; and
   j) Program (AMH, ASA, CMH, CSA)

2. Audit Documentation-Recipient Service or Non-Recipient Chart:
   a) Recipient name and identification number or if non-recipient, participant's name, address, and relation to recipient;
   b) Staff name and identification number
   c) Service date
   d) Clinical diagnosis;
   e) Start time;
   f) Duration; and
   g) Services (Group progress note)

(5) The Network Provider must develop and implement policies so that all applicable providers' employees abide by the terms and conditions of **Paragraph 39**., Information Security, of the Standard Contract. The Network Provider must submit to the Managing Entities Contract Manager, by **08/03/2022,** an attestation that all applicable Network Provider employees and subcontractors who have access to ME and Department information systems have completed the Security Agreement form as required in **Paragraph 39.** Information Security, of the Standard Contract.

(6) For licensable services purchased by this Contract, the Network Provider must have and maintain correct and current Department of Children and Families, as required by Rule 65D-30, F.A.C., Licensure Standards for Substance Abuse Services and Agency for Health Care Administration (AHCA) licenses and only bill for services under those licenses. In the event any of the Network Provider's license(s) is suspended, revoked, expired or terminated, the ME must suspend payment for services delivered by the Network Provider under such license(s) until said license(s) is reinstated.

(7) Network Providers serving persons with substance use disorders must use the American Society of Addiction Medicine (ASAM) to determine placement and level of care as required by FASAMS DCF Pamphlet 155-2.

(8) The Network Provider must ensure that individuals discharged from state mental health treatment facilities will be maintained on the medication that was prescribed for them by the facility at discharge. Maintenance includes performing required lab tests, providing the medication, and providing appropriate physician oversight.

(9) Should the ME conduct a mock emergency drill, the Network Provider must participate by activating their emergency/disaster plan and reporting on preparedness activities, response activities, and post-recovery activities.

(10) By **08/03/2022,**, the Network Provider must submit to the ME's Contract Manager an

updated Civil Rights Compliance Checklist (CF0946).

(11) By **08/03/2022**, the Network Provider must submit to the ME's Contract Manager an updated Civil Rights Certificate (CF707), signed a dated by the Network Provider's contract signer.

(12) By **08/03/2022,** the Network Provider must submit to the ME's Contract Manager a *Quality Assurance Plan* that details how the Network Provider will ensure and document that quality services are being provided to the individuals served, which is herein incorporated by reference. The Network Provider must submit updates as amended of the Quality Assurance Plan within thirty (30) days of adoption. The Quality Assurance Plan should address the minimum guidelines for the Network Provider's continuous quality improvement program, including, but not limited to:

(a) Individual care and services standards to include transfers and referrals, co-occurring supportive services, trauma informed services, cultural and linguistic competence, integrated care, recovery-oriented system of care principles.

(b) Individual records maintenance and compliance.

(c) Staff development standards.

(d) Service-environment safety and infection control standards.

(e) Peer review procedures.

(f) Incident reporting policies and procedures that include verification of corrective action and a provision that specifies that a person who files an incident report, in good faith, may not be subjected to any civil action by virtue of that incident report.

(g) Fraud, waste, abuse and other potential wrongdoing auditing, monitoring, and remediation procedures.

(h) Evidence-based practices (EBPs) utilized by the agency and how these EBPs are monitored to ensure fidelity to the model.

(i) The Continuous Quality Improvement Initiatives identified in Section B.1.a.(22) below.

(13) By **08/03/2022**, the Network Provider must submit its action plan on a template provided by the ME based on the results of the most recently completed Self-Assessment/Planning Tool for Implementing Recovery-Oriented Services (SAPT) and the Recovery Self-Assessment-R (RSA-R.) as required in Section B. 1.a (22) (a), Recovery Management Practices. The action plan will outline tasks and objectives that the Network Provider must address during the fiscal year that were identified in the self-assessments as needing improvement.

(14) By **10/03/2022**, the Network Provider must submit an attestation signed by the CEO/Executive

Director indicating that all applicable staff funded by this Contract have received a copy of this fully executed contract and will receive copies of any amendments made to this Contract.

(15) The Network Provider should operate under a "no wrong door" model as defined in s. 394.4573, F.S., as well as the other guiding principles of ROSC. The network provider must also participate in all implementation activities and Technical Assistance provided by DCF and the ME.

(16) The Network Provider must execute and/or maintain if executed a Memorandum of Understanding (MOU) with a Federally Qualified Health Center or other medical facility. The MOU provides for integration of behavioral health services and primary health care services to the medically underserved to achieve the goals specified in Section B.1.a.(23)(a) of this Attachment I. The Network Provider also agrees to accept referrals from the primary health care provider for eligible individuals who are in need of behavioral health services.

Newly executed MOU's must be submitted within ninety (90) calendar days of the effective date of this contract to the ME's Contract Manager. The Network Provider must submit copies of any amendment to the MOU, to the ME's Contract Manager, within thirty (30) calendar days of execution.

Network Providers that operate Federally Qualified Health Centers are required to submit policies and procedures that explain the access to primary care services to the medically underserved behavioral health individual served. Any revisions to the policy and procedure must be submitted to the ME's Contract Manager within 30 calendar days of its adoption.

(17) Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)

If providing case management services to adults or children with mental illnesses or co-occurring disorders who are homeless or at risk of homelessness., the Network Provider must adhere to the requirements of **Exhibit AN, Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)**.

(18) Linkage and Referral Process

(a) The Network Provider's policies and procedures must address the referral and linkage process which include a "warm handoff" when referring individuals to all levels of services. This includes, but is not limited to, referrals within a Network Provider from one level of care to another, i.e. residential to outpatient; referrals outside of the Network Provider when a service is not offered by the Network Provider; and referrals to services upon discharge from the Network Provider, regardless if a planned or unplanned discharge. This also includes when an individual presents at the Network Provider for a

service; however, they are not actually admitted to the service for varying reasons. Such referral services include, but are not limited to, detoxification services, linkages with community programs such as housing, employment, parenting supports, and primary health care.

(b) A warm handoff consists of the Network Provider coordinating and facilitating the individual's admission to the next appropriate level of care by direct communication and follow-up with the receiving provider. These efforts must be documented and maintained in the individual's clinical record and should include detailed information including dates, times, and names of people spoken to.

(c) When a referral is made for a service at another provider with the expectation to return to the referring provider, i.e. detoxification, the referring Network Provider should initiate the warm handoff and maintain follow-up with the receiving provider to coordinate entry back to the referring Network Provider. This must be documented and maintained in the individuals' clinical record and should include detailed information including dates, times, names of people spoken to, and final disposition, i.e. date returned or justification when not returning.

(19) The Network Provider must ensure provision of services to individuals with special needs

The Network Provider must ensure the coordination of specialty services including employability skills training and linkage, victimization and trauma services, infant mental health services, and services to families in recovery. The Network Provider must also ensure the availability of appropriate services to individuals with special needs such as those who are blind, deaf or hard of hearing, developmentally disabled, physically handicap, criminally involved, or individuals with forensic involvement. The ME reserves the right to modify this list as the needs of the individuals change.

(a) The Network Provider must provide early diagnosis and treatment intervention to enhance recovery and prevent hospitalization.

(b) The Network Provider must work with the ME, the state, and other stakeholders to reduce the admissions and the length of stay for dependent children and adults with mental illness in residential treatment services.

(20) System of Care Management

The ME system of care staff ensures availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children, youth, adults and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports.

The spectrum of effective, community-based services and supports is organized and coordinated through the Provider Network. The goals of the System of Care management activities include elimination/management of wait lists, the maximum utilization of treatment resources, and the delivery of clinically appropriate services in the least restrictive setting and most cost-effective manner.

System of Care Management includes pre-service authorization for some services as well as management of continued stays and billing validation.

If the Network Provider contracts for services that are managed by the ME, the Network Provider must work in collaboration and assist the ME in fulfilling its contractual obligation and agrees to:

(a) The Network Provider agrees to assist the ME in the reporting and managing of the waiting list for all applicable levels of care:

i. Substance Abuse Residential Treatment Level II
ii. Mental Health Residential Treatment Level II
iii. Care Coordination
iv. Florida Assertive Community Treatment (FACT)
v. Short-term Residential Treatment
vi. Statewide Inpatient Psychiatric Program
vii. Specialized Therapeutic Group Homes

(b) The Network Provider agrees to submit real-time services data when required by the Prime Contract, state and/or federal rules, regulations, or the ME's policies and procedures, the Network Provider must submit to the ME real-time data in KIS Express, or other similar data structure, for services purchased by this contract. The Network Provider agrees to implement the new data reporting system(s) when notified and as directed by the ME.

(c) The Network Provider will have a data system in place that adequately supports the collection, tracking, and analysis of data necessary to perform the system of care management activities, reviews of clinical/administrative performance related to levels of care, clinical outcomes, and adherence to clinical/administrative standards.

(d) The Network Provider agrees to conduct financial screening to ensure maximization of fiscal resources including other third-party payors such as, but not limited to KidCare, Medicaid, Medicare, and other HMOs. These methods may include programs of intervention and/or diversion. System of Care management includes not only managerial and supervisory strategies, methods and tools to ensure timely

access to care, but also includes processes to promote continuous improvement to manage resources.

(e) The Network Provider will offer individuals served a multi-level continuum of care services for treatment of behavioral health services and supports within the least restrictive, most normative environments that are clinically appropriate.

(21) Continuous Quality Improvement Programs

(a) The Network Provider must maintain a continuous quality improvement program and report on the continuous quality improvement activities. The program is the responsibility of the Director and is subject to review and approval by the governing board of the service Network Provider. Each director must designate a Quality Assurance Officer/Compliance Officer who will be responsible for the continuous quality improvement program.

The continuous quality Improvement program should objectively and systematically monitor and evaluate the appropriateness and quality of care to ensure that services are rendered consistent with prevailing professional standards and identify and resolve problems.

(b) The quality improvement program must include at minimum:

i. Activities to ensure that fraud, waste and abuse do not occur.

ii. Composition of quality assurance review committees and subcommittees, purpose, scope, and objectives of the continuous quality assurance committee and each subcommittee, frequency of meetings, minutes of meetings, and documentation of meetings.

iii. A framework for evaluating outcomes, including:

1. Output measures, such as capacities, technologies, and infrastructure that make up the system of care.

2. Process measures, such as administrative and clinical components of treatment.

3. Outcome measures pertaining to the outcomes of services;

iv. A system of analyzing those factors which have an effect on performance;

v. A system of reporting the results of continuous quality improvement reviews; and,

vi. Best practice models for use in improving performance in those areas which are deficient.

vii. Establishment of a Seclusion and Restraint Oversight Committee per Chapter 65E-5.180, F.A.C. for agencies utilizing seclusion and/or restraint.

(22) Continuous Quality Improvement Initiatives – Network Providers must comply with all of the provisions for the initiatives outlined below:

(a) Recovery Management Practices

The Network Provider must operate under the principles of a Recovery Oriented System of Care (ROSC) in accordance with the requirements of **Exhibit BH, Recovery Management Practices**. ROSC principles promote a coordinated network of community-based services and supports that is person-centered, self-directed care, and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life. A ROSC is inclusive of clinical services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. As such, the Trauma Informed Care, Cultural and Linguistic Competence, and Integration of Behavioral Health Services and Primary Care initiatives are components of ROSC and will remain as integral parts of ROSC.

The Network Provider will work with the ME on the implementation of a Recovery Management system of care framework that aligns with the standards in **Exhibit BH**. The Network Provider agrees to conduct self-assessments annually, at minimum, or when directed by the ME, using the SAPT and RSA-R below, report the results to the ME when requested, and develop an action plan based on the results. The action plan should also include action steps toward implementation of the region-specific best practices as directed by the ME.

1) The Network Service Providers must use, at minimum, the following tools to assess recovery-oriented activities:

i. The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Services (SAPT) available at:

https://www.usf.edu/cbcs/mhlp/tac/documents/toolkits/self-assessment-tool-recovery-oriented-mental-health.pdf,

ii. The Recovery Self-Assessment-R (RSA) available at:

https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment, and

2) A Network Provider who employs peers must:

i. Use the Recovery Capital Scale, available at https://facesandvoicesofrecovery.org/resource/recovery-capital-scale/ , in the recovery planning process.

ii. Provide standardized training on Recovery Management best practices in employee orientation and refresher training.

iii. Adhere the terms and conditions pursuant to **Exhibit AO, Peer Service.**

3) As part of the ROSC initiative, The Network Provider must also**:**

i. Identify at least two ROSC Champions who will attend trainings and meetings. The names of the ROSC Champions will be submitted upon request by ME staff. In the event a change in staff occurs, the Network Provider must notify the ME's Contract Manager, in writing within ten (10) calendar days.

ii. Attend scheduled ROSC meetings, trainings and activities to ensure staff and agency become knowledgeable of ROSC.

(b) Integration of Behavioral Health Services and Primary Health Care

Many individuals with behavioral health issues have chronic health conditions and may have neglected their primary health needs for some time. The ME and the Southern Region are committed to developing an integrated system of care that incorporates comprehensive screening and monitoring tools that identify those affected by chronic health conditions and a system of care that meets their needs. Network Providers will be implementing Integrated Primary and Behavioral Health principles within ROSC. The integration will be ensured through linkage from the behavioral health provider with the primary health care provider of the individual through an electronic health record or other means of contact (phone, in person, etc). Referral and linkage processes will be necessary for all individuals who do not have a primary health care provider at entry into the system of care. Follow up and coordination of services are essential to meeting an individual health and behavioral health needs.

(c) Trauma Informed Care

Many individuals with behavioral health issues have experienced trauma that affects their development and adjustment. The ME and the Southern Region are committed to developing a system of care that incorporates comprehensive assessment tools that identify those affected by trauma and a system of care that meets their needs. Network

Providers will be implementing Trauma Informed Care (TIC) principles within ROSC. Progress on TIC should continue to be reported in the CQI semi-annual update, and should include, at minimum, required trauma trainings for all staff upon hire, and annually thereafter.

(d) Cultural and Linguistic Competence

It is the goal of the ME to become a culturally and linguistically proficient network, through the full implementation of The National Standards for Cultural and Linguistically Appropriate Services (the National CLAS Standards). The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and behavioral health care. In order to accomplish this task, the Network Provider:

1) Collaborate with the ME to identify and utilize the Network Provider's data to (1) identify sub-populations (i.e., racial, ethnic, Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, or Two-Spirited (LGBTQI-2S), minority groups) vulnerable to disparities and (2) implement strategies to decrease the differences in access, service use, and outcomes among sub-populations. These strategies should include the use of the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care;

2) Agrees to implement effective language access services to meet the needs of individuals with limited-English-proficiency, and/or who are deaf or hard-of-hearing, and increase their access to behavioral health care by providing sign language, translation, and interpretive services required to meet the communication needs of the individual seeking and or receiving services as required by state and federal laws, including English, Spanish and Creole. Services will meet the cultural needs and preferences of the populations served.

(e) Integration of Behavioral Health and the Child Welfare System

1) The Network Provider will ensure that behavioral health services are available to individuals and families referred by the Community Based Care Organizations (CBC) or by the Department's Child Protective Investigators in cases where behavioral health indicators are present during the initial child abuse/neglect investigation or at any point during child protective supervision or out-of-home care. Priority will be given to cases where a child is at risk for immediate removal or has been removed from the family, with a goal of reunification in the family safety plan.

Services may also be provided for the enrolled parent(s)'/caregiver(s)' family members, household residents, or significant others in need of behavioral health prevention or treatment services, as well as children in relative placements. For a detailed description

of the eligibility criteria please refer to the approved CWIST Protocols and Family Intensive Treatment Team Protocols, herein incorporated by reference, and available upon request to the MEs Contract Manager.

2) The coordination of efforts between the CBC, the ME and Network Providers is essential to the efficient service delivery for child-welfare involved families in behavioral health treatment. The ME and the Southern Region's Lead Agency for Community Based Care Provider are committed to developing an integrated system of care that meets the needs of children and their families. Network Providers will implement the Child Welfare Integration (CWI) initiative through a continuous quality improvement plan or component in the existing agency wide continuous quality improvement plan that delineates participation in the CWI initiative. As part of the plan or component of the plan must include the following:

i. Identification of at least two CWI Champions who will attend trainings and meetings. The names of the CWI Champions will be submitted upon request by ME staff. In the event a change in staff occurs, the Network Provider must notify the ME's Contract Manager, in writing within ten (10) calendar days.

ii. Attendance at scheduled CWI meetings including Integration Workgroup meetings to develop the process for identifying and responding to child-welfare involved families.

iii. Attendance at trainings regarding CWI when notified by the ME. Attendance at applicable trainings will be documented in the Continuous Quality Improvement Updates

iv. Participation in all CWI related activities to ensure staff and agency become knowledgeable of the Child Welfare system.

v. Description of the process to monitor and ensure that requests for any requested reports from the CBC or a CBC Network Provider is provided in a timely manner. The Network Provider must provide the reports within five (5) business days of receipt of the written request from the requestor. In cases of emergencies, (less than 24-hour notice), the supervisor at the Network Provider will accept the telephone call request for the report(s). The supervisor will request and ensure receipt of a written request within twenty-four (24) hours following the initial telephone call.

(f) Accreditation

The Network Provider must take appropriate steps to maintain its accreditation or become fully accredited by June 30, 2023, as required by this section, in order to promote best practices and the highest quality of care. The Network Provider must provide the ME with their full

accreditation and licensing reports upon request.

Network Provider applicants for licensure and licensed network providers must meet the most current best practice standards related to the licensable service components of the accrediting organization.

Accreditation by an accrediting organization recognized by the Department, as required by Chapter 397, F.S., is a requirement for licensure renewal of clinical substance use treatment services. The licensable substance use treatment components are listed in subsection 65D-30.002 (17), F.A.C.

Failure to meet the accreditation requirements will be considered by the ME to be a breach of this Contract and this contract may be subject to termination.

The Network Provider must participate in all implementation activities and Technical Assistance provided by DCF and the ME.

(23) Continuous Quality Improvement Updates

The Network Provider must submit semi-annual updates, by the dates specified in **Exhibit C**, **Required Reports**, on the implementation and progress of the following activities:

(a) ROSC Action Plan, including the scores from the SAPT and R-RSA.

(b) Integration of Behavioral Health Services and Primary Care, including evidence of the implementation of integrated care, including warm hand-offs and the process to track and report referrals of individuals from behavioral health to primary care and from primary care to behavioral health services.

(c) Trauma Informed Care, including required trauma trainings for all staff upon hire, and annually thereafter.

(d) Cultural and Linguistic Competence;

(e) Identification of the evidence-based practices (EBPs) utilized by the agency and address how these EBPs are monitored to ensure fidelity to the model;

(f) Participation in trainings and activities relating to the Integration of Behavioral Health and Child Welfare Systems;

(g) Monitoring processes to ensure that licensable substance use and mental health treatment services are appropriately licensed by either the Florida Department of Children and Families and/or the Agency for Health Care Administration, as applicable prior the start of services;

(24) Care Coordination

Network Providers providing care coordination, are required to implement Care Coordination services as defined in section 394.4573(1)(a), F.S., and specified on DCF Guidance Document 4, Care Coordination, and the ME's Care Coordination Exhibit AC, all documents are incorporated herein by reference and available when requested to the ME's Contract Manager.

Section 394.4573(1)(a), F.S., defines Care Coordination to "mean the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage. The purpose of care coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among priority populations." The priority populations are defined in the DCF Guidance Document 4, Care Coordination. Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. Care Coordination is not intended to replace case management.

ME Care Coordination staff identifies individuals eligible for Care Coordination through data surveillance, refer individuals to the Network Provider, track individual's progress through the service continuum, ensure e linkages to a wide range of services and monitor outcome metrics.

The Network Provider is also responsible for the identification of eligible for Care Coordination individuals through internal data surveillance. Upon identification of eligible individuals, the Network Provider refer individuals to their internal Care Coordination services internally, and to the ME Care Coordination Department.

(25) Transitional Voucher Program

The Transitional Voucher project is a flexible, individual served-directed voucher system designed to bridge the gap for persons with behavioral health disorders as they transition from acute or more restrictive levels of care to lower levels of care. The intent of this project is to enable individuals to live independently in the community with treatment and support services based on need and choice and build a support system to sustain their independence, recovery, and overall well-being. For individuals identified as meeting criteria for the transitional voucher project, the Network Provider shall adhere to the Department's Guidance Document 29, the **ME Care Coordination, Exhibit AC**, and the **Exhibit AV, Transitional Voucher Program**.

(26) Financial Audit Reports

(a) The Network Provider must submit financial statements consisting of Balance Sheet and Statement of Activity (income statement) per the schedule and to the individual(s) identified in the **Exhibit C, Required Reports**. The Network Provider agrees to provide the ME with any requests for additional financial statements/documentation.

(b) Network Providers who withhold income taxes, social security tax, or Medicare tax from employee's paychecks or who must pay the employer's portion of social security or Medicare tax must use Form 941, Employer's Quarterly Federal Tax Return, to report those taxes. On a quarterly basis, and by the dates specified in **Exhibit C, Required Reports**, the Network Provider, must submit an attestation that the 941 has been filed timely and any taxes due have been paid timely to IRS.

(c) The Network Provider must complete and submit the Department-approved Local Match Calculation Form as a supplemental report to the annual financial audit reports as required by Attachment II, Financial and Audit Compliance per the schedule and to the individual(s) identified in the **Exhibit C, Required Reports**. The Department-approved Local Match Calculation Form, Template 9 – Local Match Calculation Form is available at the following website:

https://www.myflfamilies.com/service-programs/samh/managing-entities/index.shtml

Note: Click on FY22-23 ME Templates and click on Reporting Template 9 – Local Match Calculation Form

(27) The Network Provider must ensure that its audit report will include the standard schedules that are outlined in Rule 65E-14, F.A.C. and submitted within the timeframes specified in **Exhibit C, Required Reports**.

(28) The Network Provider must implement and maintain fiscal operational procedures. These must contain but, not be limited to procedures relating to overpayments, charge-backs that directly apply to subcontractors and documentation of cost sharing (match) that comply with state and federal rules, regulations and/or ME policies and procedures and must comply with the requirements in Section 7., Audits, Inspections, Investigations, Records, and Retention.

(29) The Network Provider must make available upon request all plans, policies, procedures, and manuals to ME staff, Department staff, Network Provider staff, and to individuals served/stakeholders if applicable and appropriate.

(30) The Network Provider must comply with Children and Families Operating Procedure 215-8, OVERSIGHT OF HUMAN SUBJECT RESEARCH AND INSTITUTIONAL REVIEW BOARD DESIGNATION. The policy and guidance can be found at:

http://www.myflorida.com/apps/vbs/adoc/F2551_ITN09H13GC1Addendum10_CFOP2158.pdf

Approval from the Department through the ME is mandatory for all research conducted by any

employee, contracted organization or individual, or any public or private vendor, even if the aforementioned has their own Institutional Review Board which has granted approval.

(31) The Network Provider must meet with the ME's staff at regularly scheduled or any called meetings when notified by the ME.

(32) The Network Provider must notify the ME within forty-eight (48) hours of conditions related to performance that may interrupt the continuity of service delivery or involve media coverage.

(33) Referrals and Case Management Services to Individuals Residing in Assisted Living Facilities with a Limited Mental Health License

(a) The Network Provider agrees to comply with provisions and the reporting requirements of Exhibit L, Assisted Living Facilities with a Limited Mental Health License, if services to such residents are offered.

(b) It is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility; to an assisted living facility the license of which is under denial or has been suspended or revoked; or to an assisted living facility that has a moratorium pursuant to part II of chapter 408. Referrals to unlicensed facilities are not lawful and subject to sanctions by the Agency of Health Care Administration (AHCA).

(c) The Network Provider is directed to only refer individuals receiving mental health services to Assisted Living Facilities with a Limited Mental Health License. It is the referring Network Provider's responsibility to verify licensure. AHCA licenses can be verified at the following website:

http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx

(34) Community Resource Manual

The Network Provider must assist the ME in developing and maintaining the Community Resource Manual. This manual must be available for use by individuals served within each subcontractor location where services are provided.

(35) Work and Social Opportunities for Peer Specialists

Nationwide, health systems have accepted peers as a valuable part of the workforce. A shift to a more person-centered approach, a focus on integrated health, and a demand for more workers have increased the role peer specialists play in Florida's mental health and substance use systems. In keeping with Florida's goal of increasing the number of peer specialists, the Network Provider is encouraged to provide employment and social

opportunities to individuals who have lived experience of mental health and/or substance use conditions and/or lived experience of trauma.

If the Network Provider employs Peer Specialists anytime during the term of this Contract with funding from this Contract, the Network Provider must adhere the terms and conditions pursuant to **Exhibit AO, Peer Services**.

(36) Assist Stakeholder Involvement in Planning, Evaluation, and Service Delivery

(a) At the ME's request, the Network Provider will assist the ME in engaging local stakeholders, per section 394.9082 F.S., in its support activities for the Department's local plans.

(b) The Network Provider must work with the ME to provide performance, utilization, and other information for the Department's Substance Abuse and Mental Health Services Plan, and annual updates thereof, and to provide appropriate information for the Department's Long-Range Program Plan and its Annual Business Plan.

(37) Community Person Served Satisfaction Survey (if applicable)

The Network Provider must conduct satisfaction surveys of individuals served pursuant FASAMS DCF Pamphlet 155-2. The Network Provider must utilize a Department-approved satisfaction survey instrument. Failing to provide the required number of satisfaction surveys and/or utilizing a survey instrument other than that approved by the Department will result in a corrective action and an imposed financial penalty as described in the Standard Contract.

(38) Department-Sponsored Surveys

The Network Provider must participate in any Department-sponsored satisfaction surveys.

(39) Individual Served Trust Funds (CTF)

(a) The Network Provider must submit a letter to the Contract Manager certifying that they either are or are not the representative payee for Supplemental Security Income, Social Security Administration, Veterans Administration, Food Stamps, or other federal benefits on behalf of an individual served by **August 2, 2022.**

(b) If the Network Provider is the representative payee for Supplemental Security Income, Social Security Administration, Veterans Administration, or other federal benefits on behalf of the individual served, the Network Provider must comply with the applicable federal laws including the establishment and management of individual trust accounts (20 C.F.R. 416 and 31 C.F.R. 240).

(c) Any Network Provider assuming responsibility for administration of the personal property and/or funds of individuals served must follow the Department's Accounting Procedures Manual 7 APM, 6, incorporated herein by reference. Department or the ME personnel or their designees upon request may review all records relating to this section. Any shortages of funds in an individual served account that are attributable to the Network Provider must be repaid, plus applicable interest, within one (1) week of the determination.

(d) All reports specified in the Department's Accounting Procedures Manual 7 APM, 6, must be maintained onsite and available for review by Department or ME staff, and must be submitted to the ME upon request.

(e) The Network Provider must also maintain and submit documentation of all payment/fees received on behalf of SAMH individuals served receiving Supplemental Security Income, Social Security Administration, Veterans Administration, Food Stamps, or other federal benefits upon request from the ME.

b. Task Limits

The Network Provider must perform services in accordance with applicable, rules, statutes, licensing standards and policies and procedures.

The Network Provider agrees to abide by the approved Program Description, and is not authorized by the ME to perform any tasks related to the services purchased by this Contract other than those described in the approved Program Description and in this contract, without the express written consent of the ME. The Network Provider must ensure that services are performed in accordance with applicable rules, statutes, and licensing standards.

1. Staffing Requirements

a. Staffing Levels

(1) The Network Provider must maintain staffing levels in compliance with applicable rules, statutes, licensing standards and policies and procedures. See **Exhibit F, SAMH Programmatic State and Federal Laws, Rules, and Regulations**.

(2) The Network Provider must engage in recruitment efforts to maintain as much as possible staff with the ethnic and racial composition of the individuals served. The ME, at its sole discretion may request documentation evidencing recruitment efforts.

b. Professional Qualifications

(1) The Network Provider must comply with applicable rules, statutes, requirements, and standards with regard to professional qualifications. **See Exhibit F, SAMH Programmatic State and Federal Laws, Rules, and Regulations.**

(2) The Network Provider must provide employment screening for all mental health personnel

and all chief executive officers, owners, directors, and chief financial officers of service Network Providers using the standards for Level II screening set forth in Chapter 435, and s. 408.809 F.S., except as otherwise specified in s. 394.4572(1)(b)-(d), F.S. For the purposes of this contract, "Mental health personnel" includes all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities who have direct contact with individuals held for examination or admitted for mental health treatment.

(3) Additionally, the Network Provider must provide employment screening for substance use personnel using the standards pursuant to Chapter 397.4073, F.S.,

(4) Network Providers who have programs for children are required to meet the requirements of s. 39.001(2), (a) and (b) F.S.

c. Staffing Changes

The Network Provider must notify the ME's Contract Manager, in writing within ten (10) calendar days of staffing changes regarding the positions of Chief Executive Officer, Chief Financial Officer, Medical Director, Clinical Director, IT Director, Dispute Resolution Officer, Data Security Officer, and Single Point of Contact (section 504 of the ADA) , or any individuals with similar functions.

d. Subcontractors

(1) This contract allows the Network Provider to subcontract for the provision of services related to the performance required under this Contract, subject to the provisions relating to Assignments and Subcontracts in the Standard Contract and referenced therein. Written requests by the Network Provider to subcontract for the provision of services under this contract will be routed through the ME's Contract Manager for approval. The ME is not obligated nor, will it pay for any services delivered prior to its written approval of the act of subcontracting. The act of subcontracting will not in any way relieve the Network Provider of any responsibility for the contractual obligations of this contract. The pre-approval process applies to Subcontractors and not Independent Contractors as defined below.

(2) The ME has adopted the following definitions for vendors, subcontractors and/or independent contractors who are contracted by the Network Provider to do work contemplated under this contract:

(a) Vendor: A person or company offering something for sale.

(b) Subcontractor: A business to business relationship; contracting a business or person outside of one's own company to do work as part of a larger project.

(c) Independent Contractor: a person who is in an independent trade, business, or profession in which they offer their services and/or expert advice to an individual or organization. The general rule is that an individual is an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done. The earnings of a person who is working as an independent contractor are subject to Self-Employment Tax.

(3) The United States Public Health Service Act, Sections 1931(a)(1)(E), and 1916 (a)(5), and Title 45 of the Code of Federal Regulations, Part 96.135(a)(5) prohibit States from expending Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and Community Mental Health Services funds "To provide financial assistance to any entity other than a public or non-profit private entity". Ordinarily, the term "financial assistance" is used to describe a grant relationship as distinguished from a procurement relationship, typically funded by contract. While the above-referenced statute and regulations preclude States from providing grants to for-profit entities, procurement contracts may be entered into with for-profit entities. This is the latest interpretation from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (4/5/2009). [PHS Act, ss. 1931(a)(1)(E), and 1916 (a)(5), and 45 C.F.R., Part 96.135(a)(5)].

(4) Any vendor, subcontractor, or independent contractor the Network Provider contracts to do work contemplated under this contract, and who meets the definition of a Business Associate as defined in 45 C.F.R. 160.103, must sign a legally binding document with the Network Provider that contains the same restrictions and conditions of the Business Associate Agreement between the Network Provider with the ME. The binding document must meet the requirements of 45 C.F.R. s.164.504(e), Standard: Business Associate Contracts, the Privacy Rule, the Security Rule, the Breach Notification Rule, the Health Information Technology for Economic and Clinical Health ("HITECH") Act, the provisions included in the Network Provider's Business Associate Agreement with the ME, the ME's contractual requirements, and other laws and regulations pertaining to access, use, disclosure, and management of Protected Health Information ("PHI") without limitation, PHI in an electronic format (EPHI) created, received, maintained, or transmitted by the Network Provider or its subcontractors incidental to Network Provider's performance of this Contract.

(5) All agreements, for services contemplated under this contract, must adopt the applicable terms and conditions of the Network Provider's contract with the ME, including but not limited to, any Federal block grant requirements. In addition, all subcontract agreements must contain the applicable terms and conditions, and any amendments thereto, found in the ME's contract with the Department (Prime Contract), which is incorporated herein by reference. Subcontract agreements must include a detailed scope of work; term of the agreement, method of payment, clear and specific deliverables; and performance standards.

(6) The Network Provider must maintain individual subcontractor files for each subcontractor and provide a copy of all subcontract's agreements prior to the execution of those subcontracts and any amendments to the ME's Contract Manager.

(7) All independent contractor agreements, and subcontractor agreement, vendor agreements, and business associate agreements, or other legally binding agreements, for work contemplated under this contract must be available upon request by ME staff and at the time of monitoring.

(8) The Network Provider must implement and maintain procedures for subcontract procurement, development, performance, and management that comply with state and federal rules, regulation, and/or ME policies and procedures, in addition to identifying the ME's pre-approval process for approving the Network Providers act of subcontracting.

(9) The Network Provider must not subcontract for substance abuse/mental health services with any person, entity, vendor, purchase orders or any like purchasing arrangements that:

(a) is barred, suspended, or otherwise prohibited from doing business with any government entity, or has been barred, suspended, or otherwise prohibited from doing business with any government entity in accordance with s. 287.133. F.S.;

(b) is under investigation or indictment for criminal conduct, or has been convicted of any crime which would adversely reflect on their ability to provide services, or which adversely reflects their ability to properly handle public funds;

(c) has had a contract terminated by the Department or ME for failure to satisfactorily perform or for cause;

(d) has failed to implement a corrective action plan approved by the ME, the department, or any other governmental entity, after having received due notice, or

(e) is ineligible for contracting pursuant to the standards in s. 215.473(2), F.S.

(10) Regardless of the amount of the subcontract, the Network Provider must immediately terminate a subcontract for cause, if at any time during the lifetime of the agreement/subcontract, a subcontractor, **person, entity, vendor, purchase orders or any like purchasing arrangements, is:**

(a) Found to have submitted a false certification under s. 287.135, F.S., or
(b) Placed on the Scrutinized Companies with Activities in Sudan List or
(c) Placed on the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or
(d) Placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

(11) Unless the Department agrees to an alternative payment method as authorized in section 394.74, F.S., and prior to entering into any subcontract, or an amendment which modifies the previously negotiated unit cost rate or adds additional covered services, the Network Provider must conduct a cost analysis for said subcontract, in accordance with Rule 65E-14. F.A.C. A cost analysis is the review of the proposed cost elements to determine if they are necessary, allowable, appropriate and reasonable. Subcontractors will be required to comply with Rule 65E-14.19, F.A.C., Methods of Paying for Services, including but not limited to, covered services, measurement standard, descriptions, program areas, data elements, maximum unit cost rates, required fiscal reports, program description, setting unit cost rates, payment for services including allowable and unallowable units and requests for payments.

(12) The Network Provider must monitor the performance of all subcontractors and perform follow up actions as necessary. The Network Provider must notify the ME within forty-eight (48) hours of conditions related to subcontractor performance that could impair continued service delivery or involve media coverage.

2. Service Location and Equipment

a. Service Delivery Location

The location of services will be as specified in the approved Program Description required by Rule 65E-14, F.A.C.

b. Service Times

(1) A continuum of services must be provided on the days and times as specified in the approved Program Description and/or **Attachment IV, Prevention Scope of Work and/or Attachment V, Prevention Scope of Work – State Opioid Response,** if prevention services are purchased through this contract.

(2) The Network Provider must notify the ME's Contract Manager, in writing, at least ten (10) calendar days prior to any changes in days and times where services are being provided.

c. Changes in Location

The Network Provider must notify the ME's Contract Manager, in writing, at least ten **(10)** calendar days prior to any changes in location where services are being provided pursuant to Rule 65E-14, F.A.C.

d. Equipment

The Network Provider must furnish all appropriate equipment necessary for the effective delivery of the services purchased.

In the event that the Network Provider is allowed to purchase any non-expendable property with funds under this contract, the Network Provider will ensure compliance with the Tangible Property Requirements, Department operating Policies and Procedures as outlined in CFOP 40-5, CFOP 80-2, Rule 65E-14, F.A.C., which are incorporated herein by reference and may be obtained from the ME's Contract Manager. The provider must submit an inventory report, as specified in the Network Provider Inventory List, incorporated herein by reference, and by the date(s) listed in **Exhibit C, Required Reports.** The Network Provider Inventory List form may be requested from ME Contract Manager.

3. Deliverables

a. Services

The Network Provider must deliver the services specified in and described in the Program Description submitted by the Network Provider in accordance with **Exhibit G, Covered Services Funding by OCA** and in **Attachment IV, Prevention Scope of Work** and/or **Attachment V, Prevention Scope of Work – State Opioid Response**, if prevention services are purchased through this contract.

b. Reporting

(1) The Network Provider must submit reports included in **Exhibit C, Required Reports.** In all cases, the delivery of reports, ad hoc or scheduled, must not be construed to mean acceptance of those

reports. Acceptance, in writing, of required reports must constitute a separate act and must be approved by the ME's Contract Manager. The ME reserves the right to reject reports as incomplete, inadequate or unacceptable.

(2) The Network Provider must provide performance information or reports other than those required by this agreement at the request of the ME, the Southern Region's SAMH Regional Director, or their designee. For requests that are complex and difficult to address, all parties will develop and implement a mutually viable work plan.

(3) The ME, at its sole option, may allow additional time within which the Network Provider may remedy the objections noted by the ME or the ME may, after having given the Network Provider a reasonable opportunity to comply with the report requirements, declare this agreement to be in default.

c. Electronic Data Submission

The Network Provider agrees to comply with the data submission requirements outlined in FASAMS DCF Pamphlet 155-2, in SAMHIS, PBPS, as applicable, by the dates specified in **Exhibit C, Required Reports**. Upon request, the network provider must submit to the ME and the Department information regarding the amount and number of services paid for by the Substance Abuse Prevention and Treatment Block Grant.

The Network Provider must submit treatment data, as set out in subsection 394.74(3) (e), F.S. and FASAMS DCF Pamphlet 155-2.

The Network Provider is instructed to report the modifiers to procedure codes in compliance with the FASAMS DCF Pamphlet 155-2.

In addition to the modifiers to procedure codes that are currently required to be utilized as per FASAMS DCF Pamphlet 155-2, and in SAMHIS, as applicable, the Network Provider is directed to utilize the modifiers required for Block Grant funds, where applicable. The Network Provider also agrees to report to the ME and/or the Department, information regarding the amount and number of services paid for by the Community Mental Health Services Block Grant and/or the Substance Abuse Prevention and Treatment Block Grant.

Service data must be submitted electronically, weekly, by 12:00 Noon every Wednesday. Final monthly service data will be submitted electronically to the ME no later than the 4th of each month following the month of service into KIS, SAMHIS, FASAMS or other data reporting system designated by the ME and/or the Department. If the 4th falls on a weekend or holiday, data will be due on the next business day.

If the Network Provider is funded to provide substance use prevention services, the Network Provider must submit prevention services data to PBPS, maintained by Collaborative Planning Group Systems, Inc., or other data reporting system as directed by the ME, electronically no later than the 4th of each month following the month of service.

The Network Provider must also:

(a) To establish a unique Individual Served identifier for all individuals served, the Network Provider must submit the Demographic Data Set required by FASAMS DCF Pamphlet 155-2, within five (5) business days after the initial intake or admission.

(b) Ensure that the data submitted clearly documents all individuals served admissions and discharges which occurred under this contract. Ensure that substance use prevention services data entered into PBPS maintained by Collaborative Planning Group Systems, Inc., or other data reporting system designated by the ME, clearly documents all program Individual Served, programs and strategies which occurred under this contract, if applicable;

(c) Ensure that all data submitted to KIS, SAMHIS, FASAMS, or other data reporting system designated by the ME is consistent with the data maintained in the Network Provider's individuals served files/EMR-EHR systems. Ensure that substance use prevention services data entered into PBPS, or other data reporting system designated by the ME and/or the Department, is consistent with the data maintained in the Network Provider service documentation and/or individual's served files, if applicable;

(d) Review the ME's KIS error / download error reports to determine the number of records accepted and rejected. Based on this review, the Network Provider must make sure that the rejected records are corrected and resubmitted in KIS, SAMHIS, FASAMS, or other data reporting system designated by the ME. Only error-free data as processed by KIS will be accepted by the ME for monthly state reporting and payment validation;

(e) Resubmit corrected records no later than the next monthly submission deadline. The failure to submit any data set or the Network Provider's total monthly submission per data set, which results in a rejection rate of 5% or higher of the number of monthly records submitted will require the Network Provider to submit a corrective action plan describing how and when the missing data will be submitted or how and when the rejected records will be corrected and resubmitted; and

(f) In accordance with the provisions of section 402.73(1), F. S., and Rule 65-29.001, F.A.C., corrective action plans may be required for non-compliance, nonperformance, or unacceptable performance under this contract. Penalties may be imposed for failures to implement or to make acceptable progress on such corrective action plans. Failure to implement corrective action plans to the satisfaction of the ME and after receiving due notice, must be grounds for contract termination.

4. Performance Specifications

a. Performance Measures

(1) The Network Provider must meet the performance standards and required outcomes as specified in **Exhibit D, Substance Abuse and Mental Health Required Performance Outcomes/Outputs**. For Prevention services providers the individualized performance measure standards are specified in **Attachment IV, Prevention Services Scope of Work and/or Attachment V, Prevention Services Scope of Work – State Opioid Response**.

(2) The Network Provider agrees that KIS, PBPS, SAMHIS, and FASAMS, or other data reporting system designated by the ME, will be the source for all data used to determine compliance with performance standards and outcomes in **Exhibit D**, **Substance Abuse and Mental Health Required Performance Outcomes/Outputs** or other data system as specified by the ME. Any conflicts will be clarified by the ME and the Network Provider must adhere to the ME's resolution. The Network Provider must submit all service-related data for individuals receiving services funded in whole or in part by SAMH funds, local match, or Medicaid.

b. Performance Measurement Terms

FASAMS DCF Pamphlet 155-2, provides the data files and file layout requirements for collecting and reporting data on persons served in state-contracted community substance use and mental health Network Provider agencies. The elements used for various performance measures which are quantitative indicators, outcomes, and outputs used by the ME to objectively measure a Network Provider's performance and contains policies and procedures for submitting the required data. Collaborative Planning Group Systems, Inc., or any other data system designated by the ME and/or the Department, maintains the procedures for submitting the required prevention data into PBPS. The ME will also monitor the Network Provider for the performance measures.

c. Performance Evaluation Methodology

(1) The Network Provider must collect information and submit performance data and individual served outcomes, to the ME data system in compliance with FASAMS DCF Pamphlet 155-2, requirements. The specific methodologies for each performance measure may be found at the following website: **Error! Hyperlink reference not valid.**
https://www.myflfamilies.com/service-programs/samh/fasams/index.shtml

(2) The Network Provider is expected to have the capability to engage in organized performance improvement activities, and to be able to participate in partnership with the department and ME in performance improvement projects that are related to system wide transformation and improvement of services for individuals and families.

(3) By execution of this contract the Network Provider hereby acknowledges and agrees that its performance under the contract must meet the standards set forth above and will be bound by the conditions set forth in this contract. If the Network Provider fails to meet these standards, the ME, at its exclusive option, may allow a reasonable period, not to exceed six (6) months, for the Network Provider to correct performance deficiencies. If performance deficiencies are not resolved to the satisfaction of the ME within the prescribed time and if no extenuating circumstances can be documented by the Network Provider to the ME's satisfaction, the ME must terminate the contract. The ME has the sole authority to determine whether there are extenuating or mitigating circumstances.

(4) The ME will monitor the standards and outcomes specified in **Exhibit D, Substance Abuse and Mental Health Required Performance Outcomes/Outputs.**

5. Network Provider Responsibilities

a. Network Provider Unique Activities

(1) In the event of a dispute as to the ME's determination regarding eligibility for services for individuals and/or placement into the appropriate level of care, the ME's dispute resolution process, as described in the Standard Contract must be followed. An eligibility dispute must not preclude the provision of services to Individuals Served, unless the dispute resolution process reverses the ME's determination.

(2) The Network Provider is responsible for the satisfactory performance of the tasks referenced in this contract. By executing this contract, the Network Provider recognizes its responsibility for the tasks, activities, and deliverables described herein and warrants that it has fully informed itself of all relevant factors affecting the accomplishment of the tasks, activities and deliverables and agrees to be fully accountable for the performance thereof whether performed by the Network Provider or its subcontractors.

(3) The Network Provider agrees that services other than those set out in this contract will be provided only upon receipt of a written authorization from the ME's Contract Manager or an authorized ME staff member. The department through the ME has final authority to make any and all determinations that affect the health safety and well-being of the residents of the State of Florida.

(4) The Network Provider must be responsible for the fiscal integrity of all funds under this contract, and for demonstrating that a comprehensive audit and tracking system exists to account for funding by individual served and has the ability to provide an audit trail. The Network Provider's financial management and accounting system must have the capability to generate financial reports on individual service recipient utilization, cost, claims, billing, and collections for the ME. The Network Provider must maximize all potential sources of revenue to increase services, and institute efficiencies that will consolidate infrastructure and management functions in order to maximize funding.

(5) The Network Provider must ensure that the invoices submitted to the ME reconcile with the amount of funding and services specified in this contract, as well as the Network Provider's agency audit report and information system and this information is reconciled with KIS, PBPS, FASAMS, or other data reporting system designated by the ME.

(6) The Network Provider must make available source documentation of units billed by Network Provider upon request from the ME staff. The Network Provider must track all units billed to the ME by program and by Other Cost Accumulator (OCA).

(7) A Network Provider that receives block grant funding must comply with state or federal requests for information related to Substance Abuse Prevention and Treatment and Community Mental Health Services block grants.

(8) Any compensation paid for an expenditure subsequently disallowed as a result of the Managing Entity's or any Network Service Providers' non-compliance with state or federal funding regulations must be repaid to the Department upon discovery.

(9) The Network Provider must make available to the ME and the Department all records pertaining to service delivery. These records must be made available at all reasonable times for inspection, review, copying, or audit. Service delivery records include but are not limited to, invoicing, fiscal management, data management, incident reporting, clinical records for individuals served, and such documents determined to assure accountability of service provision and/or the expenditure of state and federal funds.

(10) The Network Provider must assist the ME and the Department in developing legislative budget requests based upon identified needs of the community.

(11) The Network Provider must provide to the ME, copies of, including but not limited to, evaluations, assessments, surveys, monitoring reports that pertain to licensure, accreditation, or other administrative or programmatic review, when those reports identify deficiencies that require corrective action. The Network Provider must submit to the ME all of the applicable reports, including copies of the corrective action plan(s) within ten (10) calendar days of receipt by the Network Provider from the reviewing entity.

(12) The Network Provider must cooperate with the ME and the Department when investigations are conducted regarding a regulatory complaint of the Network Provider. When additional information or documentation is requested by the ME, the Network Provider will submit the information within twenty-four (24) hours of the request unless otherwise specified in the ME's request.

(13) The Network Provider must maintain human resource policies and procedures that provide safeguards to ensure compliance with laws, rules and regulations. Integrate current and/or new state/federal requirements and policy initiatives into its operations upon provision by the Department and/or ME of the same.

(14) The Network Provider must maintain in one place for easy accessibility and review by ME and/or Department staff all policies, procedures, tools, and plans adopted by the Network Provider. The Network Provider's policies, procedures, and plans must conform to state and federal laws, the Florida Administrative Code, state and federal regulations, state and federal rules, and minimally meet expectations/ requirements contained in applicable Department of Children and Families and ME operating procedures.

(15) The Network Provider must maintain a mechanism for monitoring, updating, and disseminating policies and procedures regarding compliance with current government laws, rules, practices, regulations, and the ME's policies and procedures.

(16) The Network Provider must comply with all other applicable federal laws, state statutes and associated administrative rules as may be promulgated or amended. See **Exhibit F, SAMH Programmatic State and Federal Laws, Rules, and Regulations**, and ME policies and procedures.

Records relating solely to actions taken in carrying out the quality assurance and /or quality improvement program requirements of this contract and records obtained by the ME and/or the Department to determine a Network Provider's compliance of said programs in accordance with 394.907, F.S. and 397.4103 F.S. are confidential and exempt from s. 119.07(1) F.S. and s. 24(a), Article.

I, Constitution of the State of Florida.

(17) Coordination with other Providers/Entities

(i) The Network Provider must fulfill their designated role in implementing and/or maintaining a system of care in support of the cooperative agreements with the judicial system and the criminal justice system which define strategies and alternatives for diverting persons from the criminal justice system and address the provision of appropriate services to persons with substance use, mental health and/or co- occurring disorders who are involved with the criminal justice system. These agreements address the provision of appropriate services to persons who have behavioral health problems and leave the criminal justice system.

(ii) The Network Provider agrees to fulfill their designated role in implementing and/or maintaining a system of care in support of the ME Working Agreement, incorporated herein by reference, with the Community Based Care (CBC). The intent of the working agreement is to establish a formal linkage of partnerships with a shared vision for improving outcomes for families involved in the child welfare system by providing integrated community support and services.

(iii) The Network Provider may be required to enter into agreements with other external stakeholders.

(iv) The failure of other providers or entities does not relieve the Network Provider of any accountability for tasks or services that the Network Provider is obligated to perform pursuant to this contract.

b. State and Federal Laws, Rules, and Regulations

See **Exhibit F, SAMH Programmatic State and Federal Laws, Rules, and Regulations.**

6. Managing Entity Responsibilities

a. Managing Entity Obligations

(a) The ME must only subcontract with entities that are fiscally sound, and that can adequately ensure the accountability of public funds.

(b) The ME must assess the Network Provider's financial stability, using a risk assessment approach; the risk assessment approach will examine the impact of programmatic requirements on the Network Provider's financial stability. Any issues identified as a result of the financial risk assessment must be reported to the Department during the monthly reconciliation and performance review identified in the Prime Contract.

(c) The ME will provide administrative and programmatic oversight to ensure that Network Providers comply with all behavioral health treatment and prevention service requirements and other requirements of this contract.

(d) The ME is solely responsible for the oversight of the Network Provider and enforcement of all terms and conditions of this contract. Any and all inquiries and/or issues arising under this contract are to be brought solely and directly to the ME for consideration and resolution between the Network Provider and the ME. In any event, the ME's decision on all issues is final and solely subject to the ME's appeal process and legal rights of the Network Provider.

(e) The ME reserves the right terminate this contract in whole or in part, for non-performance as determined by the ME and to procure the services purchased through this contract to another entity and/or Network Provider.

(f) The ME is responsible for the administration, management, and oversight, and through subcontracts, the provision of behavioral health services in Miami-Dade and Monroe Counties.

(g) The ME must monitor and take action when necessary so that services which meet the standards defined herein will be provided throughout the contract period.

(h) The ME will ensure that the Network Provider utilizes the approved assessment and placement tool designated by the ME. Standardized tools and assessments approved by the ME must be used to determine placement and level of care.

(i) The ME must work with the Department to redirect administrative cost savings into improved access to quality care, promotion of service continuity, required implementation of EBPs, the expansion of the services array, and necessary infrastructure development. It acknowledges the benefits to be realized, include improved access to quality care, promotion of service continuity, implementation of EBPs, improved performance and outcomes, expansion of the service array, and necessary infrastructure development.

b. Monitoring Requirements

(1) The ME will monitor the Network Provider in accordance with this contract and the ME's Contract Accountability Policies and Procedures which can be obtained from the designated ME Contract Manager and is incorporated herein by reference. The Network Provider must comply with any coordination or documentation required by the ME's monitor(s) to successfully evaluate the programs and must provide complete access to all budget and financial information related to services provided under this contract, regardless of the source of funds.

(2) Network Providers with electronic health record (EHR) or electronic medical record systems (EMR) must provide access to ME funded service and service data contained in these systems for individuals funded under this Contract to the ME's monitoring team and provide sufficient resources to facilitate the monitoring process of services provided under this contract. Resources is defined but is not limited to, personnel, terminals, guest read-only accounts, privileges for monitors to access clinical/service records, and/or remote access into the systems by the monitors.

(3) The ME will monitor the Network Provider on its performance of all tasks and special provisions of the contract.

(4) The ME will provide a written report to the Network Provider within thirty (30) calendar days of the exit conference. If the report indicates corrective action is necessary, the Network Provider will have ten **(10)** calendar days from receipt of the monitoring report to respond in writing to the request. In the sole discretion of the ME, if there is a threat to health, life, safety or well-being of the individuals receiving services, the ME may require immediate corrective action or take such other action as the ME deems appropriate. Failure to implement corrective action plans to the satisfaction of the ME subjects the Network Provider to the remedies expressed in the Standard Contract.

c. Training and Technical Assistance

(1) The ME's contract manager, or designee, will provide training and technical assistance concerning the terms and conditions of this contract.

(2) The ME will provide technical assistance and support to the Network Provider to ensure the continued integration of services and support for individuals served, to include but not limited to, quality improvement activities to implement evidenced-based practice treatment protocols, the application of process improvement methods to improve the coordination of access and services that are culturally and linguistically appropriate.

(3) The ME will provide technical assistance and support to the Network Provider for the maintenance and reporting of data on the performance standards that are specified in **Exhibit D, Substance Abuse and Mental Health Required Performance Outcomes/Outputs**.

(4) The ME implements a training program for its staff and the Network Provider staff. The trainings assure that staff receives externally mandated and internal training. The ME may coordinate training or directly provide training to Network Provider staff.

(5) The ME will participate in the collaborative development and implementation of the working agreement with the Community Based Care and behavioral health Network Providers to ensure the integration of services and support within the community. The ME will support the development and implementation of the working agreement by providing an example of a policy working agreement, system of care information, data reporting requirements and technical assistance.

(6) The ME has the right to review the Network Provider's policies, procedures, and plans. Once reviewed by the ME, the policies and procedures may be amended provided that they conform to state and federal laws, the state Administrative Code, and federal regulations. Substantive amendments to submitted policies, procedures and plans must be provided to the ME within thirty (30) calendar days of adoption.

(7) The ME may request supporting documentation and review source documentation of units billed to the ME.

d. Managing Entity Determinations

The ME has exclusive authority to make the following determination(s) and to set the procedures that the Network Provider must follow in obtaining the required determination(s):

(1) Whether the Network Provider is meeting the terms and conditions of this contract, to include the documents that constitute this contract, any documents incorporated into any exhibit or attachment by reference, Program Description, policies and procedures and any documents incorporated herein by reference.

(2) The ME reserves the exclusive right to make certain determinations in these specifications. The absence of the ME setting forth a specific reservation of rights does not mean that all other areas of this contract are subject to mutual agreement. The ME reserves the right to make exclusively any and all determinations that it deems are necessary to protect the best interests of the State of Florida and the health, safety, and welfare of the individuals who are served by the ME either directly or through any one of its contracted Network Providers.

(3) In the event of any disputes regarding the eligibility of individuals served, the determination made by the ME is final and binding on all parties.

C. Method of Payment

Exhibit B, Method of Payment
Exhibit G, Covered Service Funding by OCA
Exhibit H, Funding Detail and Local Match
Monthly Payment Request (Incorporated by reference and available from the MEs Contract Manager upon request)

D. Special Provisions

1. The Network Provider is expected to maintain its administration cost to **10.00%** or less for Fiscal Year 2022-2023 for SAMH services purchased under this contract. The cost savings must be reallocated to support the increase of direct services, improved access to quality care, promotion of service continuity, and the implementation and/or expansion in the use of evidence-based practices. The Network Provider's SAMH Projected Operating and Capital Budget must evidence the reduction and redistribution of the cost savings.

2. The ME contracts with Mobile Response Teams (MRT's) in both Miami-Dade and Monroe Counties. MRTs provide on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and emergency rooms. MRTs are multi-disciplinary teams of behavioral health professionals and paraprofessionals with specialized crisis intervention and operations training. Mobile response services are available 24/7 with the ability to respond within 60 minutes. MRT staff triage calls in order to determine the level of severity and prioritize calls that meet the clinical threshold required for an in-person response. The primary goals of the MRTs is to lessen trauma, divert from emergency departments or juvenile/criminal justice, and prevent

unnecessary psychiatric hospitalizations. MRTs are designed to be accessible in the community at any time.

The Network Provider must provide the contact information for the Southern Region's Mobile Response Teams to parents and caregivers of children, adolescents, and young adults between the ages of 18 and 25, inclusive, who receive behavioral health services.

For Miami-Dade County the MRT Network Provider is Banyan Health Systems, Inc.
The 24-Hour Crisis Hotline is (305) 774-3616 or (305) 774-3617.
Website: https://banyanhealth.org/service/mobile-response-team/

For Monroe County, the MRT Network Provider is Guidance Care/Center, Inc.
The 24-Hour Crisis Hotline is: (305) 434-7660, option #8.
Website: http://guidancecarecenter.org/

3. Acute Care Service Utilization Reporting for Public Receiving Facilities, Detoxification and Addiction Receiving Facilities:

(a) Network Providers contracted to provide acute care services must submit acute care data (bed availability) in real time, as mandated under Section 394.9082(10), Florida Statutes.
(b) Acute care data must be provided for every licensed bed, as listed by AHCA or DCF's PLADS system, whether funded through this contract or not.
(c) The Network Provider must enter accurate and consistent data (all admissions and discharges) in the KIS Express Acute Care module, the ME's designated acute care system database. Arrangements to license and access the KIS Express Acute Care module should be coordinated through the ME's IT Department.

The Acute Care reporting manual is found in the FASAMS DCF Pamphlet 155-2 Chapter 8, Acute Care Data and can be found at:
https://www.myflfamilies.com/service-programs/samh/fasams/index.shtml

4. Real-time Data Entry:
When required by the Prime Contract, state and/or federal rules, regulations, or the ME's policies and procedures, the Network Provider must submit to the ME real-time data in KIS Express, or other similar data structure, for services purchased by this contract. The Network Provider agrees to implement the new data reporting system(s) when notified and as directed by the ME.

5. Waitlist Data Entry:
The Network Provider must submit waitlist data information through upload or direct entry into KIS Express, or other similar data structure for services purchased by this Contract, to ensure compliance with several Block Grant regulations. Waiting lists records are created for individuals who have received an assessment and a recommended service but who are unable to receive recommended service.

The Waiting List reporting manual is found in the FASAMS DCF Pamphlet 155-2 FASAMS Chapter 7, Waiting List and can be found at:
Error! Hyperlink reference not valid.https://www.myflfamilies.com/service-programs/samh/fasams/index.shtml

Failure to comply with the reporting requirements constitutes a lack of compliance with contract provisions. The Network Provider may be assessed financial consequences for failure to perform pursuant to section 8., of the Standard Contract.

6. **Purchase Firearms by Mentally Ill Persons pursuant to Chapter 790, Florida Statute, Weapons and Firearms – Applicable to Receiving and/or Treatment Facilities as defined in s. 394.455, Florida Statute (Baker Act and for Involuntary Treatment under the Marchman Act)**

Current law prohibits dealers from selling firearms to persons who have been adjudicated mentally defective or has been committed to a mental institution by a court or as provided in subsection 790.065 (2)(a)4.b., F.S., and as a result is prohibited by state or federal law from purchasing a firearm.

Subsection 790.065, F.S., provides conditions under which an individual who has been allowed to transfer to voluntary status in lieu of court-ordered involuntary commitment after being admitted for involuntary examination at a Baker Act receiving facility and is certified by an examining physician to be of imminent danger to himself of herself or others, may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license.

Within 24 hours after the person's agreement to voluntary admission, a record of the finding, certification, notice, and written acknowledgement ("petition") must be filed by the administrator of the receiving or treatment facility, as defined in s. 394.455, F.S, with the clerk of the court for the county in which the involuntary examination occurred (790.065, (2) (a).4.c.(II) F.S). No fee may be charged for such filing.

7. **Medication-Assisted Treatment Services**

   a. The Network Provider must discuss the option of medication-assisted treatment with individuals with opioid use disorders or alcohol use disorders.

   b. For individuals with opioid use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to methadone, buprenorphine-based products, and naltrexone.

   c. For individuals with alcohol use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to disulfiram, and acamprosate products.

d. The Network Provider must actively link individuals to medication-assisted treatment providers upon request of the individual served.

e. The Network Provider is prohibited from automatic discharges or discontinuing medications as a consequence of continued substance use or positive drug tests, unless the combination of substances used is medically contraindicated.

f. Access to Services: The Network Provider must not deny eligible individual from accessing its program or services based on the individual's current or past use of FDA-approved medications for the treatment of substance use disorders. Specifically, the Network Provider must ensure that:

i. The Network Provider's programs and services do not prevent the individual from participating in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program when ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder;

ii. The Network Provider must permit the individual to access medications for FDA-approved medication-assisted treatment by prescription or office-based implantation if the medication is appropriately authorized through prescription by a licensed prescriber or provider;

iii. The Network Provider must permit continuation in medication-assisted treatment for as long as the prescriber or medication-assisted treatment provider determines that the medication is clinically beneficial; and

iv. The Network Provider must prohibit compelling an individual to no longer use medication-assisted treatment as part of the conditions of any program or services if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

v. The Network Provider must prohibit caps or limits on the length of medication-assisted treatment, except for limits imposed by a documented lack of eligible public funds.

vi. The Network Provider is prohibited from requiring mandatory counseling participation requirements and mandatory self-help group participation requirements imposed as a condition of initiating or continuing medications that treat substance use disorders, except those established by methadone providers and applied to individuals on methadone pursuant to section 65D-30.014(5)(o) and section 65D-30.014(5)(m), Florida Administrative Code.

8. Prevention Services, if applicable:

a. The prevention services provided under this contract are to fund rigorous, effective, evidence-based, substance use prevention programs and strategies and promotion of wellness (positive mental health) services as part of the continuum of behavioral health care for individuals and their families. The strategies, activities, and services must be consistent with the local community ME-approved local Needs Assessment Logic Model (NALM) and the Comprehensive Community Action Plan (CCAP).

The Network Provider must work in collaboration with the funded ME Evaluation Entity, by participating in meetings and providing service data vital for the completion of a system-wide evaluation of the prevention services within the Strategic Prevention Framework.

The evaluation of the prevention system is expected to be the systematic collection and analysis of information about program activities, characteristics, and outcomes to reduce uncertainty, improve effectiveness, and assist in decision-making. The information gathered from the evaluation process will help the ME, the State and communities become more skillful and exact in describing what they plan to do, monitor what they are doing, and improve the prevention system of care. Evaluation results can and should be used to determine what efforts should be sustained and to assist in sustainability planning efforts. The ME will provide substantial input, in collaboration with the Network Provider and the Evaluation Entity, both in planning and implementation of the evaluation process and activities and will make recommendations regarding the continuance of the activities.

b. Data Submission in PBPS:

i. Upon submission of the monthly data, the Network Provider's Director of Prevention/Supervisor, must send an e-mail to the ME's Director of Prevention Services attesting that the data submitted has been reviewed and approved.

ii. Time spent in training activities, for up to twenty (20) hours, are considered Administrative Time. These twenty (20) hours are built into the negotiated unit rate in each of the prevention services listed in Exhibit G, Covered Service Funding by OCA. For additional hours spent in training, the Network Providers shall submit the data in PBPS as support time.

c. The Network Provider will accurately report the performance measures specified in **Attachment IV, Prevention Services Scope of Work** and/or **Attachment V, Prevention Services Scope of Work – State Opioid Response**.

d. Based on individual needs, the Network Provider must adhere to services as outlined in the approved Prevention Program Description, incorporated herein by reference and as set forth in **Attachment IV, Prevention Services Scope of Work and/or Attachment V, Prevention Services Scope of Work – State Opioid Response**, in addition to providing services from the list of approved covered services listed in **Exhibit G, Covered Service Funding by OCA**. Any change in the array of services must be justified in writing and submitted to the ME's Contract Manager for review and approval.

9. Intern Registration Requirements pursuant to section 491.0045, F.S.

a. The Network Provider must monitor and ensure that an individual who has not satisfied the postgraduate or post-master's level experience requirements, as specified in s. 491.005(1)(c), (3)(c), or (4)(c), F.S., register as an intern in the profession for which he or she is seeking licensure before commencing the post-master's experience requirement or for an individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience, outside the academic arena for any profession, the network provider must monitor and ensure that the individual registers as an intern in the profession for which he or she is seeking licensure before commencing the practicum, internship, or field experience.

b. An intern registration is valid for five (5) years.

c. A registration issued on or before March 31, 2017, expires March 31, 2022, and may not be renewed or reissued. Any registration issued after March 31, 2017, expires 60 months after the date it is issued. A subsequent intern registration may not be issued unless the candidate has passed the theory and practice examination described in s. 491.005(1)(d), (3)(d), and (4)(d), F.S.

d. An individual who has held a provisional license issued by the board may not apply for an intern registration in the same profession.

10. Incident Reports

a. The Network Provider must submit incident reports into the Incident Reporting and Analysis System (IRAS) on all reportable incidents per CFOP 215-6, within one (1) business day of the incident occurring. Failure to comply with the reporting requirements constitutes a lack of compliance with licensure status or contract provisions. The Network Provider may be assessed financial consequences for failure to perform pursuant to section 8., of the Standard Contract.

In the event an incident has an immediate impact on the health or safety of an individual served, has potential media impact, or involves employee-related incidents of criminal activity, the Network Provider must notify the ME Continuous Quality Improvement Manager and the ME Contract Manager immediately upon discovery.

Certain incidents may warrant additional follow-up by the ME. Follow-up may include on-site investigations or requests for additional information or documentation. When additional information or documentation is requested, the Network Provider will submit the information requested by the ME within 24 hours unless otherwise specified in the request.

It is the responsibility of the Network Provider to maintain a monthly log listing all incidents occurring at the agency, including those submitted to the Office of the Inspector General and those not reportable in IRAS, with the following information: Individual served initials, incident report tracking number from IRAS (if applicable), incident report category, date and time of incident, and follow-up action taken.

b. All designated public and private Baker Act receiving facilities, all State Mental Health Treatment Facilities, and all licensed Addictions Receiving Facilities that provide for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness must report seclusion and restraint event data in accordance with the DCF Pamphlet 155-2, Version 12.03, Chapter 14, or the latest revision thereof. This chapter is posted on the DCF website at https://myflfamilies.com/service-programs/samh/samhis/pamphlet-155-2-v12.shtml

11. Mandatory Reporting Requirements

a. The Network Provider and any subcontractor must comply with and inform its employees of the following mandatory reporting requirements. Each employee of the Network Provider, and of any subcontractor, providing services in connection with this contract who has any knowledge of a reportable incident must report such incident as follows:

1) A reportable incident is defined in CFOP 180-4, which can be obtained from the ME's Contract Manager.
2) Reportable incidents that may involve an immediate or impending impact on the health or safety of an Individual Served shall be immediately reported to the ME's Continuous Quality Improvement Manager and the ME Contract Manager.
3) Other reportable incidents must be reported to the ME's and Department's Office of Inspector General. Notification to the Inspector General shall be through the Internet at https://www.myflfamilies.com/admin/ig/rptfraud1.shtml or by completing a Notification/Investigation Request (form CF 1934) and emailing the request to the Office of Inspector General at IG.Complaints@myflfamilies.com. The Network Provider and subcontractor may also mail the completed form to the Office of Inspector General, 1317 Winewood Boulevard, Building 5, 2nd Floor, Tallahassee, Florida, 32399-0700; or via fax at (850) 488-1428.

b. In the event of a breach or potential breach of Protected Health Information, the Network Provider is directed to the reporting requirements delineated in the executed Business Associate Agreement, incorporated herein by reference.

12. Contracted Mental Health Network Providers must participate in the Department's aftercare referral process for formerly incarcerated individuals with severe and persistent mental illness or serious mental illness who are released to the community or who are determined to be in need of long-term hospitalization is required. Participation must be as specified in Children and Families Operating Procedure 155-47 (CFOP 155-47), Processing Referrals from the Department Of Corrections which can be obtained at: http://www.dcf.state.fl.us/admin/publications/policies.asp and is incorporated herein by reference.

13. Health, Safety, and Physical Environment Requirements for Substance Abuse and Mental Health Levels 1, 2, and 3 Residential Treatment Facilities

Unless abridged by a court of law, the rights of individuals who are admitted into a residential treatment facility must be assured. Each residential treatment facility must be operated in a

manner that protects the individual's rights, life, and physical safety while under the evaluation and treatment.

To avoid high risk situations such as suicide, death, serious injury, violence, and abuse of any individual the contracted residential treatment network provider must ensure that its facilities are safe and secure, for example, exposed plumbing pipes are to be covered to prevent individual access.

If for clinical reasons access to potentially dangerous grooming aids or other personal articles is contradicted for residents, staff must explain to the resident the conditions under which the articles may be used and must document the clinical rationale for these conditions in the resident's record. If clinically indicated, personal articles of residents may be kept under lock and key by staff. Such actions must be reviewed weekly for effectiveness and continued need.

14. Involuntary Commitment, Placements, Services, Treatment

a. Mental Health Services Provider: The Network Provider agrees to provide services to persons who have been court ordered into involuntary outpatient services in accordance with section 394.4655, F.S., court ordered into involuntary inpatient placements as defined in section 394.467, F.S., and court ordered for involuntary examination under 394.463, F.S.

b. Substance Use Services Provider: The Network Provider agrees to provide services to persons who have been court ordered into involuntary assessment and stabilization under section 397.6818, F.S., and/or court ordered into an involuntary substance use treatment under section 397.6957, F.S. It is the Network Provider's responsibility to be familiar with and ensure that the requirement's regarding involuntary admissions are followed pursuant to, including but not limited to ss. 397.6751, F.S.

c. Pursuant to s. 394.4655(3)-(4), and (7), F.S. and s. 397.697(4), F.S., if the court orders involuntary services, the Network Provider must submit a copy of the order to the ME, to the individuals specified in Exhibit C, Required Reports, within one (1) working day after it is received from the court. Similarly, if the court orders a program or a service that is not available, Network Provider must notify the ME within one (1) working day after it is received from the court indicating that the requested program or service is not available. Documents may be electronically submitted as directed by the ME. Documents must be submitted in a secured, password protected, or encrypted format.

15. Service Provision Requirements for Federal Block Grants, if applicable.

(a) A Network Provider that receives federal block grant funds from the Substance Abuse Prevention and Treatment or Community Mental Health Block Grants agrees to comply with Subparts I and II of Part B of Title XIX of the Public Health Service Act, s. 42 U.S.C. 300x-21 et seq. (as approved September 22, 2000) and the Health and Human Services (HHS) Block Grant regulations (45 C.F.R. Part 96).

(b) A Network Provider that receives funding from the SAPTBG certifies compliance with all of the requirements of the Substance Abuse and Mental Health Services Administration (SAMHSA) Charitable Choice provisions and the implementing regulations of 42 C.F.R. s. 54a.

(c) A Network Provider that receives block grant funding must monitor its compliance with block grant requirements and activities.

(d) The Network Provider must comply with ME, state and federal requests for information related to the SAPT and CMHS block grants.

(e) None of the funds provided under the following grants may be used to pay the salary of an individual at a rate in excess of Level II of the Executive Schedule: Block Grants for Community Mental Health Services, Substance Abuse Prevention and Treatment Block Grant, Projects for Assistance in Transition from Homelessness, Project Launch, Florida Youth Transition to Adulthood; and Florida Children's Mental Health System of Care Expansion Implementation Project.

(f) As applicable, the Network Provider must comply with the requirements set forth in 45 C.F.R. Subpart L – Substance Abuse Prevention and Treatment Block Grant and with the requirements of 42 C.F.R. Part 2.

(g) A Network Provider that receives SAPT block grant funding for the purpose of primary prevention of substance use, must comply with 45 C.F.R. s. 96.125.

(h) Behavioral health services must be provided to persons pursuant to s. 394.674, F.S., including those individuals who have been identified as requiring priority by state or federal law. The identified priority populations are found in **Exhibit A, Individuals/Participants to be Served**, however persons in categories (i) and (ii) below are specifically identified as persons to be given immediate priority over those in any other categories. These individuals may not be placed on a wait list without receiving interim services within the required timeframes.

(i) Pursuant to 45 C.F.R. s. 96.131, priority admission to pregnant women by Network Service Providers receiving SAPT Block Grant funding. If the clinically appropriate services cannot be provided for the pregnant woman, interim services, not later than forty (48) hours after the woman seeks treatment services, must be provided pursuant to 45 C.F.R. s. 96.123;

(ii) Pursuant to 45 C.F.R. s. 96.126 (b), (1) and (2), adherence with the requirement to provide interim services for injection drug users by Network Service Providers receiving SAPT Block Grant funding and until the clinically appropriate level of treatment can be provided to the individual as follows:

45 C.F.R. s. 96.126 (b), (1)- (2) Capacity of treatment for intravenous substance abusers and any other requirement.

(1) *14 days after making the request for admission to such a program; or*

(2) *120 days after the date of such request, if no such program has the capacity to*

admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request.

(i) In accordance with 45 C.F.R. s. 96.131 (a) and (b), the Network Provider that receive Block Grant funds and that serve injection drug users must publicize the following notice: "This program receives federal Substance Abuse Prevention and Treatment Block Grant funds and serves people who inject drugs. This program is therefore federally required to give preference in admitting people into treatment as follows: 1. Pregnant injecting drug users; 2. Pregnant drug users; 3. People who inject drugs; and 4. All others."

(j) In accordance with 45 CFR s. 96.123(a)(7) and s. 96.132(b), the Network Provider that receives block grant treatment or prevention funds (or both, as the case may be) shall ensure that continuing education in such services are available to the employees who provide such services or activities and this must be documented to demonstrate the provision of said education.

(k) Outreach Services to Injection Drug Users: The Network Provider must carry out outreach activities to encourage injection drug users in need of treatment to undergo such treatment pursuant to the requirements in 45 C.F.R. s. 96.126(e)., The Network Provider must document the services to demonstrate the provision of these services per the documentation requirements for Outreach services specified in Rule 65E-14, F.A.C.

(l) The Network Provider must ensure compliance with 45 C.F.R. Subpart C – Financial Management.

(m) Only if such services are purchased through this contract is the Network Provider responsible for complying with the reporting requirements outlined in Exhibit AB, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Early Intervention Funded Services for Human Immunodeficiency Virus (HIV) by the dates and to the individual(s) listed in Exhibit C, Required Reports. Subject to other applicable state and/or federal requirements, the ME may require additional reports from the Network Provider.

(n) Only if such services are purchased through this contract is the Network Provider responsible for complying with the for SAPTBG set-aside funded services for pregnant women and women with dependent children services, SAPTBG set-aside funded services for HIV Early Intervention Programs and the SAPTBG set-aside funds for Evidenced-based Outreach Services to Injection Drug Users as outlined in **Exhibit C, Required Reports**.

(o) The Network Provider must make available, either directly or by arrangement with others, tuberculosis services to include counseling, testing, and referral for evaluation and treatment pursuant to 45 C.F.R. s.96.17 and in compliance with Ch. 65D-30.,. F.A.C.

(p) The Network Provider must use SAPTBG funds provided under this contract to support both substance abuse treatment services and appropriate co-occurring disorder treatment services for individuals with a co-occurring mental disorder only if the funds allocated are used to support substance abuse prevention and treatment services and are tracked to the specific substance abuse activity as listed in Exhibit G, Covered Service Funding by OCA.

(q) The Network Provider is required to participate in the peer-based fidelity assessment process to assess the quality, appropriateness, and efficacy of treatment services provided to individuals under this contract pursuant to 45 C.F.R. 96.136.

(r) The United States Public Health Service Act, Sections 1931(a)(1)(E), and 1916 (a)(5), and Title 45 of the Code of Federal Regulations, Part 96.135(a)(5) prohibit States from expending Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and Community Mental Health Services funds "To provide financial assistance to any entity other than a public or non-profit private entity". Ordinarily, the term "financial assistance" is used to describe a grant relationship as distinguished from a procurement relationship, typically funded by contract. While the above-referenced statute and regulations preclude States from providing grants to for-profit entities, procurement contracts may be entered into with for-profit entities. This is the latest interpretation from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (4/5/2009). [PHS Act, ss. 1931(a)(1)(E), and 1916 (a)(5), and 45 C.F.R., Part 96.135(a)(5)].

(s) SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana.

16. The Network Provider agrees to maximize the use of state residents, state products, and other Florida-based businesses in fulfilling their contractual duties under this contract.

17. Option for Increased Services

The Network Provider acknowledges and agrees that the contract may be amended to include additional, negotiated, services as deemed necessary by the ME. Additional services can only be increased if the Network Provider demonstrates competence in the provision of contractual services and meets whatever criteria are established by the ME from time to time. The ME in its sole discretion must determine at what time and to which Network Provider and what amounts are to be given to Network Providers for additional services.

18. Sliding Fee Scale

The Network Provider must develop a sliding fee scale, that is updated annually, in conjunction with the Federal Poverty Guidelines and applies to individuals receiving services that are paid for by state, federal, or local matching funds. The Network Provider shall make a determination of ability to pay in accordance with the sliding fee scale for all individuals seeking substance abuse or mental health services in accordance with Rule 65E-14.018, F.A.C. Payment of fees shall not be a pre-requisite to treatment or the receipt of services.

19. Transportation Disadvantaged

The Network Provider agrees to comply with the provisions of chapter 427, F.S., Part I, Transportation Services, and Chapter 41-2, F.A.C., Commission for the Transportation Disadvantaged, if public funds provided under this contract will be used to transport individuals served. The Network Provider agrees to comply with the provisions of Children and Families Operating Procedures 40-50 (CFOP 40-5) Acquisition of Vehicles for Transporting Disadvantaged Individuals served if public funds provided

under this contract will be used to purchase vehicles which will be used to transport individuals served.

20. National Provider Identifier (NPI)

a. All Network Providers must obtain and use an NPI, a HIPAA standard unique health identifier for health care providers.

b. An application for an NPI may be submitted online at:
https://hmsa.com/portal/provider/zav_pel.ph.NAT.500.htm

c. Additional information can be obtained from one of the following websites:

(1) The National Plan and Provider Enumeration System (NPPES) located at:
https://nppes.cms.hhs.gov/NPPES/Welcome.do

(2) The CMS NPI located at:
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

21. Ethical Conduct

The Network Provider understands that performance under this contract involves the expenditure of public funds from both the state and federal governments, and that the acceptance of such funds obligates the Network Provider to perform its services in accordance with the very highest standards of ethical conduct. No employee, director, officer, agent of the Network Provider must engage in any business, financial or legal relationships that undermine the public trust, whether the conduct is unethical, or lends itself to the appearance of ethical impropriety. Network Providers' directors, officers or employees must not participate in any matter that would inure to their special gain and must recuse themselves accordingly. Public funds may not be used for purposes of lobbying, or for political contributions, or for any expense related to such activities, pursuant to Section 12., of the Standard Contract of this contract. The Network Provider understands that the ME contracts with the department, and as a subcontractor, recognizes that the department is a public agency which is mandated to conduct business in the sunshine, pursuant to section 286.011, F.S., and chapter 119, Florida Law, and that all issues relating to the business of the department, the ME and the Network Provider are public record and subject to full disclosure. The Network Provider understands that attempting to exercise undue influence on the ME, the department and its employees to allow deviation or variance from the terms of this contract other than a negotiated, publicly disclosed amendment, is prohibited by the State of Florida, pursuant to section 286.011, F.S. The Network Provider's conduct is subject to all state and federal laws governing the conduct of entities engaged in the business of providing services with government funds.

22. Information Technology Resources

If applicable, the Network Providers must receive written approval from the ME prior to purchasing any Information Technology Resource (ITR) with contract funds. The Contract Manager is responsible for serving as the liaison between the Network Provider and the ME during the completion of the process

as instructed by the Contract Manager. The Network Provider will not be reimbursed for any ITR purchases made prior to obtaining the ME's written approval.

23. Programmatic, Fiscal & Contractual Contract File References

All of the documentation submitted by the Network Provider which may include, but not be limited to the Network Provider's original proposal, Program Descriptions, SAMH Projected Operating and Capital Budget, Agency Capacity Report, are herein incorporated by reference for programmatic, contractual and fiscal assurances of service provision. These referenced contractual documents will be part of the Contract Manager's file. Documents incorporated by reference in this contract are available in the ME Contract Manager's file.

24. Employee Loans

Funds provided by the ME to the Network Provider under this contract must not be used by the Network Provider to make loans to their employees, officers, directors and/or subcontractors. Violation of this provision is considered a breach of contract and this contract will be terminated in accordance with **Section 10**., of the Standard Contract. A loan is defined as any advancement of money for which the repayment period extends beyond the next scheduled pay period.

25. Travel

The Network Provider's internal procedures will assure that: travel voucher Form DFS-AA-15, State of Florida Voucher for Reimbursement of Traveling Expenses, incorporated herein by reference, be utilized completed and maintained on file by the Network Provider. Original receipts for expenses incurred during officially authorized travel, items such as car rental and air transportation, parking and lodging, tolls and fares, must be maintained on file by the Network Provider. Section 287.058 (1) (b) F.S., requires that bills for any travel expense must be maintained in accordance with Section 112.061, F.S. governing payments for traveling expenses. CFOP 40-1 (Official Travel of State Employees and Non-Employees) provides further explanation, clarification, and instruction regarding the reimbursement of traveling expenses necessarily incurred during the performance of business.

The Network Provider must retain on file documentation of all travel expenses to include the following data elements: name of the traveler, dates of travel, travel destination, purpose of travel, hours of departure and return, per diem or meals allowance, map mileage, incidental expenses, signature of payee and payee's supervisor.

26. Property and Title to Vehicles

a. Property

(1) Nonexpendable property is defined as tangible personal property of a non-consumable nature that has an acquisition value or cost of $1,000 or more per unit and an expected useful life of at least one year, and hardback covered bound books that are not circulated to students or the general public, the value or cost of which is $250 or more. Hardback books with a value or cost of $100 or more should be classified as nonexpendable property only if they are circulated to students or to the general public. All computers, including all desktop and laptop computers,

regardless of the acquisition cost or value are classified as nonexpendable property. Motor vehicles include any automobile, truck, airplane, boat or other mobile equipment used for transporting persons or cargo.

(2) When state property will be assigned to a provider for use in performance of a contract, the title for that property or vehicle must be immediately transferred to the Network Provider where it must remain until this contract is terminated or until other disposition instructions are furnished by the ME's Contract Manager. When property is transferred to the Network Provider, the department must pay for the title transfer. The Network Provider's responsibility starts when the fully accounted for property or vehicle is assigned to and accepted by the Network Provider. Business arrangements made between the Network Provider and its subcontractors must not permit the transfer of title of state property to subcontractors. While such business arrangements may provide for subcontractor participation in the use and maintenance of the property under their control, the ME must hold the Network Provider solely responsible for the use and condition of said property. Network Provider inventories must be conducted in accordance with CFOP 80-2.

(3) If any property is purchased by the provider with funds provided by this contract, the Network Provider must inventory all nonexpendable property including all computers. A copy of which must be submitted to the along with the expenditure report for the period in which it was purchased. At least annually, the provider must submit a complete inventory of all such property to the ME whether new purchases have been made or not.

(4) The **Network Provider Inventory List,** incorporated herein by reference, and available from the designated ME Contract Manager upon request, must include, at a minimum, the identification number; year and/or model, a description of the property, its use and condition, current location, the name of the property custodian, class code (use state standard codes for capital assets), if a group, record the number and description of the components making up the group, name, make, or manufacturer, serial number(s), if any, and if an automobile, the VIN and certificate number; acquisition date, original acquisition cost, funding source, information needed to calculate the federal and/or state share of its cost.

(5) The ME's Contract Manager must provide disposition instructions to the Network Provider prior to the end of the contract period. The Network Provider cannot dispose of any property that reverts to the ME or department without the Contract Manager's approval. The Network Provider must furnish a Closeout Inventory Form no later than 30 days before the completion or termination of this contract. The Closeout Inventory Form must include all nonexpendable property including all computers purchased by the Network Provider. The Closeout Inventory Form must contain, at a minimum, the same information required by the annual inventory.

(6) The Network Provider hereby agrees that all inventories required by this contract must be current and accurate and reflect the date of the inventory. If the original acquisition cost of a property item is not available at the time of inventory, an estimated value must be agreed upon by both the Network Provider and the ME and must be used in place of the original acquisition cost.

(7) Title (ownership) to and possession of all property purchased by the Network Provider pursuant to this contract must be vested in the ME upon completion or termination of this contract. During the term of this contract, the Network Provider is responsible for insuring all property purchased by or transferred to the Network Provider is in good working order. The Network

Provider hereby agrees to pay the cost of transferring title to and possession of any property for which ownership is evidenced by a certificate of title. The Network Provider must be responsible for repaying to the ME the replacement cost of any property inventoried and not transferred to the ME upon completion or termination of this contract. When property transfers from the Network Provider to the ME, the Network Provider must be responsible for paying for the title transfer.

(8) If the Network Provider replaces or disposes of property purchased by the Network Provider pursuant to this Contract, the Network Provider is required to provide accurate and complete information pertaining to replacement or disposition of the property as required on the Network Provider's annual inventory.

(9) The Network Provider hereby agrees to indemnify the ME and the department against any claim or loss arising out of the Network Provider's operations of any motor vehicle purchased by or transferred to the Network Provider pursuant to this contract.

(10) A formal contract amendment is required prior to the purchase of any property item not specifically listed in the approved contract budget.

b. Title to Vehicles

(1) Title (ownership) to, and possession of, all vehicles acquired with funds from this contract must be vested in the ME upon completion or termination of the contract. The Network Provider will retain custody and control during the contract period, including extensions and renewals.

(2) During the term of this contract, title to vehicles furnished by the state or acquired at the direction of the state (using state or federal funds) must not be vested in the Network Provider. Subcontractors must not be assigned or transferred title to these vehicles. The Network Provider hereby agrees to indemnify the ME or the department against any claim or loss arising out of the operations of any motor vehicle purchased by or transferred to the provider pursuant to this contract.

27. National Voter Registration Act (NVRA) of 1993

a. The Network Provider must comply with the National Voter Registration Act (NVRA) of 1993, Pub. L. 103-31 (1993), ss. 97.021 and 97.058, F.S., and ch. 1S-2.048, F.A.C., in accordance with Guidance 25 – National Voter Registration Act Guidance, incorporated herein by reference;

b. As a Voter Registration Agency, the Network Provider must designate a Voting Registration Activities Coordinator and provide the contact information of the Coordinator by the date and to the individual(s) identified in **Exhibit C, Required Reports**. The Network Provider must notify the ME's Contract Manager, in writing within (10) calendar days of staffing changes regarding this position.

c. As a Voter Registration Agency, the Network Provider must provide individuals seeking services and/or individuals served with an opportunity at admission or when they change their address, to either register or update their voter registration. The National Voter Registration Act

Preference Form/Application are DS-DE77-ENG and DS-DE77-SPN, are available at the link provided in paragraph f., below

d. The Network Provider must submit a NVRA Voter Registration Agencies Quarterly Activities Report Form, DS-DE131, by the dates and to the individual(s) identified in **Exhibit C, Required Reports**. The Quarterly Activity Report Form is available at the link provided in paragraph f., below.

e. Any person aggrieved by a violation of either the National Voter Registration Act or a voter registration or removal procedure under the Florida Election Code may file a written complaint with the Department of State by completing and submitting the NVRA Complaint Form (DS-DE 18).

f. The Department of State has published all form referenced herein, along with online training and additional guidance to implement NVRA at:

http://dos.myflorida.com/elections/for-voters/voter-registration/national-voter-registration-act/

28. Special Insurance Provisions

a. The Network Provider must notify the ME Contract Manager within thirty **(30)** calendar days if there is a modification to the terms of insurance including but not limited to, cancellation or modification to policy limits.

b. The Network Provider acknowledges that, as an independent contractor, the Network Providers, and its subcontractors, at all tiers are not covered by the State of Florida Risk Management Trust Fund for liability created by s. 284.30, F.S.

c. The Network Provider must obtain and provide proof to the ME's Contract Manager of comprehensive general liability insurance coverage (broad form coverage), specifically including premises, fire and legal liability to cover managing the Network Provider and all of its employees. The limits of Network Provider's coverage must be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

d. If any officer, employee, or agent of the Network Provider operates a motor vehicle in the course of the performance of its duties under this contract, the Network Provider must obtain and provide proof to the Department and the Managing Entity of comprehensive automobile liability insurance coverage. The limits of the Network Provider's coverage must be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

e. If any officer, employee, or agent of the Network Service Provider, at all tiers, provides any professional services or provides or administers any prescription drug or medication or controlled substance in the course of the performance of the duties of the Network Service Provider, the Managing Entity must cause the Network Service Provider, at all tiers, to obtain and provide proof to the Managing Entity and the Department of professional liability insurance coverage, including

medical malpractice liability and errors and omissions coverage, to cover all Network Service Provider employees with the same limits.

f. The ME and the Department must be exempt from, and in no way liable for, any sums of money that may represent a deductible or self-insured retention under any such insurance. The payment of any deductible on any policy must be the sole responsibility of the Network Provider purchasing the insurance.

g. All such insurance policies of the Network Providers, and its subcontractors at all tiers, must be provided by insurers licensed or eligible to do and that are doing business in the State of Florida. Each insurer must have a minimum rating of "A" by A. M. Best or an equivalent rating by a similar insurance rating firm and must name the ME and the Department as an additional insured under the policy(ies). The Network Provider must use its best good faith efforts to cause the insurers issuing all such general, automobile, and professional liability insurance to use a policy form with additional insured provisions naming the ME and the Department as an additional insured or a form of additional insured endorsement that is acceptable to the ME and the Department in the reasonable exercise of its judgment.

h. The requirements of this section must be in addition to, and not in replacement of, the requirements of Section 24., Insurance, of the Standard Contract but in the event of any inconsistency between the requirements of this section and the requirements of the Standard Contract, the provisions of this section must prevail and control.

i. If the Network Provider is an agency or subdivision of the State, its obligation to indemnify, defend and hold harmless the ME shall be to the extent permitted by section 768.28, F.S. or other applicable law, and without waving the limits of sovereign immunity.

E. List of Exhibits

The Network Provider agrees to comply with the requirements contained in the exhibits listed below. The following exhibits, or the latest revisions thereof, are incorporated in and made a part of the contract.

1. **Exhibit A, Clients/Participants to be Served**
2. **Exhibit B, Method of Payment**
3. **Exhibit B, Method of Payment for FY 2022-23**
4. **Exhibit C, Required Reports**
5. **Exhibit C, Required Reports for FY 2022-23**
6. **Exhibit D, Substance Abuse and Mental Health Required Performance Outcomes and Outputs**
7. **Exhibit D, Substance Abuse and Mental Health Required Performance Outcomes and Outputs for FY 2022-23**
8. **Exhibit F, State and Federal Laws, Rules and Regulations**
9. **Exhibit G, Covered Service Funding by OCA**
10. **Exhibit G, Covered Service Funding by OCA for FY 2022-23**

11. **Exhibit H, Funding Detail & Local Match Plan**
12. **Exhibit H, Funding Detail & Local Match Plan for FY 2022-23**
13. **Exhibit K, SAMH Pre-Authorization Utilization Management Roster**
14. **Exhibit R, Substance Abuse Residential Level II**
15. **Exhibit AC, Care Coordination Report Narrative and Chart**
16. **Exhibit AE, Women's Special Funding - Substance Abuse Services for Pregnant Women, Mothers, and Affected Families (OCA's MS027 and MS081)**
17. **Exhibit AO, Peer Services**
18. **Exhibit AV, Transitional Voucher Program**
19. **Exhibit BD, State Opioid Response Discretionary Grant Service (2) – Medication Assisted Treatment Services for Opioid Use Disorders and Evidence Based Treatment to Address Stimulant Misuse and Use Disorders OCA; MSSM3**
20. **Exhibit BH, Recovery Management Practices**

EXHIBIT B
For Fiscal Year
2022-2023
METHOD OF PAYMENT

1. PAYMENT CLAUSES

a. Fee-for-Service: This is a Fee-for-Service contract, paid in accordance with subsection 65E-14.021(2), F.A.C. The unit prices for the covered services purchased under this contract are listed in **Exhibit G, Covered Service Funding by OCA**. The ME may pay the Network Provider for the delivery of service units provided in accordance with the terms and conditions of this contract for a total dollar amount not to exceed **$3,170,539.00**, subject to the availability of funds and satisfactory performance of all terms by the Network Provider.

b. Case Rate: This contract purchases (**Name the Program**) services and is reimbursed by the ME using a Case Rate in accordance with subsection 65E-14.021(2), F.A.C. The ME shall pay the Network Provider for the delivery of services provided in accordance with the service delivery described in the approved Program Description, incorporated herein by reference, and terms and conditions of this contract for a total dollar amount not to exceed **($0.00)**, subject to the availability of funds. The approved Case Rate is listed in **Exhibit G, Covered Services Funding by OCA under OCA (Identify OCA)**.

c. Capitation Rate: This contract purchases (**Name the Program**) services and is reimbursed by the ME using a Capitation Rate in accordance with subsection 65E-14.021(2), F.A.C. The ME shall pay the Network Provider for the delivery of services provided in accordance with the service delivery described in the approved Program Description, incorporated herein by reference, and terms and conditions of this contract for a total dollar amount not to exceed **($0.00),** subject to the availability of funds. The Capitation Rate is listed in **Exhibit G, Covered Services Funding by OCA under OCA (Identify OCA).**

d. Cost Reimbursement: The ME shall reimburse the Network Provider for allowable expenditures incurred pursuant to the terms of this contract and the terms in Exhibit M-1, Services to be Provided, for a total dollar amount not to exceed **($0.00)**, subject to the availability of funds and Exhibit M-2, Line Item Operating Budget.

e. The total contract amount for services purchased through this contract is **$3,170,539.00** of the total Contract amount, the ME will be required to pay **$2,642,116.00** subject to the delivery and appropriate billing for services. The remaining amount of **$528,423.00** represents "Uncompensated Units Reimbursement Funds", which the ME, at its sole discretion and subject to the availability of funds, may pay to the Network Provider, in whole or in part, or not at all, for Exemplary Performance by the Network Provider. Exemplary Performance will be demonstrated by the Network Provider's service delivery and billing for those services in excess of those units of service the ME will be required to pay. The ME's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract between the ME and the Department. Any costs or services eligible to be paid for under any other contract or from any other source are not eligible for payment under this Contract.

2. GROUP SERVICES

Aftercare, Intervention, Outpatient, and Recovery Support Services (Substance Abuse) are eligible for special group rates. Group services shall be billed based on a direct staff hour, at 25% of the contract's established rate for the individual services for the same covered service. Excluding Outpatient, total hourly reimbursement for group services shall not exceed the charges for fifteen (15) individuals per group. Group size limitations outlined in the current Medicaid Handbook apply to Outpatient group services funded under this contract.

3. FLEXIBILITY

Unless otherwise notified in writing by the ME, the Network Provider is authorized to use the funds within each Other Cost Accumulator ("OCA"), and for the approved covered services within that OCA as listed **in Exhibit G, Covered Services Funding by OCA**, with 100% flexibility without the need for an amendment to this contract.

4. LOCAL MATCH REQUIREMENT

a. Pursuant to s. 394.76(3), Florida Statutes (F.S.), the Network Provider agrees to provide local matching funds in the amount of **$432,987.00** as indicated in **Exhibit H, Funding Detail and Local Match Plan**.

b. Should the Network Provider receive any funding from the *"Uncompensated Units Reimbursement Funds"*, then the amount of Local Match Plan as it appears on **Exhibit H, Funding Detail**, will automatically change, utilizing the following formula:

The additional match required on the uncompensated units = Uncompensated Substance Abuse Services X 16.67% + Uncompensated Mental Health Services that is not exempt from local match requirements X 33.33%. *

*The following MH services are exempt from the local match requirement

i. Deinstitutionalization Projects

Case Management
Intensive Case Management
Residential Services I-IV
Supported Housing/Living
Short Term Residential Treatment (not exempt if funded by Baker Act funds or operated by a public receiving facility)
FACT Teams

ii. CMH Programs (100435 Category & 102780 (PRTS) Category) that are not grant funded.

5. CORRECTIVE ACTION PLANS

In accordance with the provisions of s. 402.73(1), F.S., and Rule 65-29.001, Florida Administrative Code (F.A.C.), corrective action plans may be required for noncompliance, nonperformance, or unacceptable performance under this contract. Penalties may be imposed, to include contract termination in whole

or in part, for failures to implement or to make acceptable progress on such corrective action plans.

6. REDUCTION OR WITHOLDING OF FUNDS

a. The ME may reduce or withhold funds pursuant to Rule 65-29.001, F.A.C., if the Network Provider fails to comply with the terms of the contract and/or fails to submit client reports and/or data as required in DCF PAM 155-2, Rule 65E-14, F.A.C. and by the due dates listed on **Exhibit C, Required Reports.**

b. The ME's decision to reduce or withhold funds will be submitted to the Network Provider in writing. The written notice will specify the manner in which the Network Provider has failed to comply with the terms of the contract. When, and if, compliance is achieved, the withheld funds will be disbursed to the Network Provider.

7. CLOSURE OR SUSPENSION OF SERVICES

If the Network Provider closes or suspends the provision of services funded by this contract, the Network Provider agrees to notify the ME in writing thirty (30) calendar days prior to their intent to close, suspend or end service(s). If the Network Provider fails to notify the ME, the Network Provider hereby agrees not to request payment for services provided in prior months if the actual number of services in the month for which payment is being requested is less than twenty-five percent (25%) of the prorated amount of services by covered service as given on **Exhibit G, Covered Service Funding by OCA**, or twenty-five percent (25%) of the prorated share of the amount of funding as specified on **Exhibit G, Covered Service Funding by OCA**.

8. PURCHASE OF ADDITONAL SERVICES

The ME in its sole discretion and subject to funding availability, may purchase from any Network Provider prior to the end of the contract period any service units provided at any time during the term of the contract.

9. ADDITIONAL RELEASE OF FUNDS

At its sole discretion, the ME may approve the release of more than the monthly prorated amount when the Network Provider submits a written request justifying the release of additional funds, if funds are available and services have been provided.

10. THIRD PARTY BILLING

a. For the purposes of payment, the Department nor the ME shall be considered a liable third-party payer for Medicaid or other publicly funded benefits assistance program. A Medicaid enrolled Network Provider shall not bill the ME for Medicaid covered services provided to a Medicaid eligible recipient. The Network Providers shall not bill the ME for:

i. Any Covered Service that is partially compensated by Medicaid, or another publicly funded benefits program source. This shall include any difference in a network provider's rate for a Covered Service and any discount or contracted rate payable by another source, or

ii. An individual's share of service cost, when that cost is reimbursable by Medicaid, or another publicly funded benefits program.

Nothing in this section shall be construed to prevent payment for Covered Services that are not covered by Medicaid or another publicly funded benefits assistance program or provided to an individual who has depleted other fund sources.

b. Department funds may not reimburse services provided to:

i. Individuals who have third party insurance coverage when the services provided are covered under the insurance plan; or

ii. Medicaid enrollees or recipients of another publicly funded health benefits assistance program, when the services provided are covered by said program.

c. Department funds may reimburse services provided to:

i. Individuals who have lost coverage through Medicaid, or any other publicly funded health benefits assistance program coverage for any reason during the period of non-coverage; or

ii. Individuals who have a net family income at or above 150 percent of the Federal Poverty Income Guidelines, subject to the sliding fee scale requirements in Rule 65E-14.018 F.A.C.

iii. The Network Provider shall ensure that Medicaid funds are accounted for separately from funds for this contract.

d. In no event shall Medicaid, any health insurance, another publicly funded health benefits assistance program, or the ME be billed for the same service provided to the same individual on the same day.

e. Medicaid earnings cannot be used as local match.

f. The Network Provider shall ensure that Medicaid payments are accounted for in compliance with federal regulations.

g. The Network Provider shall ensure that Medicaid funds will be accounted for separately from funds for this Contract. This includes services such as Statewide Inpatient Psychiatric Program ("SIPP"), Florida Assertive Community Treatment ("FACT'), Community Action Treatment ("CAT"), Family Intensive Treatment ("FIT"), and Central Receiving Facilities.

11. PAYMENT FROM MEDICAID HEALTH MAINTENANCE ORGANIZATIONS, PREPAID MENTAL HEALTH PLAN, OR PROVIDER SERVICE NETWORKS

a. The Network Provider shall make every reasonable effort to identify and collect benefits from third-party payers for services rendered to eligible individuals. Third party payers are, unless waived in Section D (Special Provisions) of this contract, the Network Provider agrees that payments from commercial insurers such as worker's compensation, TRICARE, Medicare, Health Maintenance Organization, Managed Care Organizations, or other payers liable, to the extent that they are required by contract or law, to participate in the cost of providing services to a

specific individual.

b. Requirements for all Medicaid-enrolled Network Service Providers, prior to invoicing the Managing Entity for any services provided to any Medicaid-enrolled recipients, the Network Provider must maintain documentation for each individual served in a format that is easily accessible and retrievable for monitoring or auditing purposes by the ME or Department that it has:

i. Submitted a prior authorization request for any Medicaid-covered services provided.

ii. Appealed any denied prior authorizations.

iii. Provided assistance to appeal a denial of eligibility or coverage.

iv. Verified the provided service is not a covered service under Florida Medicaid, as defined in Chapter 59G-4, F.A.C., or is not available through the individual's MMA Plan.

v. In cases where the individuals Medicaid-covered service limit has been exhausted for mental health services, an appropriately licensed mental health professional has issued a written clinical determination that the individual continues to need the specific mental health treatment service provided.

vi. In cases where the individual's Medicaid-covered service limit has been exhausted for substance use disorder treatment services a qualified professional as defined in Section 397.311, F.S., has issued a written clinical determination that the individual continues to need the specific service provided.

12. TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BILLING, IF APPLICABLE

The Network Provider's attention is directed to its obligations under applicable parts of Part A or Title IV of the Social Security Act and the Network Provider agrees that TANF funds shall be expended for TANF participants in accordance with Chapters 414, and 445, F.S. and the Department's State Plan for Temporary Assistance for Needy Families, renewal October 1, 2020 – September 30, 2023, or the latest revision thereof. Department's State Plan for Temporary Assistance for Needy Families can be obtained from the contract manager, or can be found at the following web site:

https://www.myflfamilies.com/service-programs/access/docs/TANF-Plan.pdf

The contract shall specify the unit cost rate for each covered service contracted for TANF funding, which shall be the same rate as for non-TANF funding, but the contract shall not specify the number of TANF units or the amount of TANF funding for individual covered services.

13. INVOICE REQUIREMENTS

a. The rates negotiated with any Network Provider may not exceed the rate as specified in in **Exhibit G, Covered Service Funding by OCA** and/or the amounts listed in **Exhibit M-2, Line Item Operating Budget**, where applicable.

b. Network Providers are required to comply with Rule 65E-14.021, F.A.C., Schedule of Covered Services, including but not limited to, covered services, methods of payments, descriptions, program areas, data elements, required fiscal reports, program description, rate setting

process, payment for services including allowable and unallowable units and requests for payments.

c. For Network Providers that receive block grant funding, the invoice shall include the minimum data elements to satisfy the Department's application and reporting requirements.

d. A Network Provider that receives block grant funding shall, in its invoice, provide sufficient detail that captures, reports, and tests the validity of expenditures and service utilization.

e. The Network Provider shall request payment monthly through submission of a properly completed invoice, within eight (8) days following the end of the month for which payment is being requested for the delivery of service. Payment to the Network Provider by the ME is subject to the availability of funds and payments received from the Department. The invoice, Monthly Payment Request, is incorporated herein by reference and available upon request from the ME's Contract Manager.

f. If no services are due to be invoiced from the preceding month, the Network Provider shall submit a written document to the ME indicating this information within eight (8) calendar days following the end of the month. Should the Network Provider fail to submit an invoice or written documentation if no services are due to be invoiced from the preceding month, within thirty (30) calendar days following the end of the month, then the ME at sole discretion can reallocate funds. If the Network Provider fails to submit an invoice or written documentation for two (2) consecutive months within a twelve (12) month period, the ME at sole discretion can terminate the contract.

g. The Network Provider's final invoice must reconcile actual service units provided during the contract period with the amount paid by the ME. The Network Provider shall submit their fiscal year final invoice to the ME within twenty (20) days after the end of each state fiscal year in the contract period.

h. The Network Provider shall ensure that the year-to-date number of units of service reported on a request for payment or any associated worksheet shall reconcile with the total number of units reported and accepted in KIS, PBPS, FASAMS, or other data system designated by the ME.

i. Pursuant to 65E-14.021(7)(a)2., F.A.C., the Network Provider shall not invoice for any Covered Services paid for under any other contract or from any other source. The Network Provider must subtract all units which are billable to Medicaid, and all units for SAMH client services paid from other sources, including Social Security, Medicare payments, Food Stamps, and funds eligible for local matching which include patient fees from first, second, and third-party payers, from each monthly request for payment. Should an overpayment be detected upon reconciliation of payments, the Network Provider must immediately refund any overpayment to the ME, including but not limited to services provided to a Medicaid-eligible individual prior to becoming a Medicaid recipient when those services are subsequently covered under a retroactive Medicaid reimbursement determination. For services provided based on bed-day availability, the Network Provider must report any payments received from all other sources on the "Schedule of Bed-Day Availability" at the end of the fiscal year and refund any overpayment.

j. Invoices shall be submitted in detail sufficient for a proper pre-audit and post-audit.

14. SUPPORTING DOCUMENTAITON

a. The Network Provider agrees to maintain and submit to the ME, if applicable, service documentation for each service billed to the ME pursuant to this contract. The Network Provider shall track all units billed to the ME by program and by Other Cost Accumulator (OCA). Proper service documentation for each SAMH covered service is outlined in Rule 65E-14.021, F.A.C., **Exhibit Y, Temporary Assistance for Needy Families (TANF) Funding Guidance,** if applicable.

b. The Network Provider shall maintain documentation to support all units billed to the ME and units subtracted for SAMH client services on each monthly request for payment.

c. Upon request, the network provider must submit to the ME and the Department information regarding the amount and number of services paid for by the Substance Abuse Prevention and Treatment Block Grant.

d. The Network Provider shall ensure that all services provided are entered into KIS, PBPS, FASAMS, or other data system designated by the ME.

e. The ME, Department and the State's Chief Financial Officer, reserve the right to request supporting documentation at any time after actual units have been delivered.

15. The Network Provider shall comply with the policies set forth in the Department of Financial Services Reference Guide for State Expenditures for guidance regarding the requirements applicable to the disbursement of funds from the State Treasury, regardless of payment methods. The Reference Guide for State Expenditures can be obtained at the following website:

https://www.myfloridacfo.com/Division/AA/Manuals/default.htm

The Network Provider shall also comply with active Comptroller/Chief Financial Officer Memoranda issued by the Division of Accounting and Auditing. The Division of Accounting and Auditing Memoranda website is found in the link below:

https://www.myfloridacfo.com/Division/AA/Memos/default.htm

16. FUNDING SWEEPS

The Network Provider agrees that at the sole discretion of the ME and at such time and upon terms, conditions or criteria set by the ME, a review of the funding utilization rate or pattern of the Network Provider may be conducted by the ME. Based upon such review, if it is determined that the rate of utilization may result in a lapse of funds, then in that event the ME may amend the Network Provider's total amount of funding by reducing same to prevent the potential lapse. Additionally, the Network Provider's funding may be reduced and reallocated within the system of care, as determined by the ME and its sole discretion, to meet the changing needs of the system of care. The ME will notify the Network Provider in writing of the reduction prior to amending the total amount of funding. The ME's Lapse Policy is incorporated herein by reference.

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Required Reports	Due Date	# of Copies	Send to:
Response to Monitoring Reports and Corrective Action Plans	Within 10 business days from the day the report is received	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** SFBHN staff member issuing CAP
External Quality Assurance Reviews, Monitoring Reports, Surveys and Corrective Actions, as applicable	As requested by the Contract Manager or other SFBHN staff	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager
Memorandum of Understanding (MOU) with a Federally Qualified Health Center (FQHC) **or** Federally Qualified Health Centers are required to submit policies and procedures that explain the access to primary care services to the medically underserved behavioral health client	Within 90 calendar days of the effective date of the contract between the ME and the Network Provider (for newly executed MOU's); Within 30 calendar days for renewed MOU's; Updates to P&P for FQHC's shall be submitted within 30 calendar days of adoption	1 (Electronic Submission via E-mail)	ME Contract Manager
Sliding Fee Scale [reflecting the uniform schedule of discounts referenced in 65E-14.018(4)]	Prior to contract execution	1 (Electronic Submission via E-mail)	ME Contract Manager
Final FY 2021-2022 (1) Projected Cost Center Operating and Capital Budget, (2) Budget Narrative, (3) Network Providers Agency Service Capacity Report, (4) Cost Center Personnel Detail Report	Submitted annually prior to contract execution. Submit updates within 30 calendar days of execution of an amendment to the contract affecting the budget.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Program Description (1) Organizational Profile (2) Service Activity Description (3) Supplemental Program Description(s)	Annually, prior to contract execution. Submit updates within 30 calendar days of amendment	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Behavioral Health
Affidavit Regarding Debarment	Annually prior to contract execution, or as requested by the Contract Manager	1	ME Contract Manager
Incident Report	**(1)** Events that have immediate impacts on the health or safety of an individual served, has potential media impact, or involves employee-related incidents of criminal activity, the Network Provider must notify the ME Continuous Quality Improvement Manager and the ME Contract Manager immediately upon discovery. **(2)** Within 24 hours of occurrence, in accordance with CFOP 215-6 and reportable incidents defined CFOP 180-4 Mandatory Reporting Requirements to the Office of the Inspector General	ME Continuous Quality Improvement Manager and the ME Contract Manager Submission through IRAS	ME Continuous Quality Improvement Manager *and* the ME Contract Manager Submission through IRAS
Acute Care Service Utilization Reporting for Public Receiving Facilities, Detoxification and Addiction Receiving Facilities.	Real-time data submission as mandated by subsection 394.9082(10), Florida Statutes	Electronically	KIS Express Acute Care System

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Monthly Data Required by DCF FASAMS PAM 155-2	Service data shall be submitted electronically, weekly, by 12:00 Noon every Wednesday. Final monthly shall be submitted electronically to the ME no later than the 4th of each month following the month of service	Electronically	KIS, PBPS, or other data system designated by the ME or the Department
ADA Client Communication Assessment Auxiliary Aid Service Record Monthly Summary Report (Applicable to agency's that employ fifteen (15) or more employees)	By the 4th business day following the reporting month	1 (Electronic Submission via E-mail)	https://fs16.formsite.com/DCFTraining/Monthly-Summary-Report/form_login.html Confirmation E-mail to the ME Contract Manager
Monthly Service Invoice	Monthly, by the eighth (8th) calendar day after the month of service	1	ME Sr. Accountant (Fiscal Department)
Invoice Review Supporting Documentation	Submitted with the monthly invoice, as appropriate, and/or as requested by SFBHN staff	1	As requested by ME staff
Exhibit K, Resource Management Roster for Substance Abuse and Mental Health Residential Level II Services	Monthly, with the monthly invoice by the eighth (8th) calendar day after the month of service	1	**1.** ME Sr. Accountant (Fiscal Department) **2.** ME ASOC Manager **3.** ME CSOC Manager 4. ME Contract Manager
Exhibit AC, Monthly Care Coordination Report Narrative and Chart	Monthly by the 5th calendar day after the month of service	1	1. ME Care Coordinator 2. ME Contract Manager
Final Invoice	By July 20 of each fiscal year and/or 20 days after contract end date	1	ME Sr. Accountant (Fiscal Department)

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Designation of Dispute Resolution Officer	Within 5 working days of contract execution	1 (Electronic Submission via E-mail)	ME Contact Manager
Court Ordered Involuntary Commitment, Placements, Services, Treatment	If the court ordered service is not available, submit copy of court order within one (1) working day of receiving from the court if the service is not available	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Manager 2. ME Contract Manager
Affidavit of Employment Eligibility in accordance with 448.095, FS	08/03/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Inventory Report	8/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Attestation of Network Provider's Verification that all applicable employees and subcontractors with access to ME and/or DCF information systems have signed a DCF	8/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Civil Rights Compliance Checklist (CF0946)	8/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Civil Rights Certificate (CF707)	8/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Client Trust Fund Letter	8/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Quality Assurance/Quality Improvement Plan	8/3/2022	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Continuous Quality Improvement Manager

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Action Plans for the: 1. Self-Assessment/Planning Tool for Implementing Recovery Oriented Services (SAPT) 2. Recovery Self-Assessment -R (RSA)	**August 3, 2022**	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** CQI Specialist Peer Services Manager
Signed Florida Department of Children and Families Employment Screening Affidavit that all required staff have been screened or Network Provider is awaiting the results of screening	8/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
Peer/ROSC Champions, per Exhibit AO.	8/3/2022	1 (Electronic Submission via E-mail)	1. ME contract manager 2. Peer Services Manager
Attestation signed by the CEO/Executive Director indicating that all applicable staff funded by this Contract have received a copy of the fully executed Contract and will receive a copy of any amendments made to this Contract.	10/3/2022	1 (Electronic Submission via E-mail)	ME Contract Manager
NVRA Voter Registration Agencies Quarterly Activities Report Form (DS-DE131; effective 01/2012 or latest revision thereof, if applicable	**July 6, 2022** (Period: 04/01/22 - 06/30/22) **October 5, 2022** (Period: 07/01/22 - 09/30/22) **January 5, 2023** (Period: 10/01/22 - 12/31/22) **April 5, 2023** (Period: 01/01/23 - 03/31/23) **July 5, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	**1.** ME Voter Registration Activities Coordinator **2.** ME Contract Manager

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Quarterly Financial Statements (Balance Sheet and Statement of Activity)	**October 31, 2022** (Period: 07/01/22 - 09/30/22) **January 31, 2023** (Period: 10/01/22 - 12/31/22) **April 28, 2023** (Period: 01/01/23 - 03/31/23) **July 31, 2023** (Period: 04/01/23 - 06/30/23)	1 (Electronic Submission via E-mail)	**1.** ME VP of Finance **2.** ME Contract Manager
Attestation indicating the filing of Form 941 and payment of any taxes due to the IRS have been paid.	**October 31, 2022** (Period: 07/01/22 - 09/30/22) **January 31, 2023** (Period: 10/01/22 - 12/31/22) **April 28, 2023** (Period: 01/01/23 - 03/31/23) **July 31, 2023** (Period: 04/01	1 (Electronic Submission via E-mail)	ME Contract Manager
Continuous Quality Improvement Updates	**January 31, 2023** (Period: 07/01/22 - 12/31/23) **July 31, 2023** (Period: 01/01/23 - 06/30/23)	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Continuous Quality Improvement Manager
Year-End Financial Reports for Network Provider's Not Requiring Audits Per Attachment II			
Certification indicating that recipient expended less than $750,000 in Federal Awards or in State Awards during the fiscal year	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Schedule of State Earnings	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance

Exhibit C
Required Reports
For Fiscal Year 2022-2023

	recorded during the state's fiscal year.		
Projected Cost Center Operating and Capital Budget Actual Expenses & Revenues Schedule	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Local Match Calculation Form - Template 9 - Department of Children and Families form, available at the following website: https://www.myflfamilies.com/service-programs/samh/managing-entities/2020-contract-docs.shtml	Due 180 days after the end of the Network Provider's fiscal year or within 30 days(federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Schedule of Bed-Day Availability Payments	Due 180 days after the end of the Network Provider's fiscal year or within 30 days(federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Agency Prepared Financial Statements (Balance Sheet and Statement of Activity	Due 180 days after the end of the Network Provider's fiscal year or within 30 days(federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Year-End Financial Reports for Network Provider's Requiring Audits Per Attachment II			
Correspondence from the Auditor showing proof of submission of the Audit Report and Management Letter to the Network Provider.	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Management letter addressed to the Network Provider issued by the Auditor	Due 180 days after the end of the Network Provider's fiscal year or within 30 days(federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance

Exhibit C
Required Reports
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Financial & Compliance Audit to include the necessary schedules per Attachment II	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Schedule of State Earnings	Due 180 days after the end of the Network Provider's fiscal year or within 30 days(federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Schedule of Related Party Transaction Adjustments	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Local Match Calculation Form - Template 9 - Department of Children and Families form, available at the	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first,	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance

Exhibit C
Required Reports
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following website: Managing Entities - Florida Department of Children and Families (myflfamilies.com)	directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.		
Projected Cost Center Operating and Capital Budget Actual Expenses & Revenues Schedule	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Schedule of Bed-Day Availability Payments	Due 180 days after the end of the Network Provider's fiscal year or within 30 days (federal) or 45 (state) of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes The schedule shall be based on revenues and expenditures recorded during the state's fiscal year.	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** VP of Finance
Reports Required for Children's Mental Health Providers, as applicable			
Children's Crisis Response Team (CCRT)	Per Exhibit S - Monthly Census Report by the 15th of every month following the month of service	One (1) Encrypted Electronic Submission attachment to an email to each recipient	**1.** ME Contract Manager **2.** Children's System of Care Manager
Reports Required for Behavioral Health Network (BNet) Provider			

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Alternative Services Provision Documentation (Other than Pharmaceuticals)	Within 15 calendar days after end of month	One (1) Encrypted Electronic Submission attachment to an email to each recipient	**1.** ME Contract Manager **2.** ME BNet Coordinator **3.** Children's Mental Health State Program Office
Alternative Services Provision Documentation (Pharmaceuticals only)	Within 15 calendar days after end of month	One (1) Encrypted Electronic Submission attachment to an email to each recipient	**1.** ME Contract Manager **2.** ME BNet Coordinator **3.** Children's Mental Health State Program Office
Statement of Program Cost	September 1st following close of the contract year (June 30)	One (1) Encrypted Electronic Submission attachment to an email to each recipient	**1.** ME Contract Manager **2.** ME BNet Coordinator **3.** Children's Mental Health State Program Office
Reports Required for Project for Assistance in Transition from Homelessness (PATH) Providers			
PATH Monthly Report (generated from the HMIS system)	Monthly, by the 5th calendar day after the month of service	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME Housing Coordinator
PATH Monthly Client Tracker	Monthly by the 10th calendar day after the month of service	1 (Electronic Submission via E-mail-Encrypted and Password Protected)	1. ME Contract Manager 2. ME Housing Coordinator
PATH Annual Data Report into the PATH Data Exchange (PDX) data system	No later than November 17th	1 (Electronic Submission via E-mail)	https://www.pathpdx.org/
Reports Required for Adult Mental Health Providers, as applicable			
Assisted Living Facility with a Limited Mental Health License Client Quarterly Report, per Exhibit L	**Provider to Maintain the Report on file and submit upon Request by ME staff** **October 5, 2022** (Period: 07/01/22 - 09/30/22) **January 5, 2023** (Period: 10/01/22 - 12/31/22) **April 5, 2023** (Period: 01/01/23 - 03/31/23) **July 5, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail) Encrypted and Password Protected	Requestor
Report Required for Florida Assertive Community Treatment (FACT) Providers			

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Contact Information for the: 1. Psychiatrist or Psychiatric APRN 2. Administrative Supervisor	Within thirty (30) calendar days of contract execution.	1 (Electronic Submission via E-mail)	1. ME Contract Manager
Vacant Position(s) Report	Monthly by the 15th of each month following the month of service	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Adult System of Care Specialist
FACT Report (Template 29) Link to Template 29: Guidance 29 Transitional Vouchers.pdf (myflfamilies.com)	**October 14, 2022** (Period: 07/01/22 - 09/30/22) **January 13, 2023** (Period: 10/01/22 - 12/31/22) **April 14, 2023** (Period: 01/01/23 - 03/31/23) **July 14, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Adult System of Care Specialist
FACT Monthly Progress Report	Monthly by the 15th of each month following the month of service	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Adult System of Care Specialist
Outcomes Measures	**October 14, 2022** (Period: 07/01/22 - 09/30/22) **January 13, 2023** (Period: 10/01/22 - 12/31/22) **April 14, 2023** (Period: 01/01/23 - 03/31/23) **July 14, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Adult System of Care Specialist
Report Required for Miami-Dade Forensic Alternative (MDFAC) Providers			
Daily Census Report	Daily, by 10:00 am, Monday - Friday	1 (Electronic Submission via E-mail)	1. Regional Forensic Coordinator 2. ME Contract Manager
Monthly Program Quality Review Tracking Report	By the 15th of each month following the month of services	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Director of the Adult System of Care

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Monthly Performance Measures Report	By the 15th of each month following the month of services	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** ME Adult System of Care Specialist
Reports Required for Forensic Services Providers			
Monthly Report for Individuals on Conditional Release, if applicable	By 10th of each month	1	**1.** Mental Health Administrator Office **2.** ME Contract Manager
Reports Required for Forensic Multidisciplinary Team Provider			
Monthly Forensic Multidisciplinary Team Report – DCF Template 25: https://www.myflfamilies.com/service-programs/samh/managing-entities/2021-contract-docs.shtml	By 10th of each month for the preceding months' services	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Monthly Vacant Position(s) Reports	By 10th of each month for the preceding months' services	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Monthly Court Reports	By 10th of each month for the preceding months' services	1 (Electronic Submission via E-mail)	1. Court 2. Forensic Team at Community Health of South Florida, Inc. 3. ME Adult System of Care Specialist 4. ME Contract Manager
Reports Required for Consumer-Driven Agencies			
Enrollment/Membership Report	**October 5, 2022** (Period: 07/01/22 - 09/30/22) **January 5, 2023** (Period: 10/01/22 - 12/31/22) **April 5, 2023** (Period: 01/01/23 - 03/31/23) **July 5, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	ME Contract Manager

Exhibit C
Required Reports
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Reports Required for Substance Abuse Services Providers			
Report for HIV Early Intervention Services, SAPT Block Grant Set Aside Funded Services Only	**January 6, 2023** (Period: 07/01/22 - 12/31/22) **July 5, 2023** (Period: 01/01/23 - 06-30-23)	1 (Electronic Submission via E-mail)	ME Contract Manager
Annual Report for Evidenced-based Injection Drug User Outreach Services, SAPT Block Grant Mandate, Designated Providers Only	Upon Request	1 (Electronic Submission via E-mail)	ME Contract Manager
Annual Report for Pregnant Women and Women with Dependent Children SAPT Block Grant Set Aside Funded Services Only	Upon Request	1 (Electronic Submission via E-mail)	ME Contract Manager
Monthly Outcomes for Women's Expansion Grant – Special Appropriation	Due monthly, by the 4th of every month following the month of service	1 (Electronic Submission via E-mail)	**1.** ME IT Office **2.** ME Contract Manager
Reports Required for State Opioid Response Discretionary Grant Providers			
Monthly SOR Data Collection Report **Exhibit BD**	Due monthly, by the 15th of every month following the month of service	1 (Electronic Submission via E-mail) Encrypted and Password Protected	ME Contract Manager
Reports Required for Substance Abuse Prevention Services Providers			

Exhibit C
Required Reports
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Monthly Data Required by DCF FASAMS PAM 155-2 and/or PBPS	Prevention service data shall be submitted electronically to PBPS no later than the 4th of each month following the month of service.	Electronically	PBPS, or other data system designated by the ME or the Department
Monthly Data to the ME's contracted evaluation entity - BSRI	Monthly, by the 4th calendar day after the month of service	Electronically	In the BSRI database system or any other format requested by BSRI
Monthly Service Invoice	Monthly, by the eighth (8th) calendar day after the month of service	1	ME Sr. Accountant (Fiscal Department)
Invoice Review Supporting Documentation - from PBPS in a jpeg format	Submitted with the monthly invoice	1	ME Sr. Accountant (Fiscal Department)
Monthly E-Mail Notification to the ME Prevention Services Director and ME Data Analyst verify that the data in the PBPS system has been checked and is correct and complete and may be used for Block Grant reporting and payment. *Refer to Scope of Work Attachment to the Contract for specifics*	Monthly, by the 4th calendar day after the month of service	1 (Electronic Submission via E-mail)	1. ME Director or Prevention Services 2. ME Data Analyst
Final Annual Site Schedule	8/31/2022	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME Director of Prevention Services
Memorandum of Understanding (MOU) with a Community Coalition	Within 30 calendar days of the effective date of the contract (for newly executed MOU's) **OR** Within 30 calendar days for renewed MOU's	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME Director or Prevention Services
Reports Required for Prevention Partnership Grant Providers			

Exhibit C
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Monthly E-Mail Notification to the ME Prevention Services Director and ME Data Analyst verify that the data in the PBPS system has been checked and is correct and complete and may be used for Block Grant reporting and payment. *Refer to Scope of Work Attachment to the Contract for specifics*	Monthly, by the 4th calendar day after the month of service	1 (Electronic Submission via E-mail)	1. ME Director or Prevention Services 2. ME Data Analyst
Prevention Services Quarterly Reports (Fidelity to Evidence-Based Practices) – Program Status Report as Required by RFA #11L2GN1.	As Required by the Evaluation Entity (BSRI)	1 (Electronic Submission via E-mail)	In the BSRI database system or any other format requested by BSRI
Memorandum of Understanding (MOU) with a Community Coalition	Within 30 calendar days of the effective date of the contract (for newly executed MOU's) **OR** Within 30 calendar days for renewed MOU's	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME Director or Prevention Services
Final Annual Site Schedule	**8/31/2022**	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME Director of Prevention Services
Reports Required for Evaluation Entity for Prevention Services			
Monthly Service Report (Deliverables per Attachment IV, Scope of Work)	Monthly by 20th calendar day after the month of service	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME Director of Prevention Services

Exhibit C
Required Reports
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Quarterly Expenditure Report	**October 31, 2022** (Period: 07/01/22 - 09/30/22) **January 31, 2023** (Period: 10/01/22 - 12/31/22) **April 28, 2023** (Period: 01/01/23 - 03/31/23) **July 31, 2023** (Period: 04/01/23 - 06/30/23)	1 (Electronic Submission via E-mail)	1. ME Contract Manager, 2. ME VP of Finance, and 3. ME Director of Prevention Services

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Reports Required for Providers Receiving Specific Appropriations			
Quarterly Updates on Return on Investment Report - Per Exhibit AM	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023** (Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager
Reports Required for the Navigate Program Provider			
Quarterly Services Report	**October 31, 2022** (Period: 07/01/22 - 09/30/22) **January 31, 2023** (Period: 10/01/22 - 12/31/22) **April 28, 2023** (Period: 01/01/23 - 03/31/23) **July 31, 2023** (Period: 04/01/23 - 06/30/23)	1 (Electronic Submission via E-mail)	ME Contract Manager
Navigate Program Quarterly Expenditure Report	**October 31, 2022** (Period: 07/01/22 - 09/30/22) **January 31, 2023** (Period: 10/01/22 - 12/31/22) **April 28, 2023** (Period: 01/01/23 - 03/31/23) **July 31, 2023** (Period: 04/01/23 - 06/30/23)	1 (Electronic Submission via E-mail)	ME Contract Manager
Reports Required for the 2-1-1 Helpline			
Monthly Outreach Log	Due monthly, by the 30th of every month following the month of service	1 (Electronic Submission via E-mail)	**1.** ME Contract Manager **2.** Children's System of Care Manager **3.** VP of Contracts & Procurement
Exhibit P-1, 2-1-1-Monthly Call Volume Report .	Due monthly, by the 30th of every month following the month of service	1 (Electronic Submission via E-mail)	ME Contract Manager

Exhibit C
Required Reports
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Follow-Up on Referrals Pilot Project Report	Due monthly, by the 30th of every month following the month of service	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. Children's System of Care Manager 3. VP of Contracts & Procurement
Updated Resource Manual/Directory	October 31, 2022	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. Children's System of Care Manager 3. VP of Contracts & Procurement
Reports Required for the Forensic Mental Health Services Program			
Appendix A, Conditional Release Report	By the 10th of every month following the reporting month	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Weekly Statewide Census Report	Weekly by 12:00 Noon every Thursday	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Appendix B, Monthly Diversion Report	By the 10th of every month following the reporting month	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Quarterly SMHFT Visit Report	Due within thirty (30) calendar days of date of the visit	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Staffing Report	Weekly by 10:00 A.M. for the previous work week	1 (Electronic Submission via E-mail)	1. ME Adult System of Care Specialist 2. ME Contract Manager
Reports Required for the Community Action Treatment Team (CAT Team) Program			
Weekly Census Report	Weekly by 12:00 noon, every Monday	1 (Electronic Submission via E-mail) Encrypted and Password Protected	1. ME's Children's System of Care Manager 2. ME's Contract Manager

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Monthly Data Required by DCF FASAMS PAM 155-2	Monthly shall be submitted electronically to the ME no later than the 4th of each month following the month of service	Electronically	KIS, FASAMS, or other data system designated by the ME or the Department
Appendix 1 - Persons Served and Performance Measure Report	By the 8th calendar day of the month after the month of service	1 (Electronic Submission via E-Mail)	1. ME's Children's System of Care Manager 2. ME's Contract Manager
Appendix 2 - Quarterly Supplemental Data Report	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023** (Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	1. ME's Children System of Care Manager 2. ME's Contract Manager
Appendix 3- CAT Team Monthly Invoice	Monthly, by the eighth (8th) calendar day after the month of service	1	1. ME Sr. Accountant (Fiscal Department) 2. ME's Children's System of Care Manager
Invoice Review Supporting Documentation (incidental expenses)	Submitted with the monthly invoice, as appropriate, and/or as requested by SFBHN staff	1	1. ME Sr. Accountant (Fiscal Department) 2. ME's Children's System of Care Manager
Reports Required for the Mobile Response Teams			
Mobile Response Team Report	Monthly by the 10th following the month of service	1 (Electronic Submission via E-mail) - Encrypted, password protected	1. ME Contract Manager 2. ME VP of Behavioral Health Services 3. ME Data Analysts
MRT Policies and Procedures	**October 1, 2022**	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME VP of Behavioral Health Services 3. ME Data Analysts
Memorandum of Understanding/ Agreement with the Local School District	**October 1, 2022,or any addendums**	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME VP of Behavioral Health Services 3. ME Data Analysts

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Outreach Activities Log	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023** (Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)	1 (Electronic Submission via E-mail)	1. ME Contract Manager 2. ME VP of Behavioral Health Services
Reports Required for Family Intensive Treatment Team (FIT) Service Providers			
Weekly - Child Welfare Program Active Cases Weekly Report (Appendix 1 of Exhibit AI)	Each Monday by close of business following the week of services (a week is defined as Tuesday - Monday)	1 (Electronic Submission via E-mail)	ME's Child Welfare Integration Coordinator
Access Database Report	By the 13th day of the month following the month of services	1 (Electronic Submission via E-mail)	1. Contract Manager 2. Child Welfare Integration Coordinator
Reports Required for Child Welfare Specialty Program Provider			
Weekly - Child Welfare Program Active Cases Weekly Report (Appendix 1 of Exhibit J)	Each Monday by close of business following the week of services (a week is defined as Tuesday - Monday)	1 (Electronic Submission via E-mail)	1. ME's Child Welfare Integration Coordinator 2. ME Contract Manager
Monthly - Child Welfare Monthly Tracker	By the 18th day of the month following the month of services	1 (Electronic Submission via E-mail)	1. ME's Child Welfare Integration Coordinator 2. ME Contract Manager
Monthly – Child Welfare Specialty Program Outreach Log	By the 8th day of the month following the month of services	1 (Electronic Submission via E-mail)	1. ME's Child Welfare Integration Coordinator 2. ME Contract Manager
Reports Required for Child Welfare Integration & Support Teams (CWIST)			
Monthly Family Navigator Tracker	Monthly by the 5th for the preceding month's services.	1 (Electronic Submission via E-mail)	1. ME Child Welfare Integration Coordinator 2. ME Contract Manager

Exhibit C
Required Reports
For Fiscal Year 2022-2023

Monthly Behavioral Consultant Activity Log	Monthly by the 5th for the preceding month's services.	1 (Electronic Submission via E-mail)	1. ME Child Welfare Integration Coordinator 2. ME Contract Manager
Reports Required for Network Providers Providing SA Treatment Services to Pregnant Women, Mother's and their Affected Families (OCA's: MS027 and MS081)			
Women's Special Appropriation Data Reporting - Per Exhibit AE	By the 8th day of the month following the month of services	One (1) Password, protected and encrypted Electronic Submission	1. Data Analysts 2. ME Contract Manager
Supported Employment Report – Special Proviso Funded Clubhouses			
Supported Employment Template 30, Proviso Project Return on Investment And Template 31, Clubhouse Supported Employment Report	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023** (Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)	One (1) Password, protected and encrypted Electronic Submission	1. ME Peer Services Manager 2. ME Contract Manager
Reports Required for Network Providers screening for Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)			
Certificate of online SOAR course completion	Within ten (10) business days of completion	1 (Electronic Submission via E-mail)	1. SOAR Local Lead 2. ME Contract Manager
Records review per Exhibit AN,	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023** (Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)	One (1) Password, protected and encrypted Electronic Submission	1. SOAR Local Lead 2. ME Contract Manager
Crisis Stabilization Units – Recidivism Rates Data Collection			
CSU Recidivism Rate Data Collection (Attachment I, Section D. Special Provisions)	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023**	1 (Electronic Submission via E-mail)	1. VP of IT and Data Analytics 2. ME Contract Manager

Exhibit C
Required Reports
For Fiscal Year 2022-2023

	(Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)		
Peer Support Services			
Peer Support Employment Report (Monthly, per Exhibit AO)	By the 10th day of the month following the month of services	One (1) Password, protected and encrypted Electronic Submission	1. ME Peer Services Manager 2. ME Contract Manager
Peer Support Services Report (Monthly, , per Exhibit AO)	By the 10th day of the month following the month of services	One (1) Password, protected and encrypted Electronic Submission	1. ME Peer Services Manager 2. ME Contract Manager
Prison Aftercare Services			
Outpatient Report (Monthly)	By the 15th day of the month following the month of services	One (1) Password, protected and encrypted Electronic Submission	1. Adult System of Care Department 2. ME Contract Manager
Department of Corrections Referrals for Baker Act Services (Quarterly)	**October 12, 2022** (Period: 07/01/22 - 09/30/22) **January 10, 2023** (Period: 10/01/22 - 12/31/22) **April 11, 2023** (Period: 01/01/23 - 03/31/23) **July 11, 2023** (Period: 04/01/23- 06/30/23)	One (1) Password, protected and encrypted Electronic Submission	1. Adult System of Care Department 2. ME Contract Manager

Note: When a regular due date for a required report falls on a weekend or a legal holiday, the due date is extended to the next business day immediately following the weekend or holiday.

EXHIBIT D

Substance Abuse & Mental Health Required Performance Outcomes & Outputs

Network Provider Name:	Miami-Dade County through its Community Action & Human Services Department
Contract #:	ME225-12-28
Date:	7/1/2022
Amendment #:	2

The Network Provider is directed to the Department's Guidance Document 24, Performance Measurement Manual for program guidance on the measures in Tables 1 & 2 below. To access the Department's FY 22-23 Guidance Document 24, click on the link below: https://www.myflfamilies.com/service-programs/samh/managing-entities/index.shtml. *Note: Click on FY22-23 ME Templates and click on Guidance Document 24 – Performance Measurement Manual*

Table 1 -Network Provider Measures				
Target Population and Measure Description	**Annual Target**	**Minimum Acceptable Performance**	**Performance This Period**	**Year to Date Performance**
Adults Community Mental Health				
a. MH003- Average annual days worked for pay for adults with severe and persistent mental illness	40	38		
b. MH703- Percent of adults with serious mental illness who are competitively employed	24%	22.8%		
c. MH742 - Percent of adults with severe and persistent mental illnesses who live in stable housing environment	90%	85.5%		
d. MH743 - Percent of adults in forensic involvement who live in stable housing environment	67%	63.7%		
e. MH744 - Percent of adults in mental health crisis who live in stable housing environment	86%	81.7%		
Adult Substance Abuse				
a. SAA73 - Percentage change in clients who are employed from admission to discharge	10%	9.5%		
b. SA754 - Percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge	15%	14.3%		
c. SA755 - Percent of adults who successfully complete substance abuse treatment services	51%	48.5%		
d. SA756 - Percent of adults with substance abuse who live in a stable housing environment at the time of discharge	94%	89.3%		
Children's Mental Health				
a. MH012 - Percent of school days seriously emotionally disturbed (SED) children attended	86%	81.7%		
b. MH377 - Percent of children with emotional disturbances (ED) who improve their level of functioning	64%	60.8%		
c. MH378 - Percent of children with serious emotional disturbances (SED) who improve their level of functioning	65%	61.8%		
d. MH778 - Percent of children with emotional disturbance (ED) who live in a stable housing environment	95%	90.3%		
e. MH779 - Percent of children with serious emotional disturbance (SED) who live in a stable housing environment	93%	88.4%		
f. MH780 - Percent of children at risk of emotional disturbance (ED) who live in a stable housing environment	96%	91.2%		
Children's Substance Abuse				
a. SA725 - Percent of children who successfully complete substance abuse treatment services	48%	45.6%		

b. SA751 - Percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge	20%	19.0%		
c. SA752 - Percent of children with substance abuse who live in a stable housing environment at the time of discharge	93%	88.4%		

Table 1 – Network Service Provider Performance Measures	Annual Target	Minimum Acceptable Performance	Performance This Period	Year to Date Performance

Network Provider Compliance: Network Providers shall achieve a minimum of 95% of the annual target levels in Table 1. The measures shall be demonstrated on an annual basis but will be monitored by the ME monthly.

For each measure where the Year-to-Date performance falls below the Minimum Acceptable Performance, the Network Provider will submit a brief narrative, at the request of the ME, describing each of the following elements:

1. Any specific challenges, obstacles, or other operational considerations which are identified as significant factors underlying the unsatisfactory level of performance.
2. Any extenuating circumstances beyond the Network Provider's scope which are identified as significant factors underlying the unsatisfactory level of performance.
3. Efforts the Network Provider has undertaken to support improved performance during this reporting period.
4. Efforts the Network Provider will undertake in the future to support improved performance during subsequent reporting periods.
5. Any region-wide guidance, capacity, training, or other logistical supports needed to support improved performance during subsequent reporting periods.

Inserted 6/30/22

	Table 2 Network Service Provider Output Measures – Persons Served For Fiscal Year FY22-23	
	Service Category	**FY Target**
Adult Mental Health	**Residential Care**	N/A
	Outpatient Care	N/A
	Crisis Care	N/A
	State Hospital Discharges	N/A
	Peer Support Services	N/A
Children's Mental Health	**Residential Care**	N/A
	Outpatient Care	N/A
	Crisis Care	N/A
Adult Substance Abuse	**Residential Care**	378
	Outpatient Care	1200
	Detoxification	0
	Women's Specific Services	155
	Injecting Drug Users	80
	Peer Support Services	0
Children's Substance Abuse	**Residential Care**	N/A
	Outpatient Care	N/A
	Detoxification	N/A
	Prevention	N/A

Network Provider Compliance: Failure to meet the applicable standards established in Tables 1 and 2 shall be considered nonperformance pursuant to **Standard Contract, Section 8. Financial Consequences for Network Provider's Failure to Perform**.

Inserted 6/30/22

REVISED EXHIBIT F
SAMH PROGRAMMATIC STATE AND FEDERAL LAWS, RULES, AND REGULATIONS

The Network Provider and its subcontractors shall comply with all applicable state and federal laws, rules and regulations, as amended from time to time, that affect the subject areas of the contract. Authorities include but are not limited to the following:

F2-1 Federal Authority

F2-1.1 Block Grants Regarding Mental Health and Substance Abuse

F2-1.1.1 Block Grants for Community Mental Health Services

42 U.S.C. ss. 300x, et seq.

F2-1.1.2 Block Grants for Prevention and Treatment of Substance Abuse

42 U.S.C. ss. 300x-21 et seq.

45 CFR Part 96, Subpart L

F2-1.2 Department of Health And Human Services, General Administration, Block Grants

45 CFR Part. 96

F2-1.3 Charitable Choice Regulations Applicable to Substance Abuse Block Grant and PATH Grant

42 CFR Part 54

F2-1.4 Confidentiality Of Substance Use Disorder Patient Records

42 CFR Part 2

F2-1.5 Security and Privacy

45 CFR Part 164

F2-1.6 Supplemental Security Income for the Aged, Blind and Disabled

20 CFR Part 416

F2-1.7 Temporary Assistance to Needy Families (TANF)

42 U.S.C. ss. 601 - 619

45 CFR, Part 260

F2-1.8 Projects for Assistance in Transition from Homelessness (PATH)

42 U.S.C. ss. 290cc-21 – 290cc-35

F2-1.9 Equal Opportunity for Individuals with Disabilities (Americans with Disabilities Act of 1990)

42 U.S.C. ss. 12101 - 12213

F2-1.10 Prevention of Trafficking (Trafficking Victims Protection Act of 2000)

22 U.S.C. s. 7104

2 CFR Part 175

F2-1.11 Governmentwide Requirements for Drug-Free Workplace (Financial Assistance)

2 CFR Part 182

2 CFR Part 382

F2-2 Florida Statutes

F2-2.1 Child Welfare and Community Based Care

Ch. 39, F.S.	Proceedings Relating to Children
Ch. 402, F.S.	Health and Human Services: Miscellaneous Provisions

F2-2.2 Substance Abuse and Mental Health Services

Ch. 381, F.S.	Public Health: General Provisions
Ch. 386, F.S.	Particular Conditions Affecting Public Health
Ch. 394, F.S.	Mental Health
Ch. 395, F.S.	Hospital Licensing and Regulation
Ch. 397, F.S.	Substance Abuse Services
Ch. 400, F.S.	Nursing Home and Related Health Care Facilities
Ch. 414, F.S.	Family Self-Sufficiency
Ch. 458, F.S.	Medical Practice
Ch. 464, F.S.	Nursing
Ch. 465, F.S.	Pharmacy
Ch. 490, F.S.	Psychological Services
Ch. 491, F.S.	Clinical, Counseling, and Psychotherapy Services
Ch. 499, F.S.	Florida Drug and Cosmetic Act
Ch. 553, F.S.	Building Construction Standards
Ch. 893, F.S.	Drug Abuse Prevention and Control
S. 409.906(8), F.S.	Optional Medicaid Services – Community Mental Health Services

F2-2.3 Developmental Disabilities

Ch. 393, F.S.	Developmental Disabilities

F2-2.4 Adult Protective Services

Ch. 415, F.S.	Adult Protective Services

F2-2.5 Forensics

Ch. 916, F.S.	Mentally Ill And Intellectually Disabled Defendants
Ch. 985, F.S.	Juvenile Justice; Interstate Compact on Juveniles
S. 985.19, F.S.	Incompetency in Juvenile Delinquency Cases
S. 985.24, F.S.	Use of detention; prohibitions

F2-2.6 State Administrative Procedures and Services

Ch. 119, F.S.	Public Records
Ch. 120, F.S.	Administrative Procedures Act
Ch. 287, F.S.	Procurement of Personal Property and Services

Ch. 435, F.S.	Employment Screening
Ch. 815, F.S.	Computer-Related Crimes
Ch. 817, F.S.	Fraudulent Practices
S. 112.061, F.S.	Per diem and travel expenses of public officers, employees, and authorized persons; statewide travel management system
S. 112.3185, F.S.	Additional standards for state agency employees
S. 215.422, F.S.	Payments, warrants, and invoices; processing time limits; dispute resolution; agency or judicial branch compliance
S. 216.181(16)(b), F.S.	Advanced funds for program startup or contracted services

F2-3 Florida Administrative Code

F2-3.1 Child Welfare and Community Based Care

Ch. 65C-13, F.A.C.	Foster Care Licensing
Ch. 65C-14, F.A.C.	Child-Caring Agency Licensing
Ch. 65C-15, F.A.C.	Child-Placing Agencies

F2-3.2 Substance Abuse and Mental Health Services

Ch. 65D-30, F.A.C.	Substance Abuse Services Office
Ch. 65E-4, F.A.C.	Community Mental Health Regulation
Ch. 65E-5, F.A.C.	Mental Health Act Regulation
Ch. 65E-10, F.A.C.	Psychotic and Emotionally Disturbed Children - Purchase of Residential Services Rules
Ch. 65E-11, F.A.C.	Behavioral Health Services
Ch. 65E-12, F.A.C.	Public Mental Health Crisis Stabilization Units and Short Term Residential Treatment Programs
Ch. 65E-14, F.A.C.	Community Substance Abuse and Mental Health Services - Financial Rules
Ch. 65E-20, F.A.C.	Forensic Client Services Act Regulation
Ch. 65E-26, F.A.C.	Substance Abuse and Mental Health Priority Populations and Services

F2-3.3 Financial Penalties

Ch. 65-29, F.A.C.	Penalties on Service Providers

F2-4 MISCELLANEOUS

F2-4.1 Department of Children and Families Operating Procedures

CFOP 155-10 / 175-40	Services for Children with Mental Health and Any Other Co-Occurring Substance Abuse or Developmental Disability Treatment Needs in Out-of-Home Care Placements
CFOP 155-11	Title XXI Behavioral Health Network
CFOP 155-47	Processing Referrals From The Department Of Corrections
CFOP 215-6	Incident Reporting and Analysis System (IRAS)

F2-4.2 Standards applicable to Cost Principles, Audits, Financial Assistance and Administrative Requirements

S. 215.425, F.S.	Extra Compensation Claims prohibited; bonuses; severance pay
S. 215.97, F.S.	Florida Single Audit Act
S. 215.971, F.S.	Agreements funded with federal or state assistance
Ch. 65I-42, F.A.C.	Travel Expenses
Ch. 69I-5, F.A.C	State Financial Assistance
CFO's Memorandum No. 01	Contract and Grant Reviews and Related Payment Processing Requirements
CFO's Memorandum No. 02	Reference Guide for State Expenditures
Comptroller's Memorandum No. 04	Guidance on all Contractual Service Agreements Pursuant to Section 215.971, Florida Statutes
CFO's Memorandum No. 20	Compliance Requirements for Agreements
2 CFR, Part 180	Office of Management and Budget Guidelines to Agencies on Government Wide Debarment and Suspension (Non-procurement),
2 CFR, Part 200	Office of Management and Budget Guidance - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200
2 CFR, Part 300	Department of Health and Human Services - Office of Management and Budget Guidance - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Adoption of 2 CFR Part 200
45 CFR, Part 75	Uniform Administration Requirements, Cost Principles, and Audit Requirements for HHS Awards

F2-4.3 Data Collection and Reporting Requirements

S. 394.74(3)(e), F.S.	Data Submission
S. 394.9082, F.S.	Behavioral health managing entities
S. 394.77, F.S.	Uniform management information, accounting, and reporting systems for providers
S. 397.321(3)(c), F.S.	Data collection and dissemination system
DCF PAM 155-2	Financial and Services Accountability Management System (FASAMS)

MDC-Community Action & Human Services Dept.
ME225-12-28

	COVERED SERVICES	FUNDING / RATE	AMH									
			MH001	MH009	MH018	MH026	MH072	MH076	MH094	MH0CF	MH0CN	TOTAL
			-	-	-	-	-	-	-	-	-	$ -
01	**Assessment**	**$ 103.42**										$ -
02	Case Management	$ -										$ -
03	Crisis Stabilization	$ -										$ -
04	Crisis Support/Emergency	$ -										$ -
06	**Day Treatment**	**$ 84.41**										$ -
07	Drop-In/Self Help Centers	$ -										$ -
08	In-Home/On-Site	$ -										$ -
11	**Intervention - Individual**	**$ 88.37**										$ -
42	**Intervention - Group**	**$ 22.09**										$ -
12	Medical Services	$ -										$ -
13	**Medication-Assisted Treatment**	**$ 6.30**										$ -
14	**Outpatient - Individual**	**$ 122.71**										$ -
35	**Outpatient - Group**	**$ 30.68**										$ -
15	Outreach	$ -										$ -
18	Residential Level I	$ -										$ -
	Residential Level I (new SIPP rate)	$ -										$ -
19	**Residential Level II**	**$ 109.00**										$ -
20	Residential Level III	$ -										$ -
21	**Residential Level IV**	**$ 60.90**										$ -
24	Substance Abuse Detox	$ -										$ -
25	Supported Employment	$ -										$ -
26	Supportive Housing	$ -										$ -
27	TASC	$ -										$ -
28	**Incidental Expenses**	**$ 1.00**										$ -
66												
	TOTAL FUNDING	**$ 2,642,116**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	TOTAL UNCOMPENSATED	$ 528,423										$ -

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MDC-Community Action & Human Services Dept.
ME225-12-28

	COVERED SERVICES	FUNDING / RATE	CMH									
			MH001	MH009	MH018	MH071	MH0BN	MH0CN	MH0CF	MH01S	MH09S	TOTAL
			-	-	-	-	-	-	-	-	-	$ -
01	**Assessment**	**$ 103.42**										$ -
02	Case Management	$ -										$ -
03	Crisis Stabilization	$ -										$ -
04	Crisis Support/Emergency	$ -										$ -
06	**Day Treatment**	**$ 84.41**										$ -
07	Drop-In/Self Help Centers	$ -										$ -
08	In-Home/On-Site	$ -										$ -
11	**Intervention - Individual**	**$ 88.37**										$ -
42	**Intervention - Group**	**$ 22.09**										$ -
12	Medical Services	$ -										$ -
13	**Medication-Assisted Treatment**	**$ 6.30**										$ -
14	**Outpatient - Individual**	**$ 122.71**										$ -
35	**Outpatient - Group**	**$ 30.68**										$ -
15	Outreach	$ -										$ -
18	Residential Level I	$ -										$ -
	Residential Level I (new SIPP rate)	$ -										$ -
19	**Residential Level II**	**$ 109.00**										$ -
20	Residential Level III	$ -										$ -
21	**Residential Level IV**	**$ 60.90**										$ -
24	Substance Abuse Detox	$ -										$ -
25	Supported Employment	$ -										$ -
26	Supportive Housing	$ -										$ -
27	TASC	$ -										$ -
28	**Incidental Expenses**	**$ 1.00**										$ -
66												
	TOTAL FUNDING	**$ 2,642,116**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	TOTAL UNCOMPENSATED	$ 528,423										$ -

MDC107

MDC-Community Action & Human Services Dept.
ME225-12-28

	COVERED SERVICES	FUNDING / RATE	ASA MS003	MS011	MS021	MS023	MS025	MS027	MSSM4	MSSM5	TOTAL
			1,420,517	598,957	-	-	-	322,642	75,000	225,000	$ 2,642,116
01	**Assessment**	**$ 103.42**									$ -
02	Case Management	$ -									$ -
03	Crisis Stabilization	$ -									$ -
04	Crisis Support/Emergency	$ -									$ -
06	**Day Treatment**	**$ 84.41**		383,932				11,000			$ 394,932
07	Drop-In/Self Help Centers	$ -									$ -
08	In-Home/On-Site	$ -									$ -
11	**Intervention - Individual**	**$ 88.37**		114,106				38,158			$ 152,264
42	**Intervention - Group**	**$ 22.09**									$ -
12	Medical Services	$ -									$ -
13	**Medication-Assisted Treatment**	**$ 6.30**							6,000	40,000	$ 46,000
14	**Outpatient - Individual**	**$ 122.71**		100,919				49,300	6,000	40,000	$ 196,219
35	**Outpatient - Group**	**$ 30.68**							1,500	5,000	$ 6,500
15	Outreach	$ -									$ -
18	Residential Level I	$ -									$ -
	Residential Level I (new SIPP rate)	$ -									$ -
19	**Residential Level II**	**$ 109.00**	1,236,036					219,678	61,500	140,000	$ 1,657,214
20	Residential Level III	$ -	-								$ -
21	**Residential Level IV**	**$ 60.90**	184,481					4,506			$ 188,987
24	Substance Abuse Detox	$ -									$ -
25	Supported Employment	$ -									$ -
26	Supportive Housing	$ -									$ -
27	TASC	$ -									$ -
28	**Incidental Expenses**	**$ 1.00**									$ -
66											
	TOTAL FUNDING	**$ 2,642,116**	$ 1,420,517	$ 598,957	$ -	$ -	$ -	$ 322,642	$ 75,000	$ 225,000	$ 2,642,116
	TOTAL UNCOMPENSATED	$ 528,423									$ 528,423

MDC108

MDC-Community Action & Human Services Dept.
ME225-12-28

	COVERED SERVICES	FUNDING / RATE	CSA									
			MS003	MS011	MS021	MS023	MS025	MS0PP	MS0CN	MS0CF	MS0TB	TOTAL
			-	-	-	-	-	-	-	-	-	$ -
01	**Assessment**	**$ 103.42**										$ -
02	Case Management	$ -										$ -
03	Crisis Stabilization	$ -										$ -
04	Crisis Support/Emergency	$ -										$ -
06	**Day Treatment**	**$ 84.41**										$ -
07	Drop-In/Self Help Centers	$ -										$ -
08	In-Home/On-Site	$ -										$ -
11	**Intervention - Individual**	**$ 88.37**										$ -
42	**Intervention - Group**	**$ 22.09**										$ -
12	Medical Services	$ -										$ -
13	**Medication-Assisted Treatment**	**$ 6.30**										$ -
14	**Outpatient - Individual**	**$ 122.71**										$ -
35	**Outpatient - Group**	**$ 30.68**										$ -
15	Outreach	$ -										$ -
18	Residential Level I	$ -										$ -
	Residential Level I (new SIPP rate)	$ -										$ -
19	**Residential Level II**	**$ 109.00**										$ -
20	Residential Level III	$ -										$ -
21	**Residential Level IV**	**$ 60.90**										$ -
24	Substance Abuse Detox	$ -										$ -
25	Supported Employment	$ -										$ -
26	Supportive Housing	$ -										$ -
27	TASC	$ -										$ -
28	**Incidental Expenses**	**$ 1.00**										$ -
66												
	TOTAL FUNDING	**$ 2,642,116**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	TOTAL UNCOMPENSATED	$ 528,423										$ -

MDC109

EXHIBIT H - FUNDING DETAIL

Provider: MDC-Community Action & Human Services Dept. **Contract #: ME225-12-28** **Amendment # 2**

ADULT MENTAL HEALTH

OCA DESCRIPTION	NEW OCA	AMOUNT
Residential Services	MH001	$ -
Non-Residential Services	MH009	$ -
Crisis and Baker Act Services	MH018	$ -
Early Intervention - Psychotic Disorders	MH026	$ -
Community Forensic Program	MH072	$ -
Indigent Drug Program	MH076	$ -
Proviso Allocation - Citrus	MH094	$ -
Carry Forward	MH0CF	$ -
Care Coordination	MH0CN	$ -
Forensic Hospital Multidisciplinary Team	MH0FH	$ -
FACT Team	MH0FT	$ -
PATH Grant	MH0PG	$ -
TANF Services	MH0TB	$ -
Residential Services SUP 1	MH01S	$ -
Non-Residential Services SUP 1	MH09S	$ -
Crisis and Baker Act Services SUP 1	MH18S	$ -
Expanding 211 Call	MH211	$ -
Early Intervention Services MHBG SUP1	MH26S	$ -
Core Crisis Set Aside MHBG SUP1	MHCCS	$ -
Emergency COVID-19 Grant Supplemental	MHCOS	$ -
Short Term Residential Treatment (SRT)	MHCR2	$ -
Supported Employment Services	MHEMP	$ -
Forensic Transitional Beds	MHFMH	$ -
Residential stability Coord MHBG SUP1	MHRES	$ -
Emergency COVID-Supplemental	MHSCS	$ -
For Profit Sub-Recipeint - Key West HMA	MHSFP	$ -
Suicide Prevention MHBG SUP1	MHSPV	$ -
Telehealth Behavioral Health Services	MHTLH	$ -
MDC - Central Receiving Facility	MDCRF	$ -
Specialty Programs	SPLTY	$ -
Community Action Treatment (CAT) Team	MHCAT	$ -
Mobile Crisis Team	MHMCT	$ -
CSOC Grant Year 2	CSOC2	$ -
TOTAL ADULT MENTAL HEALTH =		**$ -**

CHILDREN MENTAL HEALTH

OCA DESCRIPTION	NEW OCA	AMOUNT
Residential Services	MH001	$ -
Non-Residential Services	MH009	$ -
Crisis and Baker Act Services	MH018	$ -
Purchased Residential Treatment (PRTS)	MH071	$ -
Special Appropriation - ICFH	MH0BN	$ -
Care Coordination	MH0CN	$ -
Carry Forward	MH0CF	$ -
Residential Services SUP 1	MH01S	$ -
Non-Residential Services SUP 1	MH09S	$ -
Crisis and Baker Act Services SUP 1	MH18S	$ -
Community Action Treatment (CAT) Team	MHCAT	$ -
Core Crisis Set Aside MHBG SUP1	MHCCS	$ -
Mobile Crisis Team	MHMCT	$ -
Suicide Prevention MHBG SUP1	MHSPV	$ -
Telehealth Behavioral Health Services	MHTLH	$ -
CSOC Grant Year 2	CSOC2	$ -
Specialty Programs	SPLTY	$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
TOTAL CHILDREN MENTAL HEALTH =		**$ -**

ADULT SUBSTANCE ABUSE

OCA DESCRIPTION	NEW OCA	AMOUNT
Residential Services	MS003	$ 1,420,517
Non-Residential Services	MS011	$ 598,957
Detox Services	MS021	$ -
HIV Services	MS023	$ -
Prevention Services	MS025	$ -
Women's Services	MS027	$ 322,642
Pregnant Women Project	MS081	$ -
FIT Team	MS091	$ -
Care Coordination	MS0CN	$ -
Carry Forward	MS0CF	$ -
TANF Services	MS0TB	$ -
Residential Services SUP 1	MS03S	$ -
Non-Residential Services SUP 1	MS11S	$ -
Detox Services SUP 1	MS21S	$ -
Prevention Services SUP 1	MS25S	$ -
Care Coordination- Judgement	MS923	$ -
Community Based Services	MSCBS	$ -
NES/SEN Care Coord SAPT SUP1	MSCS2	$ -
Opioid Response Disc. Rec Comm Org-Year 2	MSRC2	$ -
Opioid Response Disc. Rec Comm Org-Year 3	MSRC3	$ -
Opioid Response Disc. Rec Comm Org-Year 4	MSRC4	$ -
Opioid Response Disc. Rec Comm Org-Year 5	MSRC5	$ -
Opioid Response Disc. Grant- GPRA Year 3	MSSG3	$ -
SOR-MAT Year 2	MSSM2	$ -
SOR-MAT Year 3	MSSM3	$ -
SOR-MAT Year 4	MSSM4	$ 75,000
SOR-MAT Year 5	MSSM5	$ 225,000
Suicide Prevention SAPT SUP1	MSSPV	$ -
Specialty Programs	SPLTY	$ -
TOTAL ADULT SUBSTANCE ABUSE =		**$ 2,642,116**

CHILDREN SUBSTANCE ABUSE

OCA DESCRIPTION	NEW OCA	AMOUNT
Residential Services	MS003	$ -
Non-Residential Services	MS011	$ -
Detox Services	MS021	$ -
HIV Services	MS023	$ -
Prevention Services	MS025	$ -
Prevention Partnership Grant	MS0PP	$ -
Care Coordination	MS0CN	$ -
Carry Forward	MS0CF	$ -
TANF Services	MS0TB	$ -
Residential Services SUP 1	MS03S	$ -
Non-Residential Services SUP 1	MS11S	$ -
Detox Services SUP 1	MS21S	$ -
Prevention Services SUP 1	MS25S	$ -
Proviso Allocation - Here's Help	MS903	$ -
Here's Help Opioid Training	MS921	$ -
NES/SEN Care Coord SAPT SUP1	MSCS2	$ -
Prevention Partnership Prog SAPT SUP1	MSPPS	$ -
Suicide Prevention SAPT SUP1	MSSPV	$ -
SOR- Prevention Year 3	MSSP3	$ -
SOR- Prevention Year 4	MSSP4	$ -
SOR- Prevention Year 5	MSSP5	$ -
Specialty Programs	SPLTY	$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
		$ -
TOTAL CHILDREN SUBSTANCE ABUSE =		**$ -**

FUNDS NOT REQUIRING MATCH:

Drug Abuse Services	$ 1,268,155
Prevention	$ -
Deinstitutionalization Project	$ -
CMH Program	$ -
SOR Grant	$ 75,000
TOTAL FUNDS NOT REQUIRING MATCH	**$ 1,343,155**

TOTAL ALL PROGRAMS =	$ 2,642,116
UNCOMPENSATED UNITS =	$ 528,423
TOTAL =	**$ 3,170,539**
TOTAL FUNDS REQUIRING MATCH =	$ 1,298,961
LOCAL MATCH REQUIRED =	**$ 432,987**

NOTES

FY 2021-22 Adjustments:
2/25/21 All the SOR allocations including GPRA funding are withdrawn, as these allocations are not recurring.
'6/10/21 SOR allocations are added based on tentative allocations for FY 201-22, OCA allocations may change once the approved Schedule of funds for the new year is received.
'6/21/21 AMH-Care Coordination funds are replaced with ASA-MS0CN funds, recurring.
'10/2/21 $25,000 is reduced from MSSM2, $75,000 from MSSM3 and $200,000 is added to MSSM4 to align with SFBHN's SOF allocation.
10/21/20 SA Match calculations are revised based on prior year treatment data (% non-Alcohol Clients).
FY 2022-23 Adjustments:
3/7/22 MSSM2, MSSM3 allocations are withdrawn; MSSM4 and MSSM5 allocations are made based on projected utilization.
MS0CN budget is removed as the Care Coordination services are funded on a Team approach.

MDC-Community Action & Human Services Dept.

REQUIRED MATCH: $ 432,987

			AMH		CMH		ASA		CSA	
	COST CENTERS	**RATE**	**UNITS**	**MATCH**	**UNITS**	**MATCH**	**UNITS**	**MATCH**	**UNITS**	**MATCH**
01	**Assessment**	**$ 103.42**	-		-		4,186.69	$ 432,987	-	
02	Case Management	$ -								
03	Crisis Stabilization	$ -								
04	Crisis Support/Emergency	$ -								
06	**Day/Night**	**$ 84.41**	-		-		-		-	
07	Drop-In/Self Help Centers	$ -								
08	In-Home/On-Site	$ -								
11	**Intervention - Individual**	**$ 88.37**	-		-		-		-	
42	**Intervention - Group**	**$ 22.09**	-		-		-		-	
12	Medical Services	$ -								
13	**Medication-Assisted Treatment**	**$ 6.30**	-		-		-		-	
14	**Outpatient - Individual**	**$ 122.71**	-		-		-		-	
35	**Outpatient - Group**	**$ 30.68**	-		-		-		-	
15	Outreach	$ -								
18	Residential Level I	$ -								
	Residential Level I (new SIPP rate)	$ -								
19	**Residential Level II**	**$ 109.00**	-		-		-		-	
20	Residential Level III	$ -								
21	**Residential Level IV**	**$ 60.90**	-		-		-		-	
24	Substance Abuse Detox	$ -								
25	Supported Employment	$ -								
26	Supportive Housing	$ -								
27	TASC	$ -								
28	**Incidental Expenses**	**$ 1.00**	-		-		-		-	
29	Aftercare - Individual	$ -								
43	Aftercare - Group	$ -								
30	Information & Referral	$ -								
34	FACT Team	$ -								
36	Room & Board Level I	$ -								
37	Room & Board Level II	$ -								
38	Room & Board Level III	$ -								
39	Short-term Residential Treatment	$ -								
40	Clubhouse Services	$ -								
44	CCST - Individual	$ -								
45	CCST - Group	$ -								
46	Recovery Support - Individual	$ -								
47	Recovery Support - Group	$ -								
48	Prevention - Indicated	$ -								
49	Prevention - Selective	$ -								
50	Prevention - Universal Direct	$ -								
51	Prevention - Universal Indirect	$ -								
52	A0- Forensic Multidisciplinary Team	$ -								
53	A1- BNET	$ -								
54	A2- FIT Team	$ -								
55	A5- First Episode Team	$ -								
56	A7- Federal Project Grant	$ -								
57	B3- Cost Reimbursement	$ -								
58	B4- CAT Team	$ -								
59	B5- FACT Team	$ -								
60	B6- Provider Proviso Projects	$ -								
61	C0- Other Bundled Projects	$ -								
	MATCH ALLOCATION:			$ -		$ -		$ 432,987		$ -
	GRAND TOTAL:	**$ 432,987**								

REVISED EXHIBIT K

Resource Management Roster for Substance Abuse & Mental Health Residential Level II Services

(1) Provider Name and Address: _____
_____
_____

(2) Contract No: _____
(4) Invoice Period: _____

(3) SAMH Program: _____
(5) Page ___ of ____

(6) Client Count	(7) Authorization Number	(8) Client Name (Last, First)	(9) Social Security Number	(10) Placement Authorization No.	(11) Service Period	(12) Cost Center	(13) Unit Rate	(14) No. of Units of Services Rendered	(15) Total Service Cost (Col. 13 x 14)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
							Totals		**$**

MDC112

Provider's Authorized Representative
I CERTIFY THAT THE ABOVE IS ACCURATE AND CORRECT

_____ _____
Provider's Signature **Date**

_____ _____
Name (Print or Type) **Title**

REVISED EXHIBIT R
Substance Abuse Residential Level II

The Network Provider is contracted to provide Substance Abuse Residential Level II services. Substance Abuse Residential Level II facilities are licensed, structured rehabilitation-oriented group facilities that have twenty-four hours per day, seven days per week, supervision. Level II facilities treat individuals who have significant deficits in independent living skills and need extensive support and supervision. Level II services provide a range of assessment, treatment, rehabilitation, and ancillary services in a less intensive therapeutic environment with an emphasis on rehabilitation and may include formal school and adult educational programs.

This level of care provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare individuals for outpatient treatment. Individuals in this level of care are able to tolerate and use full active milieu. Level II encompasses residential services that are co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

Residential Level II services are directed by nonphysician addiction specialists rather than medical personnel. They are appropriate for individuals whose primary problems involve emotional, behavioral, cognitive, readiness to change, relapse, or recovery environment concerns. Intoxication, withdrawal, and biomedical concerns, if present, are safely manageable in a clinically managed service. The skilled treatment services include a range of cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; random drug screening; planned clinical activities and professional services to develop and apply recovery skills; family therapy; educational groups; occupational and recreational therapies; art, music or movement therapies; and related services directed exclusively toward the benefit of the individual served.

Residential II services are designed to improve the patient's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the individual's substance use disorder symptoms, to help them develop and apply sufficient recovery skills, and to develop and practice prosocial behaviors such that immediate or imminent return to substance use upon transfer to a less intensive level is avoided.

For level II, each individual shall receive services each week in accordance with subsection 65D-30.007(5)(c), F.A.C., including at least 10 hours of counseling per week.

I. Priority Populations

Target and priority populations are listed in Exhibit A, Individuals/Participants to be Served. Substance Residential Level II treatment services must be provided to individuals pursuant to 394.674, F.S., including those individuals who have been identified as requiring priority by state of federal law. Network Providers must give priority status for access to treatment to:

- **a)** Pregnant, injecting drug users
- **b)** Pregnant women
- **c)** Injection drug users;
- **d)** Women with dependent children;

e) Families with children who have been determined to require substance abuse and mental health services by child protective investigators and meet the target population in the subsection below:

f) Parents or caregivers in need of adult substance abuse services pursuant to s.394.674(1)(c)3., F.S., based on the risk to the children due to a substance abuse disorder.

g) Individuals who are involuntarily admitted under Part V, Chapter 397, F.S.;

Homeless Individuals: Network Providers will inform homeless individuals of their waitlist status at the point of initial assessment. Although homelessness is not a priority target population, efforts are made to provide immediate placement when possible in order to minimize loss of contact.

II. PROCEDURES

II.A. Obtaining Consent: Prior to conducting a screening/assessment, Network Provider agencies are required to obtain consent from individuals. The consent form used is provided by the ME. The consent shall include authorization for sharing the information gathered in the assessment with the Department, the ME and any other entities requiring access to ensure coordinated quality care. All entities privileged to access the assessment are identified on the consent form appendix.

II.B. Accessing Residential Treatment

1. Assessment: Network Providers wishing to refer to the ME funded Substance Abuse residential treatment level II must demonstrate that the individual meets the level of care. All individuals must undergo an assessment including the completion of an ASAM III.5 Level of Care placement tool to document the need for the level of care. Once the ASAM has confirmed criteria for Substance Abuse Residential Treatment level II treatment, Network Providers enter individuals on their own waitlist and submitted to it to the ME for inclusion on the regionwide waitlist.

2. Referral and Placement: Following the completion of the ASAM Level of Care Placement Tool and assessment, the Network Provider will submit their waitlist the ME for inclusion on the regionwide waitlist. The Network Provider is responsible to:

a) Offer, and provide or coordinate interim services and document such efforts

b) Maintain contact with the individual until a treatment bed becomes available.

c) Communicate with the ME at a minimum of three times a week regarding program bed availability.

d) Upon program bed availability, the Network Provider is responsible for coordinating the admission and removing the individual from their waitlist.

e) If a priority population individual is identified during the assessment and the referring Network Provider has a bed available, they will immediately contact the ME for approval of immediate placement prior to admitting the individual. If the assessing Network Providers does not have immediate treatment bed availability, they will call the ME for assistance in identifying a bed within another SA Residential Level II Treatment Network Provider.

f) ME makes referral to available treatment bed; the Network Provider will contact the individual to schedule admission within 24 hours having received the referral Network

Provider.

g) If the individual referred is unable to be located after 3 attempts or within 72 work week hours, the Network Provider may "release" the bed for another referral and notify the ME.

h) Network Providers must immediately contact the ME if the referred individual will not be admitted into the program. Network Providers must provide a written clinical explanation on denial of admission, including official review and recommendation from a licensed clinician as to the appropriate level of care. In addition, the Network Provider is responsible for coordinating and facilitating the linkage and referral and acceptance to their recommended level of care, as described in the Attachment I to this Contract. This includes, maintain the ME informed of their actions, to be submitted to the ME. If residential treatment is clinically not appropriate, the Network Provider must provide recommendations to an appropriate level of care.

i) Network Providers must immediately contact the ME to coordinate the next appropriate level of care if the individual served no longer meets, or violates, the rules/criteria of their program. Network Providers must submit written clinical explanation on their decision, including evidence of official review and recommendation from a licensed clinician as to the appropriate level of care. In addition, the Network Provider is responsible for coordinating and facilitating the referral and acceptance to their recommended level of care. This includes, maintain the ME ASOC staff informed of their actions and seek their assistance as appropriate.

j) A Warm handoff should be utilized prior to discharge. "Warm Hand-off" as defined by the U.S. Department of Health and Human Services is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of cate allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask question about their care. Warm handoffs engage the patient through structured communication and improves the safety by helping prevent communication breakdowns.

k) Hospitalizations: If the individual is hospitalized, the Network Provider shall communicate with the hospital treatment team daily to ensure continued communication and coordination of return to program. If the Network Provider determines that the individual does not meet their criteria for return to program, they must follow procedures listed on item #9.

l) Network Providers will consult with the ME's Housing Coordination Team to identify and understand the status of homeless individuals on the HMIS System individuals

All admissions into an available treatment program bed must be pre-approved by ME.

3. **Bed Availability**: The Network Provider is responsible for updating the census daily with the new admissions, discharges and available beds. The Network Provider will submit the updated census daily Monday through Friday by 10:00 AM.

4. **Adult Waitlist Management**

a) Network Providers hold their specific waitlists. Individuals on the Network Provider's waitlist are also added to the Regionwide waitlist list.

b) Individuals on the waitlist contact with the assessing Network Providers for bed availability; Individual may also contact the ME at 1-866-833-7477

c) Network Provider communicates with the ME about treatment bed availability to coordinate admission for those on their waitlist.
d) ME conducts weekly search of waitlist for individuals identified under one of the Priority Populations, and other specific information based on availability, to attempt to place into treatment regardless of the whether the individual has maintained contact with the assessing Network Provider or the ME for bed availability.
e) Network Provider shall request bed availability from the ME for treatment beds at SARES2@sfbhn.org.
f) When there is an available bed, the referring Network Provider and/or ME ASOC Specialist will contact individual in order of priority, or by date of assessment to offer residential placement.

5. Youth Waitlist Management

1) Network Providers hold their specific waitlists. Youth on the Network Provider's waitlist are also added to the Regionwide waitlist list.
2) ME places youth on waiting list upon receipt of completed assessment, ASAM, and consent form
3) If a youth is receiving treatment within a network provider, that current provider will maintain youth in treatment until the residential treatment program becomes available.
4) Parents, legal guardians and/or referral sources may contact the ME for status of treatment program availability.
5) Youth meeting the priority population listed in Section I, are prioritized. Otherwise, referrals are sent to the Network Provider based on chronological order of receipt of referral.
6) ME notifies parent or legal guardian that referral was sent to the Network Provider.
7) Network Provider coordinates admission with parent or legal guardian and existing provider.

II.C. Initial Authorization

1) ME ill issue initial authorization for every admission into residential level II treatment.
2) ME will issue initial 90-day authorization for youth and individuals meeting criteria for the priority population listed in Section 1. All other populations received a 60-day authorization.
3) ME generates an authorization effective only upon admission into the treatment agency.
4) Authorizations for the specified length of stay with a start and end date are emailed by the ME.
5) Reimbursement will only be provided for service dates covered by the authorization.
6) The ASOC Specialist may provide authorization for an alternative length if indicated, on an individual basis.

II.D. Continued Stay Criteria: The individual must meet criteria in Dimension 1 and *at least one* of the Dimensions 2, 3, 4, 5, or 6:

A. Dimension 1: Acute Intoxication and/or Withdrawal.

1) Individual has no signs or symptoms of withdrawal, or his or her withdrawal needs can be

safely managed in a Level I or II setting.

B. Dimension 2: Biomedical Conditions and Complications:

1) Biomedical problems, if any, are stable and do not require 24-hour monitoring and the individual is capable of self-administering any prescribed medications; or
2) A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The biomedical problem requires monitoring, which can be provided by the program or through an arrangement with another Network Provider.

C. Dimension 3: Emotional, Behavioral, Cognitive Conditions and Complications: (If any of these conditions are present, individual must be in a Dual Diagnosis Capable or Enhanced Program).

The individual's status is characterized by *one* of the following:

1) Individual's psychiatric condition is stabilizing. However, the individual is unable to control use of alcohol or other drugs and/or antisocial behaviors, with probability of harm to self or others. The resulting level of dysfunction is so severe that the individual is unable to participate in a less structured or intensive level of care.
2) Individual demonstrates repeated inability to control impulses to use alcohol or other drugs and/or engage in antisocial behavior, with likelihood of harm to self or others. The resulting level of dysfunction is so severe that the individual is unable to participate in treatment in the absence of the 24-hour support and structure of a Level I or II program.
3) Individual demonstrates antisocial behaviors that have led or could lead to significant criminal justice problems, lack of concerns for others and extreme lack or regard for authority, and which the individual is unable to participate in a less structured or intensive level of care.
4) Individual has significant functional deficits, which are likely to respond to staff interventions. However, the individual is not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential program.
5) Individual's related personality disorders are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.
6) Individual's mental status is assessed as sufficiently stable to permit the individual to participate in therapeutic interventions and to benefit from treatment.

D. Dimension 4: Readiness to Change: The individual's status is characterized by *one* of the following:

1) Because of the intensity of the addictive disorder or the mental health problem, the individual has little awareness of the need for continuous care, the existence of substance use or mental health problem and need for treatment and thus has limited readiness to change.
2) Despite serious consequences, the individual has difficulty in understanding the relationship between the substance use, addiction, mental health or life problems, their impaired coping skills and level of functioning, often blaming others for their problems.
3) Individual demonstrates passive or active opposition to addressing the severity of their

mental or addiction problem or does not recognize the need for treatment. This poses a danger of harm to self or others. However, assessment indicates that treatment interventions available at Level I or II may increase the individual's degree of readiness to change.

4) Individual requires structured therapy and 24-hour program setting to promote treatment progress/recovery because other interventions have failed at a less intensive level of care and are not likely to succeed in the future at a less intensive level of care.

5) Individual's perspective impairs their ability to make behavior changes without repeated, structure, clinically directed motivational interventions, delivered in a 24-hour program setting.

E. Dimension 5: Relapse, Continued Use or Continued Problem Potential: the individual's status is characterized by *one* of the following:

1) Individual does not recognize relapse triggers and is not committed to continuing care. Continued substance use poses an imminent danger of harm to self or others without 24-hour monitoring and structured support.

2) Individual's psychiatric condition is stabilizing. However, despite efforts, individual is unable to control use and/or antisocial behaviors with a probability of harm to self or others. Continued substance use poses an imminent danger of harm to self or others without 24-hour monitoring and structured support.

3) Individual's cognitive impairment has limited their ability to identify or cope with relapse triggers and high-risk situations. Individual requires relapse prevention activities that are delivered at a slower pace and in a setting that provides 24-hour structure and support to prevent imminent danger or dangerous consequences.

4) Individual is in imminent danger of relapse, with dangerous emotional, behavioral or cognitive consequences, because of a crisis situation.

5) Despite recent participation in treatment at a less intensive level of care, the individual continues to use or to deteriorate psychiatrically, with imminent serious consequences and is at high-risk for continued use and deterioration without 24-hour monitoring and treatment.

F. Dimension 6: Recovery Environment: the individual's status is characterized by *one* of the following:

1) Individual has been living in an environment that is characterized by a moderately high of initiation or repetition of physical, sexual or emotional abuse, or substance use where the individual is assessed as being unable to obtain or maintain recovery in a less intensive setting.

2) Individual is in danger of victimization and requires 24-hour supervision.

3) Individual's social network is characterized by social isolation/withdrawal, such that recovery goals are unachievable at a less intensive setting.

4) Individual's social network involves living with an individual who is a regular user, abuser or dealer of drugs, or the living environment is highly invested in alcohol or drug use that their recovery goals are unachievable.

5) Due to cognitive limitations, individual is in danger of victimization by another and requires 24-hour supervision.

6) Individual's living environment is characterized by criminal behavior, victimization and

other antisocial norms and values.

G. In addition to meeting the criteria outlined in Section II. C., the following must also be met:

1) An individualized plan of active treatment is required. This plan should contain, at a minimum, clinical evidence of therapeutic goals that must be met before the individual can return to the previous or other living situation.
2) Evidence of continued support 24 hours a day through a therapeutic living situation.
3) Evidence of coordination and access to active therapeutic interventions and services directed at the alleviation of clinical symptoms that are interfering with the individual's ability to return to a less intensive level of care.

II.E. **Procedures for Continued Stay Request**: The Network Provider must review individual's information and determine the primary clinical reasoning for extending services at the same level of care.

1) Network Providers seeking continued stay request, must submit the following to the ASOC Department for review and determination:
  a) A thoroughly completed "Continued Stay Authorization Request Form", available upon request
  b) The initial individualized treatment plan along with all revisions and updates.
  c) A Continued Stay ASAM form

2) The request must be received by the ASOC Department no later than 14 calendar days prior to the expiration date of the current authorization. Continued stay requests submitted after the 14 days will be disallowed one unit for each day it is late.
3) Network Providers may request a continued stay after the 14-day interval for special circumstances (i.e., individual relapse). These requests will be considered on an individual basis.
4) It is the responsibility of the Network Provider to ensure that all submitted documentation has been received by the ME ASOC Specialist. Once all required documentation has been received, the request will be processed within 5 business days and the Network Provider informed of the decision to authorize or deny for continued residential treatment.
5) Continued Stays are provided in 30-day intervals. If the individual clinically requires a continue stay, a new request for additional time must be submitted, including all documentation listed in items a) through c), in section II.E. 1), above, for reviewed and approval.
6) Alternate authorization time intervals may be considered on an individual basis.

II.F. Court Involved Individuals

Marchman Act Individuals: Network Providers shall admit individuals transported by law enforcement pursuant to a Marchman Act order. Network Providers are responsible to coordinate detox/medical clearance for individuals assessed/perceived as needing it upon their arrival. Coordination, includes and is not limited to arranging transportation, communicating with the detox/medical facility, and ensuring communication is maintained for admission post clearance. Please refer to the Attachment I to this Contract for additional requirement on admissions and the process for referrals and linkages to appropriate levels of care.

Network Providers will immediately communicate with the ME and Marchman Act Court if there are barriers for admission. Immediate written and verbal communication of any difficulty communicating/engaging an individual under the Marchman Act into treatment (this includes if the individual leaves the facility) should be submitting to:

ME to SARES2@sfbhn.org
Marchman Act Court Case Manager at: ccharles@jud11.flcourts.org

Network Providers shall submit a report to Marchman Act court of the individual's progress in treatment within the first 45 days of admission into treatment.

Drug Court, Veterans, Jail Diversion or other court cases: Network Providers shall ensure that they maintain ongoing communication with court programs including but not limited to regularly scheduled reports to court and informing court of any significant changes to treatment process. Network Providers must inform, and confirm that court, has received notice of expected discharges -scheduled or unscheduled.

III. Required Report for Invoicing

The Network Provider must submit a completed Pre-Authorization Resource Management Roster for Substance Abuse & Mental Health Residential Level II Services Only, per Exhibit K, along with the monthly invoicing that is due by the 8th of every month following the month of services.

Revised Exhibit AC
Care Coordination Services

I. OVERVIEW

A. DEFINITIONS

Section 394.4573(1)(a), F.S., defines Care Coordination to "mean the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage. Examples of Care Coordination activities include development of referral agreements, shared protocols, and information exchange procedures. The purpose of Care Coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among priority populations."

B. PURPOSE AND GOALS

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

Care Coordination is not a service in and of itself, it is a collaborative effort to efficiently target treatment resources to needs, effectively manage and reduce risk, and promote accurate diagnosis and treatment due to consistency of information and shared information. It is an approach that includes coordination at the funder level, through data surveillance, information sharing across regional and system partners, partnerships with community stakeholders (i.e., housing providers, judiciary, primary care, etc.), and purchase of needed services and supports.

At the provider level, it includes a thorough assessment of needs, inclusive of a level of care determination, and active linkage and communication with existing and newly identified services and supports. Care Coordination assesses for and addresses behavioral health issues as well as medical, social, housing, interpersonal problems/needs that impact the individual's status. It is a mechanism for linking providers of different services to enable shared information, joint planning efforts, and coordinated/collaborative treatment. Engagement of available social supports to address identified basic needs for resources such as applying for insurance/disability benefits, housing, food, and work programs is essential. Care Coordination also facilitates transitions between providers, episodes of care, across lifespan changes, and across trajectory of illness. By definition, there is currently no equivalent, reimbursable service by Florida Medicaid or any other commercial insurance.

At the person level, it incorporates shared decision making in planning and service determinations and emphasizes self-management. Persons served and family members should be the driver of their goals and recognized as the experts on their needs and what works for them.

Care Coordination is not intended to replace case management. Based on the person's needs and wishes, case management may be a service identified in the person's care plan for which they will be referred.

Case management may be ongoing for those determined eligible for this service based on current standards.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care,
- Increase diversions from state mental health treatment facility admissions,
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness, and
- Focus on an individual's wellness, physical health, and community integration.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model of well-being and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

C. CORE COMPETENCIES

The Department has compiled a set of guiding principles and core competencies that must be considered in service design. The guiding principles stipulate that service delivery is recovery-oriented, choice and needs driven, flexible, unconditional, and data driven. Core competencies of Care Coordination include:

1. Single point of accountability – Care Coordination provides for a single entity responsible for coordination of services, supports, and cross system collaboration to ensure the individual's needs are met holistically.
2. Engagement with person served and their natural supports - the care coordinator goes to the individual and builds trust and rapport. The care coordinator actively seeks out and encourages the full participation of the individual' networks of interpersonal and community relationships. The care plan reflects activities and interventions that draw on sources of natural support.
3. Standardized assessment of level of care determination process – a standardized level of care assessment provides a common language across Network Providers that can assist in determining service needs.
4. Shared decision-making – family and person-centered, individualized, strength-based plans of care drive the Care Coordination process. The perspective of the individuals served are intentionally elicited and prioritized during all phases of the Care Coordination process. The care coordinator provides options and choices such that the care plan reflects the individual's values and preferences.
5. Community-based – services and supports take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible that safely promote an individual's integration into home and community life.
6. Coordination across the spectrum of health care - this includes, but is not limited to, physical health, behavioral health, social services, housing, education, and employment.

7. Information sharing – releases of information and data sharing agreements are used as allowed by federal and state laws, to effectively share information among Network Providers, natural supports, and system partners involved in the individual's care.
8. Effective transitions and warm hand-offs - current Network Providers directly introduce the individual to the care coordinator. The "warm hand-off" is both to establish an initial face-to-face contact between the individual and the care coordinator and to confer the trust and rapport the individual has developed with the provider to the care coordinator.
9. Culturally and linguistically competent - the Care Coordination process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the individual served, and their community.
10. Outcome based – Care Coordination ensures goals and strategies of the care plan are tied to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.
11. Care Coordination should incorporate a recovery oriented, strengths-based approach to an individual's pathway to recovery.

II. PRIORITY POPULATIONS

1) Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to potentially benefit from Care Coordination. Managing Entities and provider agencies are expected to utilize at least 50% of allocated funds in OCAs MH0CN , MS0CN and MS11S to serve the following populations

   A. Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. For the purposes of this document, high utilization is defined as:

      1. Adults with three (3) or more acute care admissions within 180 days; or

      2. Adults with acute care admissions that last 16 days or longer.

      3. Adults with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission.

   B. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

2) The Department has defined additional populations to benefit from Care Coordination using funds in OCAs MHCAS and MSCAS.

   a) Under OCA MHCAS:

   A. Children and parents or caretakers in the child welfare system with behavioral health needs, including adolescents, as defined in s. 394.492, F.S. who require assistance in transitioning to services provided in the adult system of care.

   B. Children and adolescents with a mental health diagnosis, SUD, or co-occurring disorders who demonstrate high utilization. For the purposes of this document, high utilization is defined as:

children and adolescents under 18 years of age with three (3) or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days, including:

1. Children being discharged from Baker Act Receiving Facilities, Emergency Rooms, jails, or juvenile justice facilities at least one time, who are at risk of re-entry into these institutions or of high utilization for crisis stabilization.

2. Children and adolescents who have recently resided in, or are currently awaiting admission to or discharge from, a treatment facility for children and adolescents as defined in s. 394.455, which includes facilities (hospital, community facility, public or private facility, or receiving or treatment facility) and residential facilities for mental health, or co-occurring disorders.

C. Children not currently receiving services by a Community Action Treatment ("CAT") Team.

D. Children and adolescents who are assessed voluntarily without an admission to a Crisis Stabilization Unit two or more times within 180 days.

b) Under OCA MSCAS:

A. Families with infants experiencing or at risk for Neonatal Abstinence Syndrome or Substance Exposed Newborn.

3) In addition to the priority population listed in sections 1) A – B and 2) A. – D, , the following populations have been identified as benefiting from Care Coordination and may be served:

A. Individuals referred, and enrolled in the Jail Diversion Program (JDP) who meet the following criteria:

1. Individuals must meet the following criteria (1 and 2):

i. Individuals must be receiving ME SAMH funded services or be willing to accept Care Coordination services from an ME Network Provider.

ii. Individuals must have a confirmed SPMI and/or Co-Occurring diagnosis (Diagnosis of PTSD alone is not eligible)

B. Individuals must meet at least one (1) of the following:

i. Individuals with 2 or more acute care admissions within 180 days and 2 or more arrests within 90 days.

ii. Individuals with an acute care admission that lasts 16 days or longer within 180 days and 2 or more arrests within 90 days

iii. Individuals with 2 or more acute care admissions and 4 or more arrests within 180 days or individuals with 6 or more arrests within 365 days.

AND during current arrest are classified as level 1 a or b or in Detox unit in the jail.

C. Individuals (youth and adults) referred by, or to, a Law Enforcement Agencies and followed by that Law Enforcement:

a. Youth/Adult must meet the following criteria:

i. Must be receiving ME SAMH funded services or be willing to accept Care Coordination services from an ME Network Provider.

ii. Adults have a confirmed SPMI and/or Co-Occurring diagnosis (Diagnosis of PTSD alone is not eligible). Youth must have a confirmed SED diagnosis and obtain parental / caregiver / guardian consent.

iii. Currently is in or has the potential to experience a state of crisis, substance abuse or dependence, and history of suicidal/homicidal ideation.

b. Youth / Adult must meet at least one (1) of the following:

i. Have a history of violence/aggression towards others, themselves or animals and/or bullying.

ii. Have a negative family dynamic, lack of support system, isolation, instability and/or recent traumatic event.

D. Children and youth referred from the Children System of Care (CSOC) Expansion Grant.

a. Individuals must meet one of the following criteria:

i. Individuals must be receiving CSOC Expansion Grant services and willing to accept Care Coordination services from an ME Network Provider.

ii. Individual is aging out (at least 18 years old) of Children's System of Care and needs to transition into the Adult System of Care.

iii. Individual has a history of serious emotional disturbances (SED), or has experience early onset SED/severe mental illness (SMI) in Miami-Dade County.

E. Children and youth referred by Mobile Response Teams (MRT) that meet the following criteria:

i. Youths that have come in contact (screening/assessment) with MRT services at least 2 times in 180 days.

ii. Youth that have a combination of MRT contacts (screening/assessment) and one of the above children/youth criteria

F. Adults being discharged, or no more than 30 days from discharge, from substance use and mental health Level II Residential Treatment program.

4) The ME in collaboration with the local SAMH Program office may authorize the provision of Care Coordination services for other populations including but not limited to:

A. Persons with a SMI, SUD, or co-occurring disorders who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.

B. Individual requiring reentry services referred by the Prison Aftercare Program

C. Individuals exiting higher levels of care such as residential level II treatment.

D. Caretakers and parents with a SMI, SUD, or co-occurring disorders involved with child welfare.

E. Individuals identified by the Department, managing entities, or Network Service as potentially high risk due to concerns that warrant Care Coordination, as approved by the Department.

F. Individuals may be identified by the ME's Care Coordination Team or through the ME's Network Providers.

G. Individuals released pursuant to v. State Mosher, where a judge did not issue a Conditional Release Order (CRO) and are no longer receiving Forensic Services.

H. Individuals served through Care Coordination must be ME-funded individuals.

I. Persons with a SED, SMI, SUD, or co-occurring disorders who are exiting prison and are referred through the Prison Aftercare Program, or were released from prison through the Aftercare Program within the preceding 180 days and facing violations of post release supervision leading to further institutionalization (forensic hospitalization/prison) or incarceration.

J. Care Coordination under these OCAs cannot be provided to individuals enrolled in the following team-based services FACT, Coordinated Specialty Care for Early Mental Illness/Navigate, Family Intensive Treatment (FIT), Comprehensive Community Service (CAT) Teams, Forensic Multidisciplinary Teams (FMT), and any other local multidisciplinary treatment teams that include case management; including Forensic Specialist Service Team contracted at Community Health of South Florida, Inc.

K. If necessary, Managing Entities and Network Service Providers may implement a time-limited transition plan for individuals in the process of connecting to a case manager or team-based services that includes case managers (excluding Dependency Case Management and medical case management). The transition must ensure Care Coordination may not exceed 90 days during which time both a case manager and a care coordinator may provide services to the same individual unless a longer duration is specifically approved by the Department. The transition plan shall be designed to ensure a warm hand-off and successful case management engagement.

III. IMPLEMENTATION

A. Managing Entity Responsibilities

The ME is responsible for system level care coordination and supporting Network Providers as they coordinate care at the person level. System level coordination includes the following activities:

1. Identifies individuals eligible for Care Coordination based on the priority populations identified in section II through surveillance/data runs from data submitted by Network Providers Collaborates with private receiving facilities to determine and/or confirm eligibility and referral process for those meeting criteria

2. Initiates referral to appropriate Network Provider and provides supporting documentation obtained through the data surveillance process or from private receiving facilities.

3. System level Care Coordinator activities include:

a) Evaluates eligibility of individuals identified as meeting criteria; including determination if the person is enrollment in any program that will disqualify them from meeting criteria.

b) Submit completed Care Coordination Referral Form

c) Staff referrals and provides information as appropriate

d) Tracks and ensures receipt of referral disposition within reasonable time frame:

i. acknowledgement of receipt and approval of the referral within 72 hours of having received referral

ii. Final disposition of referral within 30 days of referral submission

iii. Successful and successful discharges

4. Participate in team meeting and/or other weekly contacts with the Network Provider.

5. Monitor and support Network Provider's engagement, enrollment and timely service initiation for persons referred.

6. Facilitate communication and collaboration of Network Providers with other contracted and non-contracted providers, traditional and non-traditional community-based resources.

7. Track individuals enrolled in Care Coordination through data to monitor including but not limited to:

a) Readmission rates for individuals served in acute care settings;

b) Length of time between acute care admissions;

c) Length of time an individual waits for admission into a SMHTF;

d) Length of time an individual waits for discharge from a SMHTF; and

e) Length of time from acute care setting and SMHTF discharge to linkage to services in the community.

8. Manage Care Coordination funds and purchase services based on needs identified by Network Providers.

9. Track service needs and gaps and redirect resources as needed, within available resources.

10. Assess and address quality of care issues, including fidelity review of adherence with Critical Time Intervention (CTI).

11. Review NSP contracts to effectively track the correct implementation of CTI; with the ability to issue corrective action if determined that the model is not being properly implemented.

12. Ensure provider network adequacy and effectively manage resources.

13. Develop diversion strategies to prevent individuals who can be effectively treated in the community from entering SMHTFs.

14. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice systems, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.

15. Provide technical assistance to Network Providers and assist in eliminating system barriers.
16. Work collaboratively with the Department to refine practice.
17. Implement a quality improvement process to establish a root cause analysis when Care Coordination fails.

B. NETWORK PROVIDER RESPONSIBILITIES

The Network Provider will implement the delivery of Care Coordination services through the implementation of Critical Time Intervention as the service delivery model.

Critical Time Intervention (CTI) is an intensive 9-month care coordination model designed to assist adults age 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. CTI promotes a focus on recovery, psychiatric rehabilitation, and bridges the gap between institutional living and community services. CTI differs from traditional case management because it is time limited, focused, and follows a three phased approach. Unlike some other models, timing of movement through the phases is defined by the program model, not the readiness of the individual.

As an evidence-based practice there are four core principles that define CTI and set it apart from other services:

1. Focuses on a critical transition period, and is time-limited
2. Enhances continuity of care and prevents recurrent homelessness and hospitalizations.
3. Identifies and strengthens formal and natural community supports.
4. Complements rather than duplicates existing services.

CTI assist individuals not connected to other community-based services navigate critical transitions and meeting their needs. Critical transitions are, among other circumstances, discharge from psychiatric inpatient settings and transitioning from residential setting to independent living. CTI activities aim to prevent the reoccurrence of status that qualified the person for a referral to care coordination services.

CTI is divided into three identified phases lasting three months each, not including Pre-CTI.

Pre-CTI: Consist of outreach activities aimed to establish a relation and develop rapport with the person served. Pre-CTI services begin before an individual is discharged from a hospital or other institution in order to establish an initial relationship before the transition begins. Pre-CTI can also be used with an individual who is homeless prior to the individual moving into housing.

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Phase	Transition	Try-out	Transfer of Care
Timing	Months 1-3	Months 4-6	Months 7-9
Purpose	CTI provides assessment of social and health needs and develops and implements an individualized service plan to address immediate needs related to critical transition. In this phase, there is frequent contact with the individual in the community, focusing on active engagement with behavioral health services, and identifying and addressing housing-related issues in order to prevent future episodes of homelessness or housing instability. A transition plan is implemented while providing emotional support.	CTI supports an individual's engagement and effective participation in their own support system. Facilitates and tests the individual's new problem-solving skills. In this phase, the team increasingly encourages individuals to manage problems independently after connecting them to supportive services.	CTI remains available to solve problems in collaboration with the individual, and his/her providers and natural supports prior to discharge. This phase, promotes the transfer from CTI to other community supports, both formal and informal and termination of CTI services occurs with a support network safely in place.
Activities	CTI worker engages the individual. This includes making home visits or visits in the community including in shelters or on the street, introducing the individual to providers, and meeting with caregivers, helping the individual negotiate ground rules for relationships, mediating conflicts, and assess the potential of the individual's support system. Focuses on urgent/basic needs such as food, immediate medical care, shelter, warm clothing or blankets, access to essential medications; Accompanies individuals to community providers; Forges connections to social service systems, and assists the individual to apply for available benefits as indicated (phone, food and nutrition benefits, Medicaid, Disability, etc.);	CTI worker monitors the effectiveness of the support network; Helps to modify network as necessary; Continues case management activities as necessary; Continues community-based visits; Provides psychoeducation about self-management and successful navigation of the service systems and Completes any Phase I activities that still need resolutions. Less frequent meetings and provides social crisis interventions and troubleshooting.	CTI worker provides consultation but little direct service. The worker lets the individual solve their own problems. The worker ensures key caregivers/providers meet and agree on long term support system. Reinforces the roles of support network members; Develops and begins to set in motion plan for long-term goals (e.g. employment, education, family reunification); May hold a party or some other ceremonial recognition of successful transition out of CTI services. A final meeting is held to formally recognize the end of interventions and relationship.

C. NETWORK PROVIDERS FUNDED TO PROVIDE CARE COORDINATION SERVICES ARE RESPONSIBLE FOR THE FOLLOWING ACTIVITIES FOR INDIVIDUALS THAT ARE RECEIVING SERVICES IN THE COMMUNITY:

The Network Provider will:

1. Serve as single point of accountability for the coordination of an individual's care with all involved parties (i.e., criminal or juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
2. Conduct outreach and internal data surveillance to identify care coordination eligible candidates within their organization. Upon identification of care coordination eligible candidate, the Network Provider will self-refer and send referral for approval to the ME Care Coordination team.
3. Engage (Pre-CTI) the individual in their current setting, (e.g., crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, addiction receiving facility, etc.). Engagement should begin no earlier than 30 days from the person's expected discharge. Engagement (Pre-CTI) is critical to successfully establishing rapport with the person served. In addition, Pre-CTI offers an opportunity for the Network Provider Care Coordinator to obtain relevant clinical and personal information to assist the person in their transition to community-based care. Care Coordination serves the person in his/her environment. Individuals served should not be expected to come to the care coordinator
4. Maintains on-going communication with the ME Care Coordination team including:
    i. acknowledgement of receipt of the referral with submission back to the ME within 72 hours of having received referral
    ii. Final disposition of referral within 30 days of referral submission
    iii. Successful and successful discharges
5. Conduct at least seven engagement attempts, include multiple face-to-face attempts to locate or enroll a person. To maximize engagement opportunities Network Provider Care Coordinator will engage individuals before the transition to the community. If there is no contact with the referred individual after the required attempts, Network Providers are to complete a non-enrollment form to close the referral.
6. Develop an intervention plan (or Phase Plan) with the individual based on shared decision making that emphasizes self- management, recovery and wellness, including transition to community-based services and/or supports. Intervention plans goals should be very simple, addressing no more than 3 areas at a time and evolving with respect to the individual's progress, participation, and choices.
7. Provide frequent contact for the first 30 days of services upon enrollment, ranging from daily to a minimum of three times per week, and at least six community-based meeting per month for the other two months in Phase 1. Care coordinators should consider the individual's safety needs, level of independence, and their wishes when establishing the optimal contact schedule. This includes telephone contact or face-to-face contact (which may be conducted electronically). Leaving a voicemail is not considered contact. If the individual served is not responding to attempted contacts, the Network Provider must document attempts on the record and make physical and active attempts to locate and engage the individual.

8. Provide 24/7 on-call availability. The CTI team will pro-actively assist individuals in the prevention of social crisis episodes. The CTI team is not expected to be on call as a "first responder" for crisis events, but is expected to assist the individual in the development of a detailed crisis plan, and to assure that the plan is as widely distributed to key partners to the extent allowed by the individual.
9. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.
10. Assess the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, and public benefits, and assist them in obtaining eligible benefits. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Free training is available at: https://soarworks.samhsa.gov/course/ssissdi-outreach-access-and-recovery-soar-online-training.
11. For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the ME Care Coordination team.
12. Collaborate with the ME Care Coordination team to identify service gaps and request purchase of needed services not available in the existing system of care.
13. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
14. Providers of CTI services should utilize any tools, training, documents, forms, and learning opportunities provided by Thriving Mind.
15. Providers will ensure that any staff delivering care coordination completes, at a minimum, the Critical Time Intervention training provided by ME.
16. Ensure that caseload ratios are observed. The maximum caseload ratio for a full- time CTI worker is 1:20. The maximum caseload ratio for a full-time CTI Supervisor and a Peer Specialist is 1:10 each. Due to the varying level of intensity of work during each phase, admission to the team should be staggered to maintain a caseload of individuals who are in each phase.
17. Peer Specialist staff should have a minimum of two years working with a mental health population and be a Certified Peer Specialist or work towards certification with the support and assistance of the Network Provider.
18. CTI Supervisor should have extensive experience in the provision of service for the target population, preferably including clinical experience. In addition, to having experience in the provision of guidance, feedback, and training to team members to assure that quality services are provided to the individuals served and to maintain and facilitate the skills of the supervisee to assure all members of the team are utilizing and maintaining fidelity to the evidence-based CTI model.
19. CTI Teams meet weekly for supervision and to share practical strategies for working with individuals and their complex needs. Each meeting should include the following:
    a. Submit meeting invitations to the assigned Thriving Mind Care Coordinator.
    b. Report on previous week's activities, starting with the to do list from the last supervision meeting.
    c. Review any new cases/individuals referred to the CTI team.
    d. Reinforcement of CTI principles and practices.

e. In depth discussion of high priority cases, usually between 4-8 individuals. Additionally, each individual should be discussed at minimum once a month.

f. Plan for resolving barriers to implementation of CTI.

g. Make a "To Do List" for upcoming week.

D. CARE COORDINATION ALLOWABLE COVERED SERVICES

Pursuant to ch. 65E-14.014, F.A.C., Network Providers may not bill for services for individuals who have third party insurance, Medicaid, or another publicly funded health benefit coverage when the services provided are **paid** by said program. The Network Provider will delivery care coordination services as allowable and in ch. 65E-14.021, F . A . C . :

The Network Provider funded for Care Coordination agrees to invoice/document Care Coordination services under the following allowable covered services:

1. Outreach - allows the Network Provider to provide engagement and supervision activities associated with the model without requiring it to be direct client services events.
2. Intervention – allows the Network Provider the capture client specific service events without requiring the person to complete an "Intake" at the Network Provider agency. It also allows for the provider to maintain their services even when person served is referred and enrolled with another provider of service.
3. Recovery Supports – allows the Network Provider to deliver and measure the impact of peer services in the outcome of the intervention.

E. DATA COLLECTION AND MANAGEMENT

1. Care Coordination is a bundled service approach that is reported through an expenditure Other Cost Accumulator in accordance with DCF FASAMS Pamphlet 155-2, or project code, and using the following service modifier codes in the Modifier 2 field:

Modifier Code	Assigned OCA - Short Description
DO	MHOCN – Care Coordination
DV	MSOCN – Care Coordination SA
AS	MHCAS – Children's Care Coordination
SA	MSCAS – NAS/SEN Care Coordination

2. Only the covered services specified in this Exbibit in Section III, D, Care Coordination Covered Service may be reported using the modifier codes identified for Care Coordination.

3. Care Coordination Monthly Report shall be submitted to the ME Care Coordination Department by the 5th of the month for the previous month reporting period. Submission must be encrypted and/or password protected.

F. SOAR APPLICATIONS

SOAR application data (protected filing, approval or denial dates, etc.) will be submitted through the Online Application Tracking (OAT) system as outlined in **Exhibit AN, Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)**. For access/registration questions, please contact soaroat@prainc.com.

G. REPORTING REQUIREMENTS

1. **Monthly Care Coordination Monthly Reports (Narrative and Chart)**: The Network Provider must submit Care Coordination Monthly **Reports** using the Templates provided in this Exhibit by the 5th of every month for data from the previous month. The Network Provider will submit the monthly report to the individuals listed in **Exhibit C, Required Reports**.

2. **Ad Hoc Reports**: The Network Provider agrees to submit any ad-hoc and/or additional reports as determined necessary by the ME, Department of Children and Families and/or Miami-Dade County.

H. MEETINGS/TRAININGS

1. The Network Provider will ensure that its staff is properly trained on CTI model, goals and objectives, evidence-based practices and screenings.

2. The Network Provider shall meet with the ME's staff at regularly scheduled or specially called meetings and/or trainings when notified by the ME.

I. RESOURCES

Network Providers are encouraged to research the following list of promising practices in Care Coordination as examples of effective implementation.

a. **Recovery Support Bridgers/Navigators**

Certified Recovery Peer Specialists (CRPS) are utilized to assist individuals successfully transition back into the community following discharge from a SMHTF, CSU or Detox. The CRPS engages the individual while still inpatient and provides support and information on discharge options. They participate in discharge planning and assist the person in identifying community-based service and support needs and build self- directed recovery tools, such as a Wellness Recovery Action Plan (WRAP). The CRPS then supports the individual as they transition to the community. More information on WRAP may be accessed at: http://mentalhealthrecovery.com/

b. **Care Transition Programs®**

This intervention utilizes a Transition Coach to preferably meet an individual in the acute care setting to engage them and their family (as appropriate) and sets up in-home follow up visits and phone calls designated to increase self-management skills, personal goal attainment, and provide continuity

across the transition.[1] More information on the Care Transition Programs may be accessed at: http://caretransitions.org

c. **Medical Homes**

The Agency for Healthcare Research and Quality defines the medical home as a model of the organization of primary care that delivers the functions of primary health care with the following attributes:

i. Comprehensive Care – the medical home is accountable for meeting the individual's physical and mental health needs, which requires a team of care providers.

ii. Patient-Centered – the medical home partners with patients and their families, respecting each person's unique needs, culture, values, and preferences.

iii. Coordinated Care – the medical home coordinates care across all elements of the broader health system, including community services and supports.

iv. Accessible Services – a medical home delivers services in shorter wait times, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team.

v. Quality and Safety – a medical home uses evidence-based medicine and clinical decision support tools to guide shared decision making with patients and families, engaging in performance and improvement.2

In Indiana, WellPoint Health Plan medical homes for persons with high-service use decreased emergency department utilization by 72% and decreased controlled substance prescriptions by 38% in the 6 months pre- and post-program. Medical homes for people with substance use issues can also be a key intervention for super-utilizer programs – in Michigan, an integrated medicine clinic addressing super-utilizers with mental health and substance abuse needs decreased emergency department visits by over 50% among highest utilizers.

d. **Behavioral Health Homes**

The SAMHSA – HRSA Center for Integrated Health Solutions has proposed a set of core clinical features of a behavioral health-based health home that serves people with mental health and substance use disorders, with the belief that application of these features will help organizations succeed as health homes. This resource may be accessed at:

https://www.thenationalcouncil.org/integrated-health-coe/resources/

e. **Reducing Avoidable Readmissions Effectively**

The RARE Campaign in Minnesota was established to improve the quality of care for persons transitioning across care systems and to reduce avoidable readmissions by 20%. Five areas were identified as a focus of these efforts:

i. Patient/Family Engagement and Activation,

[1] See, http://caretransitions.org/about-the-care-transitions-intervention/, site accessed October 14, 2015
[2] See, https://pcmh.ahrq.gov/page/defining-pcmh, site accessed October 14, 2015.

ii. Medication Management,

iii. Comprehensive Transition Planning,

iv. Care Transition Support, and

v. Transition Communication

For more detail, the RARE Campaign published recommendations on actions to address the above areas of focus which can be accessed at:

https://www.rarereadmissions.org/areas/index.html

f. Telehealth

The use of technology presents another promising practice in coordinating care, specifically as it related to access. As an example, the Department of Veterans Affairs (VA) piloted a Care Coordination/home telehealth initiative that continually monitored veterans with chronic health conditions. Vital signs and other disease management data was transmitted to clinicians remotely located. The pilot reported reductions in hospital admissions and length of stay.[3]

g. Wraparound

Wraparound is an intensive, individualized care planning and management process for individuals with complex needs, most typically children, youth, and their families. The Wraparound approach provides a structured, holistic, and highly individualized team planning process which includes meeting the needs of the entire family. The philosophy of care begins with the principal of "voice and choice", which stipulates the child and family perspective and drives the planning. The values further stipulate that care be community- based and culturally and linguistically competent. The staff to family ratio typically does not exceed one Wraparound facilitator to ten families. More information on Wraparound may be accessed at: http://nwi.pdx.edu/

[3] IOM (Institute of Medicine). 2010. The healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press

Exhibit AC
Monthly Care Coordination Report - Narrative

Region of Service: _____ Circuits: _____

Managing Entity: _____ Report Period: _____
Month/Year

This report serves to track the progress of care coordination activities statewide. Please do not repeat information, if you answered a question in previous months and nothing has changed, mark "No Changes".

If applicable, describe a success story: ☐ N/A

_____
_____
_____

Care Coordination Practices

Describe the evidence-based or innovative practices you are implementing: ☐ No Changes

_____
_____
_____

What standardized level of care determination are your providers using?

☐ ASAM ☐ LOCUS ☐ Other: _____

How many individuals in Baker Act Receiving Facilities who were either on a court order or voluntary status awaiting transfer to a SMHTF did you divert during this reporting period? Briefly describe diversionary strategies, provider partnerships, and other resources utilized:

_____

List any new partnerships established in the reporting period (i.e., Memoranda of Understandings, Referral Agreements, Data Sharing Agreements, common assessments, etc.): ☐No Changes

_____
_____

Describe any service gaps or barriers identified and how they are being resolved (i.e., redirection of resources, purchase of out of network services, etc.): ☐No Changes

_____
_____

Describe how contracted network service providers are implementing care coordination practices: ☐No Changes

_____
_____

Describe SOAR activities: ☐ Are SOAR applications reported in OAT
For this reporting period, how many SOAR applications are:_____Pending_____Approved_____Not Eligible
Reasons for ineligibility (i.e., immigration status) _____

_____

How many individuals who are homeless or at risk of homelessness were housed? List types of housing resources utilized (i.e., Permanent, transitional, ALF, supportive housing, etc.)

_____

_____

If applicable, list training needs: ☐No Changes

_____

_____

Acronyms

ASAM	American Society of Addiction Medicine
LOCUS	Level of Care Utilization System
OAT	Online Application Tracking
SOAR	(SSI/SSDI) Outreach, Access & Recovery
CSU	Crisis Stabilization Unit (for purposes of this document includes facilities providing inpatient and crisis stabilization services under the Baker Act)

REVISED EXHIBIT AC

South Florida Behavioral Health Network Care Coordination Report - Chart

Provider:
Reporting Period:

Priority Populations below are defined in Guidance 4 of the ME contract	# of referrals received	# of individuals in the engagement process during the reporting period (not yet enrolled) *	A .# of individuals enrolled at beginning of the reporting period **	B. # of individuals newly enrolled during reporting period	C. # of individuals discharged during reporting period (out of those that were enrolled)	D. Total # of individuals enrolled at the end of reporting period (A + B – C)	E. Total # of individuals served to date	# of individuals identified as homeless	# of individuals involved in Child Welfare
3 or more acute care admissions within 180-day period									
3 or more detox admissions within 180-day period									
Acute care stay of 16 days or more within 180 day period									
Detox stay of 16 days or more within 180-day period									
Individuals discharged from SMHTF									
Individuals awaiting placement in SMHTF									
Other population as approved:									
Other population as approved:									
Total									

MDC138

* Individuals in the engagement process are those individuals that are identified as meeting Care Coordination criteria who have not yet received services under Care Coordination.
** Individuals enrolled in Care Coordination are those individuals that are receiving services under Care Coordination.

Revised Exhibit AO
Peer Services

Peer Support Specialists (as defined in s. 397.311(30), F.S.) and Recovery Management practices (as described in Exhibit BH, Recovery Management Practices) have become an integral part of recovery services. . The state of Florida has committed to delivering behavioral health services in a recovery-oriented and peer involved approach. A Peer Specialist is a person who uses their lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency [SAMHSA.gov]. A Peer Support Specialist may go by different names (e.g. life coach, recovery coach, recovery support specialist, peer-bridger, etc.) nevertheless they perform similar duties. The primary activities of peer specialists are to provide support and advocacy, role model recovery, and facilitate positive change, while working alongside the treatment team if applicable. Peer support is voluntary, mutual and reciprocal, equally shared power, strengths-focused, transparent, and person driven [National Practice Guidelines for Peer Supporters – International Association of Peer Supporters].

The requirements in this exhibit applies to all Network Providers providing peer support services funded by this contract.

NETWORK PROVIDER RESPONSIBILITIES

1. Employee Orientation for Peers: The Network Provider must provide standardized training on Recovery Management best practices in employee orientation and refresher trainings, as required by Exhibit BH, Recovery Management Practices.

2. Assessment Tools: Peers must use the Recovery Capital Scale available at https://facesandvoicesofrecovery.org/resource/recovery-capital-scale/ in the recovery planning process. The ME may require the Network Provider to report aggregate scores derived from the collection of Recovery Capital Scale tool. This information may be used to determine baseline data for the development of future performance measures.

3. Attain Client Consent: Initiate peer support services after voluntary consent when there is reason to believe such services will help the individuals served recovery, build resilience, or assist the individual to live successfully in their community with greater purpose.

4. Educate Peer Staff Regarding Community Resources: Peer Specialist can greatly assist individuals if the specialist is familiar with appropriate community resources that can advance the individual's recovery. Peers should be well integrated into the community to assist individuals served with the development of natural supports, community activities and employment.

5. Peer Specialist Education, Trainings, Seminars, and Committees: Peer Specialists must be allowed time for attending trainings and seminars that advance the practice of peer support and further

their professional development. They should also be allowed and encouraged to join committee meetings where their lived experience can be valued.

6. Document Peer Services Provided: Peer services must be documented in each client's clinical file, for example, development of wellness plans, WRAP Plans, the goals of the individual served, progress notes, linkages, etc. These plans should be updated regularly in consultation with the client to review progress and evidenced by proper documentation in the client file.

7. Maintain and Update Internal Policies and Procedures for Peer Services: These should include best practices and standards for delivering peer support services and supervision. Each Network Provider must solicit the input and opinions of Peer Specialists they have on staff when drafting or updating Internal Policies and Procedures. The Network Provider also must institute a process for Peer Specialists to provide perspective and input on all Policies and Procedures at any time; this process may include an online form for the Peer Specialist to complete.

8. Weekly Supervision: Weekly supervision meetings are required so case issues are addressed quickly, and also to make sure that the peer specialists are receiving supportive oversight for their own well-being.

9. Recovery Oriented: The peer must provide Recovery-Oriented care recognizing that each person must be the agent of and the central participant in their own recovery journey. All services and supports need to be organized to support the developmental stages of this process. Services should instill hope, be person- and family-centered, offer choice, elicit, and honor each person's potential for growth, build on a person's and family's strengths and interests, and attend to the overall quality of life, including health and wellness. These values can be the foundation for all services regardless of the service type.

10. Reporting Requirements: No later than the 10th of each month, the Network Provider must submit to the Managing Entity, the following monthly reports:

    A. Monthly Peer Support Employment Report -This report must be signed by the Peer Supervisor, which must include the following information:
        a. Number of Peers funded by the ME with Network Provider,
        b. Number of vacancies for Peer Specialists jobs,
        c. Position Title(s) and Program Name for current vacancies
        d. Duration of current Peer Specialist vacancies,
        e. Name of the Peer Specialist
        f. Certification Status
        g. Role/Title
        h. Status (full-time vs. part-time)
        i. Program Name

j. Number of persons served by each Peer Specialist,
k. Maximum recommended caseload for the Peer, and
l. Hours of Peer Supervision

B. **Monthly Peer Support Services Report** – This report should be completed by the Peer Specialist and signed by the Peer Supervisor.

a. Peer-to-Peer Contact
b. Groups
c. Treatment Team Staffing's
d. Outside Agency Staffing's
e. Trainings
f. Outreach
g. Trainings taken

C. The Network Provider shall submit any ad-hoc reports requested by the ME.

D. The reports must be submitted by the dates and to the individuals specified in **Exhibit C, Required Reports.**

11. ROSC Champion: By 08/02/2021, the Network Provider must submit the name and contact information of at least two IntegratedROSC Champions who will attend trainings and meetings. The information must be submitted to the individuals and by the dates listed in Exhibit C, Required Reports. One of the identified Champions should be a Peer Specialist who is providing peer services, if at all possible. In the event of change in staff occur, the Network Provider must notify the ME's Contract Manager, in writing within ten (10) calendar days.

a. Responsibilities of champion:
   i. Attendance at scheduled ROSC meetings including ROSC Steering Committee Workgroup meetings and peer or peer supervisor meetings conducted by the ME to continue the development and implementation of a recovery-oriented system of care.
   ii. Participation in all ROSC related activities to ensure staff and agency become knowledgeable of a Recovery-Oriented System of Care.
   iii. Participation in all Peer related activities to ensure staff and agency become knowledgeable of the role/supervision of peer supports.

Network Provider Compliance: Failure to meet the applicable standards established in Sections I and II shall be considered non-performance pursuant to **Standard Contract, Paragraph 8. Financial Consequences for Network Provider's Failure to Perform.**

I. MANAGING ENTITY RESPONSIBILITES

1. The ME must monitor the Network Provider's performance on all tasks identified in this Exhibit and issue corrective actions if deemed necessary.

2. The ME shall provide training and technical assistance when requested by the Network Provider.

REVISED EXHIBIT AV
TRANSITIONAL VOUCHER PROGRAM

DISCUSSION: The purpose of this document is to provide guidance for the implementation and management of the Transitional Voucher project. This project provides care coordination and vouchers to purchase treatment and support services for adults transitioning from Florida Assertive Community Treatment (FACT) teams, acute crisis services, and institutional settings to independent community living; and individuals experiencing homelessness, at risk for homelessness, or receiving care coordination services. Vouchers may also be utilized to assist eligible individuals maintain their current level of care by achieving residential stability.

I. GOALS

The Transitional Voucher project is a flexible, consumer-directed voucher system designed to bridge the gap for persons with behavioral health disorders as they transition from acute or more restrictive levels of care to lower levels of care. The intent of this project is to enable individuals to live independently in the community with treatment and support services based on need and choice and build a support system to sustain their independence, recovery, and overall well-being. The project aims to:

- Prevent recurrent hospitalization and incarceration,
- Provide safe, affordable, and stable housing opportunities,
- Maximize use of FACT resources and community supports,
- Increase participant choice and self-determination in their treatment and support service selection; and
- Improve community involvement and overall quality of life for program participants.

Transitional Vouchers provide a participant with a monthly budget to be spent on allowable services pursuant to Rule 65E-14.021, F.A.C. This service is intended to support Care Coordination efforts outlined in **Guidance 4 – Care Coordination**.

To access the Department's FY 22-23 Guidance Document 4, click on the link below:

https://www.myflfamilies.com/service-programs/samh/managing-entities/index.shtml

Note: Click on FY22-23 ME Templates and click on Guidance Document 4, Care Coordination

"Voucher" refers to any electronic or paper record documenting a Network Service Provider's agreement to pay a third party for allowable services provided to an eligible program participant. This project offers time-limited financial assistance to support consumer-driven services based on the person's needs assessment and care plan objectives. The use of vouchers requires shared decision making in planning and service determinations, emphasizing self- management. Care Coordinators provide options and choices such that the care plan reflects the individual's values and preferences.

This project has two funding and implementation components. The first component targets FACT participants and individuals discharging from a state mental health treatment facility (SMHTF) back to

their regions; the second targets additional individuals in need of specialized community integration supports.

II. FACT AND SMHTF TARGETS

This component satisfies the terms of a settlement agreement entered into by the Department and Disability Rights Florida and amended on July 27, 2018.[1] The settlement agreement requires the Department to develop a project designed to more fully utilize existing FACT resources and create additional opportunities for community integration of individuals being discharged from SMHTFs. This component is intended to transition approximately 96 FACT participants each fiscal year to less intensive community-based services and supports, allowing persons referred from SMHTFs to fill the vacated slots, if appropriate. Other allowable options for individuals discharging from SMHTFs using Transitional Voucher funds are to adult family care homes with community-based services and directly into permanent supported housing with community-based services.

Managing Entities and Network Service Providers shall select FACT participants determined to be clinically and functionally ready for lower levels of care ready to transition out of FACT services. Considerations for transition readiness include, at a minimum, the individual's choice, their ability to self-manage, and the availability of a natural support system. Transition is gradual, individualized and actively involves the participant and the next provider to ensure effective coordination and engagement.

Each Network Service Provider FACT team shall accept individuals referred for discharge from SMHTFs to replace individuals selected to receive Transitional Voucher services.

III. COMMUNITY INTEGRATION TARGETS

Research indicates that a combination of long-term housing, treatment, and recovery support services leads to improved residential stability and reductions in substance use and psychiatric symptoms[2]. The Transitional Voucher project is intended to assist eligible individuals obtain and maintain accessible, affordable housing with supportive recovery services. Each Managing Entity shall approve individuals who meet Transitional Voucher eligibility requirements. Persons eligible for services under this component must be currently receiving Department-funded SAMH services pursuant to Chapters 394 and 397, F.S., and must meet one the following alternative characteristics:

A. Experiencing homelessness, meaning an individual who lacks housing, including:

1. An individual whose primary overnight residence is a temporary accommodation provided by a supervised public or private facility, or

2. An individual who resides in transitional housing, or

3. An individual at risk for homelessness; for example: *an individual whose only housing option is shelter due to lack of affordable housing opportunities.*

[1] T.W., P.M. and Disability Rights Florida v. Michael Carroll, Department of Children and Families (Case No. 4:13-CV-457 RFUCAS) Settlement Agreement, Amended July 27, 2018

[2] Substance Abuse and Mental Health Services Administration, Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014. HHS Publication No. (SMA) 11-4629. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

4. Vouchers may also be utilized to assist eligible individuals maintain their current level of care by achieving residential stability.

Or

B. Receiving Care Coordination services pursuant to **Guidance 4.**

Or

C. Participating in FACT teams and ready to transition to a lower level of care.

Or

D. Discharging from SMHTFs to adult family care homes or directly into permanent supported housing with community-based services.

IV. REQUEST PROCESS

A. The Care Coordinator or Case Manager at the provider will ensure that services and/or supports requested cannot or are not funded through any other source. The Network Provider must exhaust all other funding alternatives before submitting a funding request to the ME. Steps taken with alternative sources must be documented in the individual's file/chart.

B. A Funds Request Form and Treatment/Service Plan should be submitted to the ME's Housing Coordinator or designee to the following email address: housing@sfbhn.org. All supports and services requested and authorized must directly address specific need to achieve goals on the current service plan or treatment plan when applicable.

1) If requesting assistance for individuals exiting a state treatment facility the State Hospital Transitional Voucher Funds Request Form must be used, attached herein as Appendix 1.

2) For all other requests, the Transitional Voucher Funds Request Form must be used, attached herein as Appendix 2

C. If requesting assistance with payments for an ALF, the following is required:

1) A copy of the AHCA Facility Finder ALF page indicating active LMH License. If ALF does not have an LMHL please include justification for other specialty license(s).

2) Description of actions that will be taken to sustain funding, including a plan of self-sustainability with an estimated end date. i.e. SSA Benefits pending (include application date), SSA Benefits suspended (date will be taken to SSA for reinstatement), Being assessed for SOAR process (date of assessment), etc.

D. The ME's Housing Coordinator or designee will review funding requests and make a determination of approval or denial of funding within 3 business days of receipt of the request. If necessary, the ME Housing Coordinator will contact the referral source to staff a case prior to approval or denial.

E. The ME Housing Coordinator or designee shall notify the Care Coordinator or Case Manager of the decision to approve or deny funding via email.

V. ALLOWABLE EXPENSES

A. Transitional Voucher services may be authorized only to the extent that they are reasonable, allowable, and necessary as determined through the assessment process; are clearly identified in the individual's service plan or treatment plan when applicable; and only when no other funds are available to meet the expense.

1) Transitional Vouchers will be approved for no more than a three (3) month period. Each month requires a new voucher request and ME approval,
2) All fund requests must be submitted to the ME for prior approval.

B. The person served is the primary decision maker as to the services and supports to be purchase and from what vendor those services are procured.

C. Allowable expenses include the following Covered Services as defined by ch. 65E-14.021, F.A.C.:

1) Aftercare;
2) Assessment;
3) Case Management;
4) Day Care;
5) Day Treatment;
6) Incidental Expenses;
7) In-Home and On-Site;
8) Intensive Case Management;
9) Intervention;
10) Medical Services;
11) Medication-Assisted Treatment;
12) Outpatient;
13) Recovery Support;
14) Respite Services;
15) Substance Abuse Outpatient Detoxification;
16) Supported Employment
17) Supportive Housing/Living

D. Allowable Incidental Expenses include time limited transportation, childcare, housing assistance, clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the Managing Entity in compliance with Rule 65E-14.021, F.A.C.

E. Network Service Providers adhere to:

1) State purchasing guidelines for allowable expenses as promulgated by the Department and the Department of Financial Services
2) The requirements of Chapter 65E-14, F.A.C., and
3) Managing Entity protocols regarding allowable purchases.

VI. NETWORK SERVICE PROVIDERS RESPONSIBILITIES

A. The Care Coordinator or Case Manager will verify that the funds requested directly address specific needs to achieve goals on the individual's current Service Plan.

B. The Care Coordinator or Case Manager will ensure Transitional Voucher funds are used only for services and supports that cannot be paid for by another funding source; specifically:

a) Network Providers and participants are responsible for locating other non-SAMH payor sources for services or supports prior to using Transitional Voucher funds.
b) In collaboration with the participant, Network Providers must certify no other payer source is available and due diligence was exercised in searching for alternative funding prior to the use of Transitional Voucher funds. Network Providers must submit a signed certification for each use of Transitional Voucher funds with the monthly invoice.

C. Establish accurate record keeping that reflects specific services offered to and provided for each participant.

D. Approve Transitional Voucher invoices and expenditures for services provided by non-Network Service Providers.

E. The Care Coordinator or Case Manager must maintain in the individuals' file a record of all individual expenses charged against the funds.

F. The Care Coordinator or Case Manager will provide the following documents in a timely manner:

a) Transitional Voucher request form with the individual's service plan or treatment plan. All supports and services requested must directly address specific needs to achieve goals on the current service plan or treatment plan.

b) Documents with attempts made to use alternative sources of funding.

G. All Transitional Vouchers must be coded with the appropriate modifier:

a) For Substance Abuse use modifier: DS
b) For Mental Health use modifier: DM

H. All invoices and supporting documentation must be submitted to the ME by the 8th of the month. Any voucher that has not been invoiced to the ME within 45 days from the approval date will be voided, and the approved amount will return to available transitional voucher funds. The Network Provider must ensure the service data is entered in FASAMS during the service month and coded with the

appropriate modifier. The service data must be less or equal to the approved voucher amount. Any discrepancies in service data will delay payment of the invoice. It is the responsibility of the Network Provider to update service data and resubmit invoice for reimbursement.

VII. ME RESPONSIBILITIES

A. For all voucher requests:

1) The ME will review the completed transitional voucher request form along with all supporting documents (i.e. service plan, treatment plan, lease agreement, etc.) for authorization.

2) The ME Housing Coordinator will provide authorization or denial to the Care Coordinator/Case Manager requesting the funds within three (3) business days via email. In case of a denial, an email will be sent with reason(s) for denial. Should the ME Housing Coordinator not be available, the ME Housing Peer or Care Coordinator Lead will provide authorization or denial for transitional vouchers within three (3) business days.

3) The ME will conduct service data validation using FASAMS service data. Service data for each invoice must be equal or less to the ME Voucher approved amount. Invoice not matching approved amount, or without service data, will not be approved for payment. The ME will inform the provider of the denial and reason for denial.

B. For all voucher reporting:

1) The ME Housing Coordinator, or designee, will keep track of the voucher requests and funding approvals.

2) The ME Housing Coordinator or monitoring team may periodically request individual files for auditing purposes.

3) Upon completion of the monthly review, the Network Provider will be notified of any discrepancies and the invoice will be adjusted accordingly.

4) The Network Provider shall adhere to the requirements identified in the Department's Transitional Voucher **Guidance Document 29, dated 7/1/2022,** or the latest revision thereof.

To access the Department's FY 22-23 Guidance Document 29, click on the link below:

https://www.myflfamilies.com/service-programs/samh/managing-entities/index.shtml

Note: Click on FY22-23 ME Templates and click on Guidance Document 29, Transitional Voucher

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A network of exceptional mental health and substance use providers.

Appendix 1
State Hospital Transitional Voucher (TV) Funds Request Form

Date of TV Submission: _____ Date of Expected Discharge: _____

Agency / Provider: _____

Funds requested by / Title: _____

Phone number: _____ Fax number: _____

Email address: _____

Individual's Name: _____

Date of Birth: _____ Sex: _____ SSN: _____

Recommended Discharge Environment: _____

Description of goods or services being requested, plan for self-sustainability:

_____

_____

_____

_____

_____

Required Additional Documentation	Choose One that Applies:
□ Attached copy of AHCA Facility Finder ALF page indicating LMH License (if applying for ALF funding) □ Attached signed consent form □ Copy of the Transition/Discharge Plan □ Completed Care Coordination Enrollment Form	□ SSA Application Date: _____ □ SSA Appointment Date for Benefits Reinstatement: _____ □ SOAR Screening Date: _____ □ Other: _____

Amount requested: _____ One time request: ☐ Yes
☐ No, Estimated end date: _____

Funding source: ☐ Mental Health ☐ Substance Abuse

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CERTIFICATION: I here certify that the information above is accurate and that this request is for appropriate therapeutic reasons which have been documented in the consumers' service and treatment plans. In collaboration with the above named participant, I certify that no other payer source is available and due diligence was exercised in searching for alternative funding prior to the use of the Transitional Voucher funds.

Form completed by: _____ Title: _____

Signature: _____ Date: _____

AUTHORIZATION OF SERVICES: (SFBHN USE ONLY)

Approved by: _____ Date: _____

Signature: _____ Title: _____

Authorization number: _____ DCF Approval Date: _____

OCA: ☐ Mental Health MHTRV ☐ Substance Abuse MSTRV

Not approved by: _____ Date: _____

Reason not approved:

_____

_____

_____

Signature: _____ Title: _____

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Appendix 2
Transitional Voucher
Funds Request Form

Date: _____ Agency / Provider: _____

Funds requested by / Title: _____

Phone number: _____ Fax number: _____

Email address: _____

Individual's Name: _____

Date of Birth: _____ Sex: _____

SSN: _____

Does the consumer fall under any of the following categories?

☐ Care Coordination ☐ Homeless/or at risk

☐ FACT Team

Description of goods or services being requested:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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The assistance requested is for (please check one):

☐ Housing Assistance	☐ Childcare
☐ Clothing	☐ Transportation (Bus passes, bicycles, airfares)
☐ Educational Services	
☐ Vocational Services	
☐ Medical Care (Medication, doctor visits)	
☐ Housing Subsidies (Utility bills, furniture, toiletries)	
☐ Other Incidentals	

Amount requested: _____ One time request: ☐ Yes ☐ No

Funding source: ☐ Mental Health ☐ Substance Abuse

CERTIFICATION: I here certify that the information above is accurate and that this request is for appropriate therapeutic reasons which have been documented in the consumers' service and treatment plans. In collaboration with the above named participant, I certify that no other payer source is available and due diligence was exercised in searching for alternative funding prior to the use of the Transitional Voucher funds.

Form completed by: _____ Title: _____

Signature: _____ Date: _____

AUTHORIZATION OF SERVICES: (SFBHN USE ONLY)

Approved by: _____ Date: _____

Signature: _____ Title: _____

Authorization number: _____

OCA: ☐ Mental Health MHTRV ☐ Substance Abuse MSTRV

Not approved by: _____ Date: _____

Reason not approved:

_____

_____

_____

Signature: _____ Title: _____

Revised Exhibit BH
Recovery Management Practices

The Network Provider must operate under the principles of a Recovery Oriented System of Care (ROSC). ROSC principles promote a coordinated network of community-based services and supports that is person-centered, self-directed care, and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life. As such, the Network Provider should operate under a "no wrong door" model as defined in s. 394.4573, F.S., as well as the other guiding principles of ROSC. The Network Provider must participate in all implementation activities and Technical Assistance provided by DCF and the ME.

The purpose of this document is to provide direction and recommendations for implementation of Recovery Management practices in Network Service Providers in accordance with the guidelines is this document and in the Department's Guidance Document 35, Recovery Management Practices, dated July 1, 2022, or the latest revision thereof, herein incorporated by reference. These practices are accomplished using Florida's Recovery-Oriented System of Care (ROSC) Framework. This document provides best practice standards to transform delivery of care to one that focuses on sustainable wellness and recovery.

I. DEFINITIONS

A. Peer Specialist: As defined in s. 397.311(30), F.S.

B. Recovery: As defined in s. 397.311(37), F.S.

Through key stakeholder engagement, SAMHSA developed the following working definition of recovery.[1]

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

This definition describes recovery as a process, not an end state. Complete symptom remission is neither a prerequisite of recovery nor a necessary process outcome. Recovery can have many pathways including professional clinical treatment and use of medications; family, school, and faith-based supports; peer support and other approaches. Four major dimensions support a life in recovery:

1. Health: Learning to overcome, manage, or more successfully live with symptoms; and making health choices that support one's physical and emotional wellbeing.

2. Home: A safe, stable place to live.

3. Purpose: Meaningful daily activities such as, work, school, volunteer activities, or creative endeavors; an increased ability to lead a self-directed life; and meaningful engagement in society.

4. Community: Relationships and social networks providing support, friendship, love, and hope.

C. Recovery Management (RM): A philosophical framework for organizing treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality-of-life enhancement for individuals and families affected by behavioral health disorders.[2]

D. Recovery-Oriented: Recovery-Oriented care recognizes that each person must be the agent of and the central participant in their own recovery journey. All services and supports need to be organized to support the developmental stages of this process.

Services should instill hope, be person and family-centered, offer choice, elicit and honor each person's potential for growth, build on a person's and family's strengths and interests, and attend to the overall quality of life,

1 (Recovery, 2010)

2 White, W. (2008). *Recovery management and recovery-oriented systems of care*. Chicago: Great Lakes Addiction Technology Transfer Center, Northeast Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

including health and wellness. These values can be the foundation for all services regardless of the service type.

E. Recovery-Oriented system of care (ROSC): A value-driven framework to guide transformation of a behavioral health system of care. The framework structures behavioral health systems to involve a network of clinical, nonclinical services, and supports that sustain long-term, community-based recovery. Formal and informal service networks are developed and mobilized to sustain long-term recovery for individuals and families impacted by behavioral health disorders. ROSC reflects variations in each community's vision, institutions, resources, and priorities. The "system" is not a treatment agency but a macro-level organization of a community, a state, or a nation.

F. Recovery Capital: Recovery capital is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery.

G. Recovery Support: As defined in s 397.311(40), F.S.

H. Support Services: As defined in s. 394.67(16)(c), F.S.

II. ROSC TRANSFORMATION OVERVIEW

Based on the Department's Florida Substance Abuse and Mental Health Plan Triennial State and Regional Master Plan[3], Florida's behavioral health, recovery-oriented transformation includes:

A. Action-Oriented Priority Areas to Foster:

1. **Collaborative Service Relationship** indicated by a mutual service relationship between the provider and the service recipient that shift from a hierarchy model to the shared decision-making process and best practices that support the service recipients.
2. **Cross-system Partnerships** indicated by strategically leveraging resources and working across sectors to achieve common goals.
3. **Community Integration** indicated by assertively connecting service recipients to natural community-based resources to promote development of interest, skills, and supportive relationships.
4. **Community Health and Wellness** indicated by a focus on prevention, early intervention, wellness and increased recovery capital through targeted community education, strategic partnership development, and improved connections between system and local communities.
5. **Peer-based Recovery Support** indicated by increasing access to peer-based recovery support services.

B. Goals of a Recovery-Oriented System of Care

1. Promote good quality of life community health and wellness for all.
2. Prevent the development of behavioral health conditions.
3. Intervene earlier in the progression of illnesses.
4. Reduce the harm caused by substance use disorders and mental health conditions on individuals, families, and communities.
5. Provide the resources to assist people with behavioral health conditions to achieve and sustain their wellness and build meaningful lives for themselves in their communities.

[3] Florida Substance Abuse and Mental Health Plan, Triennial State and Regional Master Plan, Fiscal Years 2019-2022, Department of Children and Families, Office of Substance Abuse and Mental Health, May 30, 2019

C. Best Practice Standards as defined in Table 1.

D. Performance Arenas for Quality Improvement Monitoring.

The practices below are aligned with the Department's Recovery Oriented Quality Improvement Monitoring process and protocols produced by Florida Certification Board.

1. **Meeting Basic Needs** indicated by assessment, planning and delivery of all services to first address basic needs.
2. **Comprehensive Services** indicated by treatment and recovery supports that provide for a variety of treatment and recovery support modalities.
3. **Medication Assisted Treatment** where applicable indicated by the provision of information on psychotropic medication and medication-assisted treatment (MAT).
4. **Strength Based Approach** indicated by treatment delivery and planning that are fundamentally oriented toward individual's strengths rather than deficits.
5. **Customization and Choice** indicated by the planning and delivery of all services and supports are designed to address the unique circumstances, history, needs, expressed preferences, and capabilities of individuals receiving services.
6. **Opportunity to Engage in Self-Determination** indicated by the level of involvement of the individual determining treatment approaches and other recovery-oriented services.
7. **Network Supports and Community Engagement** indicated by active efforts in the planning and delivery of services to involve environmental supports in the individual's treatment and overall recovery that promotes community integration.
8. **Recovery Focus** indicated by providing services that are centered on helping individuals to achieve recovery goals and ensuring ongoing and seamless connections with services and supports.

E. Potential Practice Changes as described in Table 1.

The Department's goal is to transform its publicly funded behavioral health services to a more recovery-oriented system. The Department also acknowledges regional and community variances in terms of visions, institutions, resources, and priorities. Due to these variations, transformation practices discussed here are not proscriptive of best practice standards and the Department does not expect that all practices will be executed in every region or community. Specific regional best practices will be directed by each Managing Entity in consultation with the Department and key stakeholders. **Table 1** includes a list of best practice standards and changes in practice.

Table 1 ROSC Implementation Crosswalk

Best Practice Standards	Performance Arenas for Quality Improvement Monitoring	Potential Practice Changes
Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.	**Meeting Basic Needs**	***Conduct Global Assessments:*** Use holistic, culturally relevant assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.
Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development). **Service Dose and Duration:** Dose and duration of total services will increase while number and duration of acute care episodes will decline; emphasis shifts from crisis stabilization to ongoing recovery coaching; great value placed in continuity of contact in a primary recovery support relationship over time. **Post-treatment Checkups and Support:** Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention.	**Comprehensive Services**	***Promote Retention:*** Enhance rates of service retention and reduce rates of service disengagement and administrative discharge by utilizing outreach workers, enhancing peer-based recovery support services in the treatment context, providing culturally competent services, providing a menu of service options so that care is individualized, and incorporating family members and other important allies as desired. Develop assertive approaches to helping people remain connected to natural community-based supports.
		Expand the Focus of Services and Supports: Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing. Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.
		Ensure a Sufficient Continuum of Care with Appropriate Dose/Duration of Services: Provide doses of treatment services across levels of care that are associated with positive recovery outcomes. Facilitate continuity of contact in a primary recovery-support relationship over time and across levels of care.
		Develop strong cross-system partnerships to achieve common goals: Build meaningful collaborations across systems such as criminal justice, behavioral health, child welfare, housing, public health, education, transportation, to strategically leverage resources and achieve intersecting goals.
		Increase Service Access: Assure rapid access to treatment with minimal wait times. During unavoidable wait times, engage people through peer-based supports within treatment. Ensure that there are no limitations to accessing treatment based on past utilization and/or outcomes.

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Table 1 ROSC Implementation Crosswalk		
Best Practice Standards	**Performance Arenas for Quality Improvement Monitoring**	**Potential Practice Changes**
Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development).	**MAT**	***Conduct Global Assessments:*** Use holistic, culturally relevant assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.
		Promote Health Activation: Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.
Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery. **Service Relationship:** Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."	**Strengths Based Approach**	***Facilitate Individualized, Person Centered Service Planning:*** Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.
		Promote Health Activation: Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.
Role of Client: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries. **Service Relationship:** Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."	**Customization and Choice**	***Promote Health Activation:*** Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.
		Promote Collaborative Service Relationships: Shift the relationship with clients and community members from a hierarchical expert-patient model to a partnership/consultant model. The helping stance changes from "this is what you must do" to "how can I help you?"
		Expand the Focus of Services and Supports: Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing. Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.

MDC157

Table 1 ROSC Implementation Crosswalk		
Best Practice Standards	**Performance Arenas for Quality Improvement Monitoring**	**Potential Practice Changes**
Engagement Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; renewed focus on the quality of the service relationship. **Retention:** Increased focus on service retention and decreasing premature service disengagement; use of peers, outreach workers, recovery coaches, and advocates to reduce rates of client disengagement and administrative discharge. **Attitude toward Re-admission:** Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.	**Opportunity to Engage in Self-Determination**	***Facilitate Individualized, Person Centered Service Planning:*** *Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.*
		Peer-based Recovery Support Services: Expand the availability of non-clinical, formal (paid) and informal (non-paid) peer-based recovery support services and integrate them with professional and peer-based services.
Service Delivery Sites: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater use of community organization skills to build or help revitalize indigenous recovery supports where they are absent or weak. **Service Relationship:** Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do." **Attitude toward Re-admission:** Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.	**Network Supports and Community Integration**	***Promote Community Integration:*** Facilitate community integration by supporting people in identifying their personal dreams, goals, and preferences for their life. Connect them to relevant resources and walk alongside them to develop the interest, skills and relationships that will enable them to enhance their life. Collaborate with indigenous recovery-support organizations (e.g., faith community); assertively link people to local communities of recovery; participate in local recovery education/celebration events in the larger community and advocate on issues that affect long-term recovery in the community (e.g., issues of stigma and discrimination). Mobilize and increase collaboration amongst diverse community resources. Partner with the community in a manner that values and integrates the knowledge, expertise, and strengths of community members.
		Promote Collaborative Service Relationships: Shift the relationship with clients and community members from a hierarchical expert-patient model to a partnership/consultant model. The helping stance changes from "this is what you must do" to "how can I help you?"
		Conduct Strength-Based Community Asset Mapping: Support prevention efforts that use a strategic approach to assess the strengths and assets within communities, rather than focus primarily on needs assessments, gaps, and identified problems.
		Assertively Engage All Community Members: Promote prevention, early engagement, and intervention via outreach and community education. For those in need of intervention, emphasize removing personal and environmental obstacles to recovery through meeting basic needs; ensure that the responsibility for motivation to change shifts from clients to service providers; use inclusive admission criteria rather than emphasis on exclusionary criteria.
		Broaden Service Delivery Sites: Increase the delivery of community integrated neighborhood and home-based services and expand recovery support services in high-need areas. Utilize and link people to existing community-based resources rather than duplicating efforts and recreating resources within segregated, institutional environments. Assist people in developing a network of natural recovery supports in order to increase their recovery capital.

III. IMPLEMENTATION

A. MANANGING ENTITY RESPONSIBILITIES

Each Managing Entity shall demonstrate progress toward implementation of a ROSC framework within its service areas. The Managing Entity shall:

1. Incorporate specific Best Practice Standards and Potential Practice Changes in **Table 1** into Network Service Provider subcontracts and monitor compliance with the Performance Arenas for Quality Improvement Monitoring aligned with the specific standards and changes selected.

2. Incorporate concepts designed to bolster the role of peer support and ROSC concepts with community stakeholders incorporating the elements of the Florida Peer Services Handbook 2016, available at:

https://www.myflfamilies.com/service-programs/samh/publications/

3. Support programmatic changes to include prevention and early intervention.

4. Promote adoption of sustainable recovery-oriented practices.

5. Analyze and assess current Managing Entity administrative, fiscal, policy, monitoring, and evaluation functions to align with recovery-oriented concepts using the Best Practices Standards in **Table 1.**

6. Identify opportunities to promote the expansion of peer-based recovery support services and recovery communities, enhance the role of peers in the workforce, and support development of peer-run organizations in their network in collaboration with the Department's local Recovery Oriented Quality Improvement Specialist.

7. Require subcontracted Network Service Providers providing direct services to use, at minimum, the following tools to assess recovery-oriented activities:

a. Annually the Provider Self-Assessment/Planning Tool process for Implementing Recovery-Oriented Services (SAPT) and shall include technical assistance as needed for improvements among three primary domains, Administration, Treatment, and Community Integration available at:

SAPT

b. The Recovery Self-Assessment-R (RSA) RSA Provider Staff and RSA Family where applicable, available at:

https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment, and

8. Require subcontracted Network Service Providers who employ peers with direct recovery-support service roles to:

a. Use the Reaching for their Dreams Using Recovery Capital as a foundation to inform the individualized recovery planning process by developing goals among applicable domines available at

Recovery Oriented System of Care | Florida Department of Children and Families (myflfamilies.com)

b. Receive standardized supervision of peer-based support services training for peer supervisors Providers - Recovery Oriented System of Care | Florida Department of Children and Families (myflfamilies.com)

9. Monitor Network Service Providers utilization of the Self-Assessment/Planning Tool (SAPT) and document areas of improvements from the SAPT and the Recovery-Oriented Quality Improvement process available at: Recovery Oriented System of Care | Florida Department of Children and Families (myflfamilies.com)

10. Require direct Network Services Providers to receive standardized training on Recovery

Management best practices in employee orientation and refresher training, developed by the Florida Certification Board.

11. Include the Department's local Recovery-Oriented Quality Improvement Specialist (ROQIS) in Managing Entity Quality Improvement monitoring, using the Recovery Oriented Quality Improvement Monitoring Blueprint, developed by the Florida Certification Board to:

    1) Conduct Recovery-Oriented Quality Improvement monitoring of Network Service Providers,

    2) Provide follow-up training and technical assistance on enhancing recovery management approaches and practices to Network Service Providers and provide technical assistance in collaboration with the Department to any Network Service Providers with a cumulative average score of less than 4.0 across all recovery domains, and

    3) Provide training and technical assistance to expand peer-based recovery services in Network Service Providers and Recovery Community Organizations.

12. Include findings from the recovery-oriented QI Monitoring Blueprint Tool in Network Service Provider monitoring or standalone reports and shall include all elements of the site visit, facility tour, policy and procedure review, person served interviews, surveys, clinical chart scoring outcomes, staff interviews, and where applicable, review of peer specialist staff job description(s). Reports shall be submitted to the Network Service Provider within 30 days of the site visit.

IV. RESOURCES

Managing Entities and Network Service Providers are encouraged to research the following recovery-oriented promising practices as examples of effective implementation:

Recovery Support Bridger's/Navigators - Certified Recovery Peer Specialists (CRPS) are utilized to assist individuals successfully transition back into the community following discharge from a SMHTF, CSU or Detox. The CRPS engages the individual while still inpatient and provides support and information on discharge options. They participate in discharge planning and assist the person in identifying community-based service and support needs and build self-directed recovery tools, such as a Wellness Recovery Action Plan (WRAP). The CRPS then supports the individual as they transition to the community. More information on WRAP may be accessed at: http://mentalhealthrecovery.com/

Care Transition Programs® - This intervention utilizes a Transition Coach to preferably meet an individual in the acute care setting to engage them and their family (as appropriate) and sets up in-home follow up visits and phone calls designated to increase self-management skills, personal goal attainment, and provide continuity across the transition.[4] More information on the Care Transition Programs may be accessed at: http://caretransitions.org/

Behavioral Health Homes - The SAMHSA – HRSA Center for Integrated Health Solutions has proposed a set of core clinical features of a behavioral health-based health home that serves people with mental health and substance use disorders, with the belief that application of these features will help organizations succeed as health homes. This resource may be accessed at: http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf

Reducing Avoidable Readmissions Effectively - The RARE Campaign in Minnesota was established to improve the quality of care for persons transitioning across care systems and to reduce avoidable readmissions by 20%. Five areas were identified as a focus of these efforts:

[4] See, http://caretransitions.org/about-the-care-transitions-intervention/, site accessed October 14, 2015.

- Patient/Family Engagement and Activation,
- Medication Management,
- Comprehensive Transition Planning,
- Care Transition Support, and
- Transition Communication

For more detail, the RARE Campaign published recommendations on actions to address the above areas of focus which can be accessed at: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf

Telehealth - Technology presents another promising practice in coordinating care, specifically related to access. For example, the Department of Veterans Affairs piloted a care coordination/home telehealth initiative that continually monitored veterans with chronic health conditions. Vital signs and other disease management data was transmitted to clinicians remotely located. The pilot reported reductions in hospital admissions and length of stay.[5]

Wraparound - Wraparound is an intensive, individualized care planning and management process for individuals with complex needs, most typically children, youth, and their families. The Wraparound approach provides a structured, holistic and highly individualized team planning process which includes meeting the needs of the entire family. The philosophy of care begins with the principal of "voice and choice", which stipulates the child and family perspective and drives the planning. The values further stipulate that care be community-based and culturally and linguistically competent. The staff to family ratio typically does not exceed one Wraparound facilitator to ten families. More information on Wraparound may be accessed at: http://nwi.pdx.edu/.

Related Articles:

- Philadelphia Behavioral Health Services Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment.
- Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services and Achara Consulting Inc. (2017). Peer Support Toolkit. Philadelphia, PA: DBHIDS.
- Davidson, L.; Tondora, J.; Ridgway, P.; & Rowe, M. (2012). Inventory of transformation characteristics for recovery-oriented systems of care. New Haven, CT: Yale University Program for Recovery and Community Health.
- Winarski, J., Dow., M, Hendry, P., & Robinson, P. (2018). Self-Assessment/Planning Tool for Implementing Recovery-Oriented Services (SAPT) Adapted for Florida's Recovery Oriented System of Care Initiative (ROSC). Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.
- Recovery concept finds common ground in mental health and addiction, Co-occurrences Newsletter of the Minnesota Co-Occurring State Incentive Grant Project.
- Recovery in Mental Health & Addiction, Davidson and White, Recovery to Practice Issue No. 14
- Kelly, J. & White, W. (Late 2010) Addiction recovery management: Theory, science and practice. New York: Springer Science.
- Monographs published by Great Lakes ATTC, available at http://www.williamwhitepapers.com/:
  - Recovery Management
  - Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation

[5] IOM (Institute of Medicine). 2010. The healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press

- Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices
- Practice Guidelines for Resilience and Recovery Oriented Treatment, Philadelphia Department of Behavioral Health and Intellectual Disability Services

Relevant Websites:

http://www.williamwhitepapers.com/

http://www.acharaconsulting.com/

http://www.acharaconsulting.com/peer-support-toolkit/

https://www.samhsa.gov/brss-tacs

https://inaps.memberclicks.net/assets/docs/RTP%20Next%20Steps%20Manual.pdf

https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf