

Major Dimensions of Managed Behavioral Health Care Arrangements
Level 3: MCO/BHO and Provider Contract

SERVICE SYSTEM/PROVIDER NETWORK COMPOSITION

◆ *Provider Type*

1. Please provide the following information on individual providers in your provider network.

| 1. Individual Providers | A Provider Payment type (Check one) | B. Is provider risk limited through any stop-loss arrangements? | C Do providers share profits? |
|-------------------------|---|---|---|
| a. Adult Psychiatrists | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Child Psychiatrists | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Adult Psychologists | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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|--|---|--|---|
| d. Child Psychologists | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Social Workers | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Certified Substance Abuse Counselors | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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|--|---|--|---|
| g. Nurses | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Other Therapists, Counselors | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Case Rate <input type="checkbox"/> f. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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2. Please provide the following information on institutional providers in your provider network.

| 2. Institutional Providers | A. Provider Payment type | B. Is provider risk limited through any stop-loss arrangements? | C. Do providers share profits? |
|--|--|--|---|
| a. Licensed inpatient general hospitals | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Licensed inpatient psychiatric hospitals | | | |
| i. State Hospital | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ii. Non-State Hospital | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| 2. Institutional Providers | A. Provider Payment type | B. Is provider risk limited through any stop-loss arrangements? | C. Do providers share profits? |
|--|--|--|---|
| c. Licensed general hospital outpatient clinics | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Licensed partial/day hospital programs | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Residential – Adults with SMI | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| 2. Institutional Providers | A. Provider Payment type | B. Is provider risk limited through any stop-loss arrangements? | C. Do providers share profits? |
|---|--|--|---|
| f. Residential – Adults with substance abuse disorders | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Residential – Children/Adolescents with severe emotional disturbances | <input type="checkbox"/> . Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Residential – Children/Adolescents with substance abuse disorders | <input type="checkbox"/> . Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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|--|--|--|---|
| i. Licensed outpatient psychiatric clinics or mental health centers | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Licensed intensive outpatient rehabilitation programs | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Community-based "wrap-around" programs (Children) | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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|---|--|--|---|
| l. Licensed mobile treatment/crisis teams | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. Licensed case management programs | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. Agency-organized drop in center or social clubs | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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|---|--|--|---|
| o. Peer drop in center or social clubs | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| p. Other (Specify) | <input type="checkbox"/> a. Budget based <input type="checkbox"/> b. Capitated <input type="checkbox"/> c. Fee-for-service <input type="checkbox"/> d. Fee-per-episode <input type="checkbox"/> e. Salaried <input type="checkbox"/> f. Other _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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[If contract provisions vary for different provider types, answer questions 3-9 for each type of provider separately.]

◆ *Medical Necessity and Benefit Coverage and Determination Procedures*

3. Is there a definition of "medical necessity" or "medically necessary" in the contract? (May also include "medically appropriate")

Yes, specify definition

No

4. Are medical necessity determinations made with reference to any of the following? (Check all that apply)

- a. Scientific models of care (e.g., ASAM criteria)
- b. Published clinical protocols (e.g., Am. Psych. Assoc. guidelines)
- c. Reviewers with demonstrated clinical competence (e.g., training, credentials, experience consistent with the treatment of people with ADM disorders)
- d. Other (Specify) _____

5. Does the contract allow for the direct involvement of the treating physician or clinician in the determination of medical necessity?

Yes, specify how the contract allows for this. _____

No

6. Is there a formal clinical appeals process for physicians/clinicians?

Yes, specify what it is. _____

No

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**7. Does this contract mandate any of the following utilization review procedures?
 If yes, briefly describe the procedure(s).**

| Service | A. Prior authorization | B. Concurrent review | C. Retrospective review |
|------------------------------------|-------------------------------|-----------------------------|--------------------------------|
| a. Inpatient | | | |
| b. Non-emergency outpatient | | | |
| c. Emergency | | | |

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ACCOUNTABILITY

◆ *Enforcement and Sanctions*

8. Does the contract include a range of sanctions for non-performance (short of termination of the contract)?

Yes, describe.

No

9. Does this contract include specific performance indicators or standards?

Yes, fill in the following grid.

No, you have completed Level 3 survey.

| A. Indicators/standards | B. Sanction |
|--------------------------------|--------------------|
| a. | a. |
| b. | b. |
| c. | c. |

THIS IS THE END OF THE LEVEL 3 SURVEY AND THE INSTRUMENT.