# Mental Health Provider Manual

## Part 1

Community-Based Mental Health Services for Children and Adults

JANUARY 2019

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# 1. DEPARTMENT OF MENTAL HEALTH DELIVERY SYSTEM AND PAYMENT REFORM

## 1.1 BACKGROUND AND REFORM GOALS

The Department of Mental Health (DMH) is changing how the Designated and Specialized Service Agencies (DA/SSA) are reimbursed to support a cultural shift in how State funded mental health providers do business. Specifically, the payment reform model moves from a focus on volume to a focus on quality and outcomes. To support this shift to value-based purchasing the State has developed a bundled payment model that allows for flexibility in how and when services are delivered and that encourages an integrated and comprehensive approach to care.

Two case rates have been developed: one for children and one for adults. The provider-specific case rates are based on a core set of mental health services and DMH's overall annual allocation for each provider including funds from the Department for Children and Families and the Department of Vermont Health Access.

This payment reform will promote and improve the delivery system by

- improving accountability and transparency,
- eliminating complex and idiosyncratic programmatic requirements,
- delivering more predictable payments,
- providing flexibility that supports comprehensive, coordinated care and,
- standardizing an approach for tracking population indicators, progress, and outcomes.

## 1.2 FEDERAL AND STATE AUTHORITIES

DMH is responsible for the direction of publicly funded mental health services, the custody and care of individuals who require involuntary treatment, and the oversight of DA/SSA community mental health programs. The Agency of Human Services (AHS)as Vermont's Medicaid Single State Agency, stipulates that DMH administer Medicaid and other state and federal mental health programs, develop policies that assist Vermonters in accessing care and support health and wellness.

DMH is authorized in Statute and charged with "planning a comprehensive mental health program."[1] The law requires the Department to "… centralize and more efficiently establish the general policy and execute the programs and services of the State concerning mental health, and integrate and coordinate those programs and services … so as to provide a flexible comprehensive service to all citizens of the State in mental health and related problems."[2] Finally, the law describes that "[t]he Department of Mental Health shall be responsible for coordinating efforts of all agencies and services, government and private, on a statewide basis in order to promote and improve the mental health of individuals through outreach, education, and other activities."[3]

[1] 18 V.S.A. § 7204
[2] 18 V.S.A. § 7201
[3] 18 V.S.A. § 7202

Through a Medicaid Section 1115 Demonstration known as the Global Commitment to Health (GC), DMH oversight and operations are guided by Medicaid regulations for Managed Care (42 CFR §438). Under the Special Terms and Conditions (STCs) of the Demonstration and Medicaid Managed Care regulations, the State is allowed enhanced flexibility to serve Vermonters. Examples of this flexibility include: use of alternative payment models; payment for healthcare and related services not traditionally reimbursable through Medicaid (e.g. pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). Vermont's GC Demonstration encourages inter-departmental collaboration and consistency across AHS programs.

Under the authority of the GC Demonstration, DMH contracts for services on behalf of Medicaid beneficiaries and authorized GC Demonstration populations. Federal participation in the DMH program is achieved through a "Per Member, Per Month" capitation arrangement from the Department of Vermont Health Access (DVHA) to DMH. DMH, in turn, makes payments to DAs and SSAs. DMH provides additional State and federal funding (non-Medicaid) for services and MH program participants not eligible for coverage under the GC Demonstration.

## 1.3 MANUAL SCOPE AND MULTI-YEAR REFORM PLAN

Part 1 of this Mental Health Provider Manual supersedes information previously published by DMH regarding the following programs and services:

| **Program** | **Fund Source**[4] |
|---|---|
| CHILDREN | |
| • Emergency Services (ACCESS) | Medicaid Program- DMH |
| • Enhanced Family Treatment (MH Waiver) | Medicaid Program- DMH<br>Medicaid Program- DCF Transfer |
| • Jump On Board for Success (JOBS) | Medicaid Program- DMH |
| • All Fee for Service | Medicaid Program- DMH |
| • Outpatient Services | Medicaid Program- DVHA transfer |
| • Transitional Living Programs | Medicaid Program- DMH<br>Medicaid Program- DCF Transfer |
| ADULTS | |
| • Emergency Services | Medicaid Program- DMH |
| • CRT (Community Rehabilitation and Treatment)<br>  • Intensive Residential Recovery Facilities (Maplewood, Hilltop, Meadowview)[5]<br>  • Other DA/SSA specific CRT related programs | Medicaid Program- DMH<br>Global Commitment Investment- DMH<br>Global Commitment Designated State Health Program- DMH |

[4] All services included in the Mental Health Case Rates are paid for through the Global Commitment to Health Section 1115 Medicaid Demonstration including State Plan, Designated State Health Program and Investment authority.

[5] Does not include Second Spring South or North IRRs, Soteria and the State operated IRR.

| | |
|---|---|
| • Outpatient Services | Medicaid Program- DMH |
| • Outpatient Services | Medicaid Program- DVHA transfer |

Provider Manual Parts 2 and 3 are under development. Future manuals are expected to include updated information regarding Integrating Family Services (Part 2) and DMH School-based Mental Health Services (Part 3).

This manual is not an exhaustive directory for all possible questions or clarifications, including those that may be necessary to comply with Medicaid requirements. Providers are responsible for seeking clarification regarding services or activities and eligibility for reimbursement when services or billing are in question. Additional information regarding state and federal Medicaid Requirements can be found in Attachment A of this manual.

### MULTI-YEAR REFORM PLAN

DMH is embarking on a multi-year reform plan and expects to revise this provider manual as needed and no more frequently than a quarterly basis to reflect changes in delivery system and payment reform. DMH will seek DA/SSA input on proposed changes through regular communications, meetings, and information posted publicly on its website.

# 2. COVERED POPULATIONS

## 2.1 GLOBAL COMMITMENT TO HEALTH ENROLLEES

Medicaid beneficiaries of all ages are eligible for DMH funded Medicaid services as outlined in this manual.

### MEDICAID ELIGIBILITY AND ENROLLMENT

Providers must confirm Medicaid eligibility and other insurance information as a condition of billing the adult or child monthly case rate. If a person is not currently enrolled, but may be eligible for Medicaid, the DA/SSA is expected to either assist the person with completing an application or support them through the application process. More information about enrollment resources can be found in Attachment B.

The DA/SSA shall have an identified mechanism in place to track and monitor Medicaid eligibility for any person served. As part of the regular Program Review of the Designated Agencies, DMH staff will audit the DA's procedures to assure that they are taking appropriate steps to verify Medicaid eligibility.

The service coordinator (or designee) must follow up at least annually to review any changes in circumstances related to potential eligibility and offer assistance as needed to apply for Medicaid benefits.

### KATIE BECKETT

Children who are not categorically eligible for Medicaid (e.g., medically needy, TANFC, SSI), but need an intensive level of community-based treatment may apply for eligibility under Medicaid's "Katie Beckett"

rule. These rules disregard family income if the child is determined to have significant disabilities as determined by the federal Disability Determination Unit.

### COMMUNITY REHABILITATION AND TREATMENT COVERAGE: DESIGNATED STATE HEALTH PROGRAM

Adults who: (1) Meet Community Rehabilitation and Treatment (CRT) criteria at section 2.2, (2) Are not Medicaid eligible, (3) Have incomes at or below 185% of the Federal Poverty Level (FPL), may receive mental health services paid for using the adult mental health case rate. The Medicaid demonstration describes these individuals and program expenditures as a "Designated State Health Program" (DSHP).

For individuals who meet CRT program criteria, providers shall indicate on the CRT Enrollment Form the person's self-declared income as a household of 1. The CRT Enrollment form indicates whether a person is under 185% FPL.

### CRT COVERAGE: NON-GLOBAL COMMITMENT TO HEALTH ENROLLEES (INVESTMENTS)

Adults who: (1) Meet CRT criteria at section 2.2, (2) Are not Medicaid eligible, (3) Have incomes above 185% of the Federal Poverty Level (FPL), may receive mental health services paid for using the adult mental health case rate. The Medicaid demonstration describes these individuals and program expenditures as an approved Global Commitment Investment for "Mental Health CRT Community Support Services".

Starting April 1, 2019, 0-paid encounter claims may be submitted under the adult case rate for services provided to individuals under this category. The Medicaid Management Information System (MMIS) will attribute the claim to the Global Commitment Investment fund source based on person-level information associated with the claim.

For individuals who meet CRT program criteria, providers shall indicate on the CRT Enrollment Form the person's self-declared income as a household of 1. The CRT Enrollment form indicates whether a person is over 185% FPL.

## 2.2 POPULATION SERVED

Medicaid beneficiaries of all ages are eligible for DMH funded Medicaid services as outlined in this manual. (See section 2.1 for information regarding coverage of DMH funded mental health services for certain individuals who are ineligible for Medicaid). Available resources must be prioritized to assure that individuals who are assessed to meet the criteria for Intensive Home and Community Based Services (IHCBS) and Community Rehabilitation and Treatment (CRT) have full access to services based on coverage criteria described in this manual. [6] [7]

### CHILDREN, YOUTH AND YOUNG ADULTS

[6] In accordance with the provisions of 33 V.S.A. chapter 43.

[7] https://legislature.vermont.gov/statutes/fullchapter/18/207

Early and Periodic Screening, Diagnostic, and Treatment Services, (EPSDT) ensure that all Medicaid eligible children receive comprehensive and preventive care to prevent or improve health conditions. The EPSDT mandate states that children with Medicaid under the age of 21 be given priority for services if they are eligible under the Federal Medicaid program. Further prioritization should be based on clinical acuity and consideration of additional resources and supports[8].

## INTENSIVE HOME AND COMMUNITY BASED SERVICES

The purpose of Children's Intensive Home and Community Based Services (IHCBS) is to serve those children, youth and families with the most disabling mental illnesses or serious emotional disturbances in community settings rather than institutional settings. Under the Global Commitment to Health waiver, Home and Community Based Services can be offered through DA/SSAs as IHCBS for children. IHCBS are a small sub-set of services formerly known as Enhanced Family Treatment or "waiver" services. IHCBS may be provided to children and adolescents who have a primary mental health diagnosis and who are receiving, or who in absence of IHCBS would otherwise require, the level of care provided in an inpatient psychiatric care facility (hospital or residential). Through IHCBS, DA/SSAs may create plans of care with an intensive level of support and also expand Medicaid coverage to services beyond State Plan covered services[9].

### IHCBS CONDITIONS OF COVERAGE

Clinical staff of the DA/SSA are responsible for assessing clinical need and creating plans of care for children who require intensive mental health services. Clinical staff of the DA/SSA will complete or review an existing primary clinical assessment for indications the individual may need Intensive Community Based Wraparound Services. A recent assessment must be a formal assessment done within 6 months of the start of the intensive services Plan of Care. Examples of formal assessments include, but are not limited to, a Psychological or Psychiatric assessment, a discharge summary from a hospital or hospital diversion program, a discharge summary from a residential setting or the Psychological component of an IEP evaluation. The assessment must contain the clinical information necessary to justify a higher level of care. Information should stress child and family strengths as well as natural supports and resources. If a child is placed out-of-home, the assessment must detail the family and child needs and skills that must be developed for successful reunification.

If a child is being placed out of their home, the criteria from the Out of Home Placement Guidelines must also be met.

Supporting documents, such as other relevant assessments, can be used to supplement the primary assessment. A Child and Adolescent Needs and Strengths (CANS) assessment must be completed for all children accessing this level of care to support the indicated need for the intensive community wrap.

Once a clinical review has been completed and medical need is established, the DA/SSA will work with the family/youth/guardian to create a Plan of Care that provides the supports necessary to keep the child/youth in the community and avoid institutional/residential care.

[8] Refer to attachment A regarding EPSDT for additional information.

[9] Conditions of covered services specific to IHCBS start at section 3.13. Information regarding access to care and prioritization criteria is found at section 4.3.

## CONTINUED ELIGIBILITY FOR IHCBS

Continued eligibility for Intensive Home and Community Based Services must be reviewed at least every six months. The review includes a thorough clinical review of the goals, the services provided, the response to treatment, progress made and any continuing challenges.

The CANS is updated every 6 months, which is the opportunity for the child/family to indicate continued need for the intensive home and community based services plan.

DMH recommends that clinical staff work in teams to review the plan of care and update or maintain any goals and add, maintain, or reduce the treatment and supports provided.

If the family/youth does not agree with changes, reductions or additions to the Plan of Care, they may appeal the decision through the DA/SSAs Grievance and Appeal Processes.

## INTENSIVE HOME AND COMMUNITY BASED SERVICES TRACKING

This process in development.

## COMMUNITY REHABILITATION AND TREATMENT (CRT)

The purpose of Community Rehabilitation and Treatment (CRT) is to provide comprehensive services, using a multi-disciplinary treatment team approach, for adults with severe mental illnesses. CRT offers a wide range of support options to help people remain integrated in their local communities in social, housing, school and work settings based on their preferences, while building strategies to live more interdependent and satisfying lives.

Adults who are eligible for Community Rehabilitation and Treatment (CRT) are defined as Individuals 18 or over with schizophrenia, other psychotic disorders and seriously debilitating mood disorders who meet **each** of the following three criteria:

1. A primary DSM-V diagnosis of at least one of the followings:

- Schizophrenia
- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder
- Unspecified schizophrenia spectrum and other psychotic disorders
- Major depressive disorder
- Bipolar I disorder
- Bipolar II disorder, and other specified bipolar and related disorders
- Panic disorder
- Agoraphobia
- Obsessive-compulsive disorder, including hoarding disorder, other specified obsessive-compulsive and related disorders, and unspecified obsessive-compulsive and related disorders.
- Borderline personality disorder.

2. Treatment History, including at least one of the following:

- Continuous inpatient psychiatric treatment with a duration of at least sixty days

- Three or more episodes of inpatient psychiatric treatment and/or a community-based crisis bed program during the last twelve months
- Six months of continuous residence or three or more episodes of residence in one or more of the following during the last twelve months:
  - residential program
  - community care home
  - living situation with paid person providing primary supervision and care
- Participation in a mental health program or treatment modality with no evidence of improvement
- The individual is on a court Order of Non-Hospitalization.

3. Functional Impairment in social, occupational or self-care skills as a result of the DSM-V diagnosis, including demonstrated evidence of two of the following during the last twelve months, with a duration of at least six months:

- Receives public financial assistance because of a mental illness
- Displays maladaptive, dangerous, and impulsive behaviors
- Lacks supportive social systems in the community
- Requires assistance in basic life and survival skills.

Community Rehabilitation and Treatment (CRT) are those covered services, identified in Section 3 below, that are targeted for persons identified as meeting the above criteria.

## CRT INTAKE

CRT enrollment must include a formal intake and screening process by the DA/SSA and should include

- acknowledgement of receipt of a referral from an individual seeking CRT services, or others, e.g. a hospital social worker, family member, primary care provider;
- release of information (if necessary) to talk with the referral source about the basis for the CRT referral and other pertinent information, e.g. the diagnosis, treatment history, and level of functioning;
- additional signed releases of information to obtain information and/or records from previous or current providers, hospitals, etc.;
- review of materials to determine potential eligibility status.

Once the intake materials are reviewed and it appears the person may potentially meet coverage criteria for CRT, an appointment is scheduled for a full, in-person, clinical assessment.

Assessments are completed (see section 3.1 Clinical Assessment) by a qualified clinician to determine the existence of a serious mental illness, any co-occurring conditions including substance use disorder, functional disabilities related to the mental health condition, and treatment history. See previous section for more information on eligibility criteria.

If it is clear the person does not meet coverage criteria, a letter will be sent to the person and referring party (if a release of information has been signed) with the reason for ineligibility and a notice of the right to appeal.

The coverage evaluation is reviewed by a screening committee with final approval of the DA/SSA CRT Program Director.

Upon request from DMH, the DA/SSA shall furnish documentation for coverage determination.

The DA/SSA CRT program will maintain a log of all requests for CRT eligibility evaluation and the resulting determinations, including referrals found not to meet coverage criteria. This log shall include the date of referral, the referring individual or organization, initials of the individual, gender, date of birth, date of the determination evaluation, result of the determination, the rationale for the coverage determinations, and date of notice of right to appeal a non-covered determination. This log will be made available to DMH upon request. These logs must be maintained for a period of at least four years from the date of the original referral.

## CRT ENROLLMENT

The CRT Program Enrollment and the Checklist for Eligibility must be completed for all new enrollees, available at http://mentalhealth.vermont.gov/forms .

The Enrollment Form is populated by the DA/SSA and uploaded to the DMH Secure Site followed by an email to DMH with notification that the form had been uploaded. DMH will send a return email noting that the form has been received. Enrollment can also be confirmed through the CRT Midmonth Report which lists all new enrollments and the effective dates. This report is sent out once a month to each DA and SSA prior to processing case rate payments for verification and correction.

## PROVISIONAL CRT COVERAGE

If coverage criteria for CRT are not met but the CRT Program Director believes that the person cannot be safely supported in the community by any other available program or services, and it is determined that there is a need for further assessment over time, the person may be provisionally enrolled in the CRT Program for a period ***not to exceed six months*** before a ***final eligibility determination*** is made. The DA/SSA will submit the CRT Program Enrollment Form including the provisional enrollment section (available at http://mentalhealth.vermont.gov/forms ). During this time the DA/SSA will ensure proactive transition and service coordination services to allow for further assessment and evaluation of the individual's clinical eligibility for continued CRT program services.

The CRT Director shall use the following DMH guidance during the provisional period (1 to 6 months):

1. Ensure completion of a comprehensive clinical assessment summarizing why the individual has been provisionally enrolled in CRT services.
2. Ensure attainment of contributing evaluations or assessments from external sources.
3. Ensure completion of an Individual Plan of Care (IPC) including planned evaluations for the provisional period.

At the end of the provisional period (six months or sooner) the DA/SSA will either

- submit the CRT Program Dis-Enrollment Form and send the individual notification of the final eligibility determination and decision to dis-enroll him/her from the CRT Program and their right to appeal the decision[10]; *or*
- notify DMH of full enrollment changing provisional to active CRT status by completing and submitting the Enrollment Form/Eligibility Checklist.

## CRT DISENROLLMENT

Coverage termination will occur whenever the individual chooses to be disenrolled, moves out of State, transfers to another program (e.g. Adult Outpatient), or dies.

If a covered individual has not received services for a six-month period, the DA/SSA shall disenroll the person from the CRT program. Documentation of the CRT program's efforts to engage the person in services during that period of time, notice to the individual informing them of disenrollment due to no contact, and notice of eligibility for automatic re-enrollment upon their request, should be maintained by the DA/SSA.

The person must be placed on inactive status if the person is expected to be incarcerated for 90 days or less, and disenrolled from CRT if the incarceration is longer. Medicaid will not pay for medical care while an individual is incarcerated.

Should any of the above events occur, the DA/SSA must notify DMH within 48 hours of its knowledge of the event by sending the CRT Dis-Enrollment form to the designated DMH staff member. The form is available on the DMH website at http://mentalhealth.vermont.gov/forms .

The death of a person enrolled in the CRT program requires the DA/SSA to complete and submit a Critical Incident Report Form. Submission of a CRT Program Dis-enrollment form will not be necessary under this circumstance. DMH will administratively disenroll the person based on the information provided by the DA/SSA in the Critical Incident Report.

As with the initial coverage determination, coverage termination is effective as of the last day of the month DMH is notified, with the exception of termination due to death, in which case the effective date would be the actual date of death (even if retroactive) per DMH agreement with Department of Vermont Health Access (DVHA).

If DMH determines that a DA/SSA failed to provide notice of disenrollment to DMH, the DA/SSA may be subject to any associated financial penalties. DMH may require a corrective action plan from the DA/SSA and will review subsequent case rate allocation payments during the course of the fiscal year to reflect corrected capitation payments received from the DVHA for all those ineligible.

## TRANSFER OF CRT COVERAGE

Transfer of an enrollee from one DA/SSA to another agency requires

- submission to DMH by the receiving DA/SSA a CRT Program Enrollment Form, highlighting the transfer section;
- submission to DMH by the sending DA/SSA a CRT Dis-enrollment Form to DMH, highlighting the disenrollment section;
- review/re-evaluation of CRT eligibility criteria by the receiving DA/SSA if the initial transfer documentation indicates that the person may be ineligible for CRT services,
- notification to the person or their representative of any reduction and/or change in services, accompanied by description of their right to appeal eligibility decisions.

The transfer will not be considered completed until both agencies involved have submitted the appropriate forms. Changes in eligibility status are subject to appeal.

#### REDETERMINATION OF CRT ENROLLMENT

A person requesting CRT services who has not been served by any CRT program in the past two-year period must go through the eligibility determination process.

#### INACTIVE CRT STATUS

DAs/SSAs are responsible for tracking service utilization of enrolled individuals and are expected to actively try to re-engage people in services, including taking appropriate steps to ensure that the failure to access services has not placed an individual at risk of experiencing an increase in symptoms. All outreach and engagement attempts should be documented in the individual's clinical record.

DAs/SSAs should consider timely transfer or discharge of those not engaged in services when there are clear indications that an individual no longer has a need, or interest in CRT services.

## 3. COVERED SERVICES

### 3.1 CLINICAL ASSESSMENT

Target Group: All Global Commitment to Health Enrollees

#### DEFINITION

Clinical assessment services evaluate individual and family strengths, needs, existence and severity of disability and functioning across environments. A clinical assessment is a service related to creating an accurate picture of an individual's needs and strengths. It may take a variety of forms and include multiple components, depending on the age and functioning of the client, and the program the individual is being considered for. An assessment includes a review of relevant information from other sources, such as the family, health care provider, child care provider, schools, other State agencies or programs, or others involved with the individual and their family.

## CONDITIONS OF COVERAGE

Clinical assessments shall include, as applicable, the following essential elements[11]

- basic demographic information (age, sex, housing, employment / education, members of household etc.);
- presenting problem/concern/issue;
- history of presenting issue (description of current problem including individual and family strengths and stressors);
- expectations of treatment,
- medical and Psychiatric history including developmental concerns,
- substance use history,
- family history including ethnicity and culture,
- past and current exposure to trauma and current functional impacts,
- support systems, including relationships/interactions with family, friends and other community members (including spiritual resources, leisure skills);
- current functional capacity, relevant history, and current stressors in areas of self-care skills, community living skills, housing, finances, employment/education, legal, parenting,
- psychiatric evaluation of mental, emotional, intellectual/cognitive, behavioral status;
- mental status exam,
- psychometric tests including screens,
- diagnosis / clinical impression,
- clinical formulation / interpretative summary (summary of findings leading to a clinical hypothesis);
- treatment/service recommendations (based on the clinical formulation and addressing individual/family's goals. These recommendations form the basis of the Individual Plan of Care.

Clinical Assessment or reassessment must be a face-to-face contact, in-person or through Telemedicine[12].

Any information gathering by a non-qualified provider for clinical assessment purposes is excluded from coverage under the clinical assessment encounter, but may qualify as community support, if staff coverage conditions for that service are met (see below).

The minimum duration for a clinical assessment encounter to be allowable for case rate billing is 15 minutes.

## DOCUMENTATION

[11] See also section 4.4 regarding service delivery expectation, including timelines for reassessment.

[12] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

Documentation must include all applicable elements described above. Functional status and history must be evaluated, and the diagnosis confirmed as documented by the signature of a licensed clinical staff and/or MD on the assessment.

### STAFF QUALIFICATIONS

Initial clinical assessments must be completed by staff who meet one of the following qualifications

- licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the Designated Agency/Specialized Services Agency
- licensed psychiatric nurse practitioner directly affiliated with the Designated Agency/Specialized Services Agency
- for non-licensed Psychiatric Nurse Practitioners refer to Section 8.5 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid Provider Manual, located at http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf;
- a staff member of the Designated Agency/Specialized Services Agency who holds one of the following credentials:
    - Licensed Psychologist
    - Licensed Marriage and Family Therapist
    - Licensed Clinical Mental Health Counselor
    - Licensed Independent Clinical Social Worker
    - For Master's level, or BA level intern providing clinical services through a formal internship as part of a clinical Master's level program, non-licensed, rostered clinical staff, Supervised Billing rules apply. For more information, refer to Section 8.5 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid Provider Manual, located at http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf
- any subcontractor must meet both of the following requirements
    - meet staff qualifications described above; and,
    - be authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.

## 3.2 EMERGENCY CARE AND ASSESSMENT SERVICES/MOBILE CRISIS SERVICES

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Emergency Care and Assessment Services (Emergency Services, ES) are time-limited, intensive supports intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources[13]. Services may be initiated by, or on behalf of, a person experiencing an acute mental health crisis as evidenced by

- a sudden change in behavior with negative consequences for well-being
- a loss of effective coping mechanisms
- presenting danger to self or others

The following Emergency Services shall be provided[14]:

### CRISIS RESPONSE

A Designated Agency shall provide mental health crisis screening and assessment services to residents of any age in their catchment area who are in acute mental or emotional distress and need crisis support or stabilization. Services may also include in-office and outreach visits, emergency placement services, and resource information and referral.

### INPATIENT SCREENING

A Designated Agency shall have the capacity to provide 24/7 screening for the following mandated populations:

- all potential admissions to involuntary inpatient care,
- all individuals enrolled in Community Rehabilitation and Treatment (CRT) programs,
- all voluntary youth (under 18 years) who have Medicaid as their primary pay source. All voluntary youth without Medicaid are approved by their insurance carrier and are not required to be assessed by a DA screener.

Inpatient screening, as completed by a screener or reported by a reliable clinician, shall consist of a statement of the presenting problem and its history, a description of the community resources considered, risk assessment and a recommendation for disposition. All required information regarding patients admitted to hospitals for psychiatric treatment shall be communicated to the hospital at the time of admission. Screening for involuntary admissions shall be performed in accordance with the Qualified Mental Health Professional (QMHP) Manual. Crisis screeners must have 24-hour, seven-day a week access to psychiatry consultation by emergency screening staff.

### COURT SCREENINGS

A Designated Agency QMHP is the 'mental health professional', referenced in *Title 13 V.S.A. § 4815,* who completes the mental health screening when requested by the court, in accordance with procedures referenced in Title 18 V.S.A. § 7504 (a) QMHP manual.

[13] For a complete listing of requirements, see Designated Agency Emergency Services Standards Manual: http://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Emergency%20Services%20Standards%202017-12.pdf

[14] See also section 4.3 Access to Care.

### COMMUNITY EMERGENCIES

The Designated Agency will maintain a Disaster response plan and will work jointly with VDH, DMH, DAIL, AHS Field Services Directors and the State of Vermont Emergency Management System, to respond to disasters. The DA shall coordinate with other providers and stakeholders to respond to emergencies in the community requiring a mental health response. Services may include outreach visits, public education, resource information, and referral.

### REASSESSMENT

Individuals under the custody of the Commissioner of Mental Health who are on Involuntary Status awaiting an inpatient hospital bed need to be reassessed twice daily (approximately 12 hours apart) to determine ongoing level of care needs.

### MOBILE OUTREACH

In addition to seeing people in the office, clinic and emergency departments, Emergency Services will have the capacity to be mobile and see people in the community. Mobile outreach shall participate actively with law enforcement as necessary. Mobile outreach shall demonstrate and track effective diversion of avoidable emergency room utilization.

## CONDITIONS OF COVERAGE

Emergency Care and Assessment Services may be face-to-face, provided by telephone or through Telemedicine[15].

The minimum duration for an emergency care and assessment encounter to be eligible for case rate billing is 15 minutes accumulated in one day.

During an emergency care and assessment service, it is allowable to include time spent transporting an individual. However, a clinician's travel time to or from the emergency scene is not considered an encounter for case rate billing.

Emergency care and assessment services must be provided under the supervision of a licensed mental health professional, working within the scope of their practice and do not require prior approval. All emergency contacts will be reviewed by a supervising clinician within 24 hours or the first working day following the contact.

Only one clinician's time will be considered an encounter regardless of the number of DA clinicians involved at the same time during a crisis service. If two separate services are provided that require unique qualifications (e.g. medication management that can only be provided by medical personnel and emergency care services that are provided by a different qualifying clinician), an encounter for each clinician's time performing unique services should be documented.

## DOCUMENTATION REQUIREMENTS

[15] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

### TELEPHONE INTERVENTION

One progress note per day is the minimum requirement to document the emergency care and assessment services provided to an individual by phone. It must include, in summary form

- identified issue or precipitant to crisis contact,
- issues addressed or discussed,
- the clinician's impressions/assessment of the issues/situation,
- disposition or plan resulting from the crisis intervention.

If telephone Emergency Care and Assessment Services are documented in a crisis note and are provided by the same individual, that crisis staff member would need to sign the page only once. However, if other crisis staff members enter contacts periodically in the crisis note, their signatures must accompany their individual notes.

Same-day phone contact related to or initiating a face-to-face assessment may be included in the face-to-face note. Additional phone contacts that are not contributing factors to the face-to-face assessment are to be documented separately from the face-to-face note, but may be combined into one daily telephone contact note.

### FACE-TO-FACE/TELEMEDICINE INTERVENTION

One progress note per face-to-face/telemedicine contact is required to document the emergency care and assessment services provided to an individual. It must include, in summary form

- identified issue or precipitant to crisis contact,
- issues addressed or discussed,
- collateral contact information as solicited or available,
- observations made by the clinician,
- the clinician's assessment of the issues/situation including mental status and lethality/risk potential,
- disposition or plan resulting from the crisis intervention,
- psychiatric consultation, as clinically indicated.

## STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

### DA QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)

Each DA is required to have QMHP's available on staff to perform emergency screenings for involuntary care and to advise the Courts as to the most appropriate site for a forensic evaluation. By agreement with designated hospitals, only QMHP's who are designated by the DMH Commissioner can screen and serve as the applicant for involuntary psychiatric admissions.

The definition of mental health professional from Title 18 of the Vermont Statutes Annotated, Section 7101(13) identifies that "mental health professional" means a person with professional training, experience and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, mental health counselor, nurse or other qualified person designated by the commissioner.

## 3.3 FACILITY-BASED CRISIS STABILIZATION AND SUPPORT SERVICES

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Facility-based Crisis Stabilization and Support Services provide short term services (hours to a few days) designed to stabilize people in an acute mental health crisis and to move to community-based supports as soon as possible with planned discharge and placement. Services are provided to individuals, their families, or their immediate support system that may be time-limited, but necessary to maintain stability or avert destabilization of an expected psychological, behavioral, or emotional crisis experiencing a mental health crisis as evidenced by: (1) a progressing change in behavior with negative consequences for well-being; (2) declining or loss of usual coping mechanisms; or, (3) increasing risk of danger to self or others. Crisis stabilization services are face-to-face services in an environment other than a person's home.

The Crisis Stabilization and Support Services program shall ensure that it has an ongoing impact on reducing the agency's bed utilization at Designated Hospitals. Referrals to the Crisis Stabilization program should be done in consultation with the DMH care management team, including step down from acute hospitalization. The program will effectively integrate and coordinate with other parts of the local services system, and link effectively to treatment planning and utilization review for agency clients to ensure effective use of intensive resources.

Crisis stabilization facilities are expected to serve dually diagnosed clients with a co-occurring substance abuse or developmental disability. They shall employ evidence-based practices when such practices are available and appropriate for the diagnoses treated.

Crisis Stabilization bed programs will take referrals and serve people from outside of the DA catchment area. Admission criteria will not preclude referral or admission of an individual who is homeless or lacks an immediate disposition plan as determined by the DA and DMH care management. If the acute crisis episode resolves and there remains no immediate housing identified, the client will be assisted in attempting to access area homeless resources, up to and including emergency housing, warming shelters, ESD support, etc. The client's primary designated agency will remain actively involved in all care planning throughout the client's stay at the crisis bed.

Support and referral include triaging aftercare needs, supportive counseling, skills training, symptom management, medication monitoring, crisis planning, and assistance with referrals from crisis

stabilization in a person's home or by phone. These services are available 24 hours a day, 7 days a week with awake staffing.

## CONDITIONS OF COVERAGE

Crisis stabilization and support services must be provided under the supervision of a Medicaid-enrolled physician or licensed mental health practitioner affiliated with the DA. This service is allowable for case rate billing without a prescription in the individual treatment plan.

The minimum encounter to be allowable for case rate billing is defined as completion of intake into the facility. Staff will continue to document one encounter per day of Crisis Stabilization and Support Services until discharge.

## DOCUMENTATION REQUIREMENTS

Crisis stabilization and support service needs must be documented upon admission, per shift and/or per 8-hour period of crisis stabilization, and upon discharge for all emergency community support services. Services requiring a qualified provider under supervised billing guidelines must be documented by the qualified provider following appropriate service documentation guidelines (i.e.: Medication Consultation, Individual Therapy, etc.)

If crisis stabilization and support service admission and discharge occur within the course of an 8-hour period, documentation may abbreviate admission, shift, and discharge information into a summary overview note to reflect the brief course of care.

Crisis stabilization and support services must include, in summary form:

<u>Admission Documentation</u>

- A description of the precipitant crisis or behavioral/psychiatric decompensation (e.g. observation of behavior supporting crisis stabilization).
- An assessment of treatment needs or anticipated benefits of proactive clinical intervention.
- A plan for treatment (e.g. issues to be addressed or discussed).
- Level of Care Utilization System (LOCUS)

<u>Per shift and/or 8-hour period of ongoing crisis stabilization</u>

- A log or record of observations made of the individual (e.g. behavioral or psychiatric indicators for ongoing crisis stabilization).
- A log or record of the interventions used and the individual's response.
- The clinician's assessment of the issues/situation/risks.
- An ongoing plan for crisis stabilization.

Discharge Summary

- A log or record of the observations of the individual's current behavior and presentation.
- The issues addressed or discussed or skills developed in the course of service.
- The clinician's assessment of the individual's response to crisis stabilization.
- A follow-up plan (e.g. appointments, supports, medication change, etc.).
- LOCUS

It is acceptable to document crisis stabilization and support services in a log. If the crisis stabilization and support services are documented in a log and are provided by the same individual, that staff member would need to sign the page only once. However, if other staff members enter notes periodically in the log, each staff member must sign their own individual notes. The log sheet must be placed in the clinical record for purposes of audit.

Daily bed utilization must be reported to DMH. Bed occupancy will be reported at minimum once every 24 hours; however, it is the expectation that programs will report as close to real time as possible.

### STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

## 3.4 INDIVIDUAL THERAPY (PSYCHOTHERAPY)

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Individual therapy may be face-to-face or through Telemedicine[16].

### CONDITIONS OF COVERAGE

[16] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

Individual therapy may be face-to-face or through Telemedicine[17].

Only one encounter may be recorded regardless of the number of therapists who are present during a session.

Individual therapy may involve the inclusion of other significant persons in the session, however the session is considered an encounter only if the Medicaid-enrolled member is present. Individual Therapy must be authorized in the consumer's Individualized Plan of Care[18].

The minimum duration for an individual therapy encounter to be allowable for case rate billing is 16 minutes.

## DOCUMENTATION REQUIREMENTS

Each session requires a discrete note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

The clinical content of a progress note for individual therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document

- the clinical intervention used,
- the current issues discussed or addressed,
- the observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment;
- if indicated, the involvement of family and/or significant others in treatment;
- the clinician's assessment of the issues,
- movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- specific plan for ongoing treatment or follow-up.

## STAFF QUALIFICATIONS

Individual Therapy services must be delivered by one of the following:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the Designated Agency/Specialized Services Agency
- Licensed psychiatric nurse practitioner directly affiliated with the Designated Agency/Specialized Services Agency or BA level intern providing clinical services through a formal internship as part of a clinical master's level program,

[17] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

[18] See also *Individualized Plan of Care (IPC) Timelines and Required Components* in Section *4.5 Care Planning* of this document.

- A non-licensed Psychiatric Nurse Practitioners refer to *Section 8.5 – Supervised Billing for Behavioral Health Services* in the Vermont Medicaid Provider Manual, located at http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf
- A staff member of the Designated Agency/Specialized Services Agency who holds one of the following credentials:
    - Licensed Psychologist
    - Licensed Marriage and Family Therapist
    - Licensed Clinical Mental Health Counselor
    - Licensed Independent Clinical Social Worker
    - For Master's level, or BA level intern providing clinical services through a formal internship as part of a clinical Master's level program, non-licensed, rostered clinical staff, Supervised Billing rules apply. For more information, refer to *Section 8.5 – Supervised Billing for Behavioral Health Services* in the Vermont Medicaid Provider Manual, located at http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf
- Any subcontractor must meet both of the following requirements:
    - Meet staff qualifications described above.
    - Be authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.

## 3.5 FAMILY AND COUPLES THERAPY (PSYCHOTHERAPY)

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Family Therapy is an intervention by a therapist with an individual and/or their family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members, and includes couples therapy.

### CONDITIONS OF COVERAGE

A family therapy session is allowed face-to-face or through Telemedicine[19].

Family therapy sessions are considered an encounter for only one Medicaid enrolled family member per session.

[19] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

Couples therapy sessions are considered an encounter family therapy for only one Medicaid enrolled member per session.

The minimum duration for an individual therapy encounter to be allowable for case rate billing is 30 minutes

Couples or Family Therapy must be authorized in the consumer's Individualized Plan of Care[20].

## DOCUMENTATION REQUIREMENTS

Each session needs a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

The clinical content of a progress note for family therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document,

- the clinical intervention used,
- the current issues discussed or addressed;
- the observations made of the individual and family (the individual or family system response to the treatment session) or any significant factors affecting treatment;
- the clinician's assessment of the issues,
- the movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- a plan for ongoing treatment or follow-up.

## STAFF QUALIFICATIONS

Family Therapy must be authorized in the consumer's Individualized Plan of Care. For more detailed information, see *Individualized Plan of Care (IPC) Timelines and Required Components* in Section *4.5 Care Planning* of this document. Family Therapy services must be delivered by one of the following:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the Designated Agency/Specialized Services Agency
- Licensed psychiatric nurse practitioner directly affiliated with the Designated Agency/Specialized Services Agency
- For non-licensed Psychiatric Nurse Practitioners refer to Section 8.4 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid Provider Manual, located at https://www.vtmedicaid.com/downloads/manuals.html.
- A staff member of the Designated Agency/Specialized Services Agency who holds one of the following credentials:

[20] For more detailed information, see *Individualized Plan of Care (IPC) Timelines and Required Components* in Section *4.5 Care Planning* of this document.

- Licensed Psychologist
- Licensed Marriage and Family Therapist
- Licensed Clinical Mental Health Counselor
- Licensed Independent Clinical Social Worker
- For Master's level, or BA level intern providing clinical services through a formal internship as part of a clinical Master's level program, non-licensed, rostered clinical staff, Supervised Billing rules apply. For more information, refer to Section 8.5 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid Provider Manual, located at http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

- Any subcontractor must meet both of the following requirements:
  - Meet staff qualifications described above.
  - Be authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.

## 3.6 GROUP THERAPY (PSYCHOTHERAPY)

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Group therapy is an intervention strategy that treats individuals simultaneously for social maladjustment issues or emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy shall focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress.

Group therapy also includes multiple families or multiple couple's therapy.

### CONDITIONS OF COVERAGE

Group Therapy sessions are face-to-face and/or through telemedicine[21].

Group Therapy sessions with a single therapist may not exceed 10; sessions with multiple therapist may not exceed 15 individuals.

The minimum duration for a group therapy encounter to be allowable for case rate billing is 45 minutes

Group therapy sessions are considered an encounter for each Medicaid member participating in the session.

[21] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

If two or more clinicians lead a group, it is considered one encounter. The clinician that bills must also be the clinician that completes the documentation to sufficiently tie the service to the billing record.

Group Therapy must be authorized in the consumer's Individualized Plan of Care[22].

## DOCUMENTATION REQUIREMENTS

The clinical content of a progress note for group therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document

- the clinical intervention used,
- the current issues discussed or addressed,
- the observations made of the individual (the individual response to the group dynamic in the treatment session) or any significant factors affecting treatment;
- the clinician's assessment of the issues,
- the movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- a plan for ongoing treatment or follow-up.

## STAFF QUALIFICATIONS

Group Therapy must be authorized in the consumer's Individualized Plan of Care. For more detailed information, see *Individualized Plan of Care (IPC) Timelines and Required Components* in Section *4.5 Care Planning* of this document.

Group Therapy services must be delivered by one of the following:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the Designated Agency/Specialized Services Agency
- Licensed psychiatric nurse practitioner directly affiliated with the Designated Agency/Specialized Services Agency
- For non-licensed Psychiatric Nurse Practitioners refer to Section 8.4 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid Provider Manual, located at https://www.vtmedicaid.com/downloads/manuals.html.
- A staff member of the Designated Agency/Specialized Services Agency who holds one of the following credentials:
    - Licensed Psychologist
    - Licensed Marriage and Family Therapist
    - Licensed Clinical Mental Health Counselor
    - Licensed Independent Clinical Social Worker

[22] See also *Individualized Plan of Care (IPC) Timelines and Required Components* in Section *4.5 Care Planning* of this document.

    - For Master's level, or BA level intern providing clinical services through a formal internship as part of a clinical Master's level program, non-licensed, rostered clinical staff, Supervised Billing rules apply. For more information, refer to Section 8.5 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid Provider Manual, located at http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

- Any subcontractor must meet both of the following requirements:
    - Meet staff qualifications described above.
    - Be authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.

## 3.7 MEDICATION EVALUATION, MANAGEMENT AND CONSULTATION SERVICES

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Medication Management and Consultation Services include evaluating the need for medication, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's mental health care in coordination with other medical providers.

Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual.

### CONDITIONS OF COVERAGE

There must be a face-to-face or telemedicine interaction that includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction (favorable or unfavorable) to the medication.

The minimum duration for a Medication Evaluation, Management and Consultation Service encounter to be allowable for case rate billing is 15 minutes.

Medication Evaluation, Management and Consultation Services must be authorized in the consumer's Individualized Plan of Care.

### DOCUMENTATION REQUIREMENTS

Documentation must indicate a face-to-face interaction with the individual that includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction

(favorable or unfavorable) to the medication. Furthermore, the reaction of the individual to the medication is not only in terms of the physical reaction (side effects) but most importantly the mental status changes at which the medication is aimed. Accurate representation of these factors requires both pharmacological and mental health psychiatric skills. Documentation must also include any discussion with the individual of other physician or laboratory reports as they pertain to their medical/mental health.

Any change in medication (addition, deletion, change in dosage) must be documented on the medication list and, if proper authorization is in place, shared with the individual's primary care provider. If the individual receives psychopharmacological supports from the DA/SSA, the medications are documented with dosage, route, and schedule. All medication changes, start dates, and refills must be documented, and medication use or benefits are reflected as well as medical/psychiatric information changes.

If medication evaluation, management, and consultation were provided in a group setting, there must be separate notes written for each individual.

### STAFF QUALIFICATIONS

Medication Evaluation, Management and Consultation Services may only be provided by a physician certified in psychiatry by the American Board of Medical Specialties or an authorized Advanced Practice Registered Nurse (APRN) who is licensed in Vermont and directly affiliated with the Designated Agency/Specialized Services Agency and operating within their scope of practice.

## 3.8 SERVICE PLANNING AND COORDINATION

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well-being of individuals (and their families) and supporting them to make and assess their own decisions.

Staff Conferences, with or without the individual's presence, for treatment-related case discussions, for developing or modifying individual plans of care, for monitoring the appropriateness of on-going treatment, or for the review and determination of current case assignment or reassignment, constitute service planning. Multiple staff members, agencies, and others may be involved in treatment planning activities. Contact with family, guardian, or primary support relationships specific to treatment planning or determining the appropriateness of current services and supports is included (and expected) in service planning and coordination services.

### SERVICE COORDINATION

Service coordination involves authorized contact with other providers from agencies other than one's own for the purpose of case review or consultation regarding the provision and coordination of services on behalf of a specific individual. Other service professionals may include: physicians, hospitals, corrections, law enforcement, state agencies, schools and community organization representatives. Service Coordination may also occur with family, guardian, landlord, employers or other primary support relationships as indicated to build and promote continuity of services with the purpose of attaining life goals. Service coordination includes both face-to-face, telephone and electronic consultation.

For individuals who are hospitalized or children who are placed in crisis bed programs or residential treatment programs, discharge planning, transition and aftercare coordination is part of service coordination when there is no duplication of service between the institution and the designated agency. The designated case manager is the staff member responsible for providing coordination.

### CONDITIONS OF COVERAGE

When multiple clinicians provide service planning and coordination on behalf of an individual, during the same encounter, only one clinician can bill for service planning and coordination.

Service Coordination must be indicated in the person's Individualized Plan of Care and may not include vocational activities[23].

The minimum duration for a Service Planning and Coordination service encounter to be allowable for case rate billing is 15 minutes accumulated in one day.

### DOCUMENTATION REQUIREMENTS

The minimum requirement for documentation of service coordination for children or adults is inclusion in a monthly progress note. If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required. Weekly progress notes or "hit" notes for each service contact are also acceptable.

All summary note documentation shall be supported by chronological encounter data which identifies the client, service provided, person delivering service, the date of service, place of service, and duration of time. Verifiable, chronological encounter data supplants the need to embed dates, times and staff specific encounters into the weekly or monthly summary notes.

Progress notes for service planning and coordination must include

- a summary of primary service planning and/or coordinating activities consistent with treatment goals,
- a summarized observations of case management contacts that may impact treatment;

[23] For more information, please see *Individualized Plan of Care (IPC) Timelines and Required Components* in Section 4.5 *Care Planning* of this document.

- the assessed effects of service planning and coordination activities and any progress toward treatment goals,
- a description of ongoing needs and plan for case management services.

### STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

## 3.9 COMMUNITY SUPPORTS

Target Group: All Global Commitment to Health Enrollees

### DEFINITION

Community Supports are individualized and goal-oriented services to assist individuals and their families with clearly documented psychosocial needs and diminished function. Services assist the individual to access community supports and develop social skills necessary to improve overall function and promote community connectedness and positive growth. These services may include support in accessing and effectively using community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.

Accessing and using community services and activities may include the development of those skills that enable an individual to seek out, clarify, and maintain resources, services, and supports for independent living in the community, including communication and socialization skills and techniques.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. This activity can be provided either face-to-face, through telemedicine[24] or by phone.

Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budgeting, meal planning, household maintenance, and community mobility skills.

Group community support may be an appropriate treatment modality. This intervention strategy must clearly align with individual treatment goals, emphasizing interactions and mutuality of issues between two or more individuals, for anticipated benefits of a group intervention.

### CONDITIONS OF COVERAGE

[24] See *Telemedicine*, *Section 10.3.53*, of the Vermont Medicaid Provider Manual for specific requirements related to the provision of telemedicine services: http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

For group community support, there must be no less than one staff member to every four (4) individuals present.

The minimum duration for a Community Support service encounter to be allowable for case rate billing is 15 minutes accumulated in one day.

Community supports do not include

- daily living and social skills interventions that are provided through the nursing facility Medicaid per diem,
- vocational and educational service activities.

Transportation that includes goal-oriented community support time with the individual can be coded as an encounter.

The service must be authorized in the consumer's Individualized Plan of Care[25].

## STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

## DOCUMENTATION REQUIREMENTS

The minimum requirement for documentation of community supports is a monthly progress note. If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required. Weekly progress notes or individual encounter notes are also acceptable.

All summary note documentation shall be supported by chronological encounter data which identifies the client, service provided, person delivering service, the date of service, place of service, and duration of time. Verifiable, chronological encounter data supplants the need to embed dates, times and staff specific encounters into the weekly or monthly summary notes.

<u>Progress notes for community supports must include</u>

- the clinical intervention used,
- a summary of major content or intervention themes consistent with treatment goals,
- observations made of the individual or responses to interventions,
- the individual or parent/guardian's assessment of effectiveness/value of the interventions,
- an assessment of progress toward the treatment goal,
- a description of ongoing needs for continued intervention and plan for next steps.

[25] For specifics please see *Individualized Plan of Care (IPC) Timelines and Required Components* in Section 4.5 *Care Planning* of this document.

## 3.10 SUPPORTED EMPLOYMENT

Target Group: Adults in CRT or youth as defined in this section.

DEFINITION

Supported employment services assist individuals with developing, achieving and sustaining work, educational, and career goals. Supported employment emphasizes an individual's strengths, capabilities, and preferences. Services are provided primarily in the community to increase positive relationships with community members and to offer service settings based on a person's preferences.

*Employment services DO NOT include assisting a person with sheltered employment, work enclaves, or agency-run work crews.*

Supported employment services shall be prioritized for individuals meeting criteria for CRT (See Section 2.2) and youth meeting the criteria outlined below.

Other individuals may access these services as resources allow.

Youth Supported Employment (also known as JOBS) eligibility criteria:

**Must meet #1 – 4 and one or more of #5**

1) 16 through 21 years old (*under 22 years old*)
2) Meet Act 264 guidelines for Severe Emotional Disturbance (see https://legislature.vermont.gov/statutes/fullchapter/33/043 for definition)
3) Eligible for Vocational Rehabilitation
4) Out-of-school (officially or unofficially "dropped out" as defined below)*

   *OR* graduated/received GED

   *OR* enrolled in Community High School or Vermont Adult Learning

   *OR* seriously at risk for leaving public high school or an alternative school program prior to successful completion due to:

- Six months or less prior to graduation and has multiple risk factors (homelessness or impending homelessness, lack of parental involvement, involvement with Corrections, etc.) *OR*
- A history of suspensions, expulsions, school violence, truancy or other serious ongoing disciplinary actions *OR*
- Scheduled to be in school less than half time *OR*
- A serious lack of accumulated academic credits

   *Note: If a participant returns to school during the JOBS Program, they stay eligible.*

5) Have one or more of the following challenges:

   - Homeless or at risk of becoming homeless *OR*
   - Receives SSI *OR*
   - Risk of initial involvement, current, or history of involvement with Corrections *OR*

- History of involvement with Department for Children and Families (foster care, juvenile justice, economic services)

*Vermont's definition of "drop out":

*A youth who has dropped out of school by state and federal definition is an individual student who is not enrolled in an approved educational program and who has not graduated from high school. In Vermont, a student who is absent for more than 10 consecutive school days without authorization is classified as "withdrawn." If a truant officer is unable to verify that the student has transferred to a different school or approved educational program (e.g., home school) before the end of the year, the student is considered to have dropped out of school.*

## ENGAGEMENT AND EMPLOYMENT ASSESSMENT

Engagement and employment assessments are provided prior to securing employment or acceptance into an educational program. They can be services provided as part of career advancement if already employed. Services that involve identifying, exploring, and gathering information from multiple sources about an individual's strengths, talents, preferences and interests, past work and educational experiences, social security benefits, and supports needed to find and maintain employment and/or achieve educational goals.

*Major activities include*

- *gathering information from multiple sources (individual, treatment team, family, employers, community partners, schools, health care facilities, etc.);*
- *consulting with treatment team members to encourage unified message of support,*
- *creating a career profile or updating an existing profile,*
- *meetings with a Vocational Rehab counselor or benefits counselor,*
- *discussing self-disclosure,*
- *practicing mock interviews,*
- *facilitating informational interviews at local businesses with individual,*
- *identifying potential accommodations that might be of benefit,*
- *developing an employment or educational plan with the individual,*
- *developing a job search plan with the individual,*
- *developing a Follow Along plan (if prior to job starting),*
- *maintaining engagement and conducting outreach activities as needed.*

## EMPLOYER RELATIONSHIPS AND JOB DEVELOPMENT

Employer relationship and job development services assist an individual to obtain competitive employment in the community, advance in a current position or field, develop self-employment, and/or help to establish and maintain positive employer relationships. These activities are located primarily in the community and are conducted on behalf of or with an individual.

*Major activities include*

- *face to face meetings with a business' hiring manager to learn about staffing and business needs,*
- *identification or enhancement of community-based job opportunities,*
- *attendance of chamber of Commerce meetings, creative Workforce Solutions meetings and/or job fairs,*
- *taking a company tour,*
- *talking to employers on behalf of the individual,*
- *writing "thank you" notes,*
- *providing consultation or education to employers and co-workers, and*
- *teaching individual about job search techniques.*

## JOB TRAINING THROUGH EDUCATION

Supported education services assist an individual, post high school, with achieving an educational degree, certificate, or GED with the goal of employment and/or career advancement.

*Major activities include*

- *assisting individuals with learning about educational and degree programs, job training programs, apprenticeships, internships, and certificate programs;*
- *taking people to visit programs, talking with instructors, advisors, school counselors, and admission staff;*
- *developing an education plan with the individual*
- *helping the individual with investigating financial aid and methods for paying for school;*
- *exploring with the individual the various accommodations and supports available to students with disabilities to succeed in school, and*
- *supporting the individual with an application process, attendance, homework, study supplies, course selection, study skills and/or securing transportation.*

## ONGOING SUPPORT TO MAINTAIN EMPLOYMENT

Ongoing supports to maintain employment are provided AFTER a person secures employment and involve activities needed to sustain paid work by the individual. Supports and services may be provided both on and off the job site and may involve long-term and/or intermittent follow-up. Services include those provided 1:1 with the individual or on behalf of the individual.

*Major activities include*

- *updating the Follow Along Support Plan with the individual*
- *assistance with buying work clothes or tools,*
- *developing a work schedule,*
- *meeting with the employer (with the individual's permission);*
- *providing individualized job supports such as:*
    - *meeting with the individual prior to the first day on the job to offer support, going with the person on the first day of the job; picking the person up from work to check in about the job,*

*job training support on or off the job (for a limited time); help with disclosure, role playing how to ask for breaks or time off, etc.;*

- *meeting with benefits counselor after a pay raise or to learn how to report income, and*
- *transportation training or support.*

### CONDITIONS OF COVERAGE

Supported employment services must be delivered in conjunction with one or more covered services listed in Section 3.1. Encounter data is required, however this service alone does not qualify to draw down the case rate regardless of duration.

Supported employment must be authorized in the consumer's Individualized Plan of Care. For specifics please see Individualized Plan of Care (IPC) Timelines and Required Components in Section 4.5 Care Planning of this document.

### SERVICE DELIVERY EXPECTATIONS

Supported employment services are expected to adhere to the evidence-based employment practices and to the principles of recovery-oriented, strength-based, and person-centered care.

### DOCUMENTATION REQUIREMENTS

The minimum requirement for documentation of a supported employment service is a monthly progress note. If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required.

The monthly progress note for supported employment must:

- describe the purpose, content, and outcome of each activity;
- describe individual's response and staff's observations,
- describe overall progress for the month in relation to the individual's plan of care, and
- identify next steps determined through shared-decision making with the individual.

### STAFF QUALIFICATIONS

The services must be provided by staff of the Designated Agency/Specialized Service Agency or a qualified provider subcontracted by the DA/SSA who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

## 3.11 DAY SERVICES

Target Group: Individuals in CRT

### DEFINITION

Community-based services may be provided in a Day Service environment, where group recovery activities are provided to adults in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are client-centered. Day Services should provide socialization, daily skills development and crisis support, and promote self-advocacy. These services can be provided by peer providers if employed by the agency, or by clinical staff.

### CONDITIONS OF COVERAGE

Days Services are not eligible to draw down the case rate as a stand-alone service. Day Services are reserved for adults in CRT who are receiving other qualifying mental health services.

### DOCUMENTATION REQUIREMENTS

A chronological log of all Day Services encounter data which identifies the client, service provided, person delivering service, the date of service, place of service, and duration of time. Indication in the monthly summary note that the client received a Day Service.

### STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency, Peer Providers, or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

## 3.12 TRANSPORTATION

Target Group: Individuals in CRT

### DEFINITION

Transportation services are for the necessary transportation of individuals covered by Medicaid to and from an agency facility in order to receive Medicaid- reimbursable services. "Necessary" means that the individual has no reasonable alternative transportation available and, without such transportation, would not be able to receive these Medicaid-reimbursable services.

### CONDITIONS OF COVERAGE

Transportation services are not eligible to draw down the case rate as a stand-alone service. Transportation services are reserved for adults in CRT who are receiving other qualifying mental health services.

### DOCUMENTATION REQUIREMENTS

A chronological log of all Transportation encounter data which identifies the client, service provided, person delivering service, the date of service, place of service, and duration of time. The monthly summary note must also include an indication that the client received a Transportation Service.

### STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

## 3.13 SPECIAL EVALUATIONS

Target Group: Children receiving IHCBS

### DEFINITION

A specialized clinical evaluation, such as a neuropsychological, psychosexual, risk assessment or an in-depth trauma evaluation, which includes a child's current level of functioning, mental health, social, and family history, a Diagnostic Statistical Manual (DSM) diagnosis as appropriate to the evaluation type, and recommendations.

### CONDITIONS OF COVERAGE

Costs related to specialized evaluations are included in the mental health child case rate. Specialized evaluations are eligible to draw down the case rate as a stand-alone service.

Special evaluations are reserved for children receiving IHCBS who are receiving other qualifying mental health services.

### DOCUMENTATION REQUIREMENTS

A copy of the special evaluation must be included in the individual's record and include all necessary elements in accordance with practice standards for the evaluation type.

Requires submissions of encounter (E01 Clinical Assessment) to document service delivery.

### STAFF QUALIFICATIONS

This service must be provided by specialized practitioners sub-contracted by the DA/SSA.

Sub-contractors must be licensed, working within their professional scope of practice, and have appropriate credentialing or evidence of successfully completing a nationally recognized training program in the specialty area.

The sub-contractor must be also be authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.

## 3.14 FAMILY EDUCATION/ CONSULTATION

Target Group: Children receiving IHCBS

### DEFINITION

Education, consultation and training services provided to family members, significant others, home providers, foster families and treatment teams to increase knowledge, skills and basic understanding necessary to promote positive change. This can include clinical consultation from a provider with a specific clinical specialty or with a provider from the private sector who has been working with the child or family.

### CONDITIONS OF COVERAGE

Costs related to family education/consultation are included in the mental health child case rate. Family education/consultation is not eligible to draw down the case rate as a stand-alone service.

Family education/consultation is reserved for children receiving IHCBS who are receiving other qualifying mental health services.

### STAFF QUALIFICATIONS

This service is provided by specialized practitioners sub-contracted by the DA/SSA. Sub-contractors must be licensed, working within their professional scope of practice, and have the appropriate credentialing or evidence of successfully completing a nationally recognized training program in the specialty area.

The sub-contractor must be also be authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.

### DOCUMENTATION REQUIREMENTS

DA's are responsible for ensuring that all sub-contractors provide documentation of the consultation they provide to families or treatment teams. Documentation must include encounter information for each individual service provided and meet all applicable standards.

## 3.15 RESPITE

Target Group: Children receiving IHCBS

### DEFINITION

Respite (hourly): In-home or community-based care for the purpose of providing a planned break for parents/guardians or foster care providers for children in foster care/therapeutic foster care.

Respite (overnight): Care for the purpose of providing a planned overnight break for parents/guardians. It is a supportive service for non-custody children/youth that are living in their own home/residence, be it a biological, adoptive, or kin-care home.

### CONDITIONS OF COVERAGE

Costs related to respite are included in the mental health child case rate. Respite is not eligible to draw down the case rate as a stand-alone service.

Respite is reserved for children receiving IHCBS who are receiving other qualifying mental health services.

Overnight respite providers must be licensed by the Department for Children and Families (DCF) as a foster home.

Children/youth in DCF custody and those living in TFC or DCF Foster Care are not eligible for DMH funded overnight respite.

### DOCUMENTATION REQUIREMENTS

Brief monthly summary of individual response and ongoing need for continued intervention.

Requires submissions of encounters to document service delivery.

### STAFF QUALIFICATIONS

Family members may not serve as paid respite providers.

## 3.16 THERAPEUTIC FOSTER CARE

Target Group: Children receiving IHCBS

### DEFINITION

These arrangements provide short-term individualized support for children in the home of a contracted foster home provider. Foster home arrangements may include 24-hour, seven-day-a-week services or a shared parenting arrangement whereby children live part time in the foster home and part time with their family as members learn new skills and positive coping strategies for family living. Home providers are expected to work closely with the service coordinator, family and treatment team to assure care is aligned with family integration goals and the child's treatment plan objectives. Home providers are considered independent contractors with a DA/SSA responsible for quality oversight and case management services on behalf of the child. If there is need for a planned overnight break for the primary foster home, the child may stay at a secondary foster home.

This out-of-home setting is designed to be short-term in nature to support the child/youth and family to develop the skills necessary to reduce psychiatric symptoms and transition back into the child/youth's home.

### CONDITIONS OF COVERAGE

All foster homes must be licensed by the Department for Children and Families (DCF).

DA/SSA provides specialized training, support, and supervision to therapeutic foster parents to apply specialized parenting skills to support children and adolescents with mental health and behavioral difficulties.

Home providers may not also serve as case managers or guardians for children in their care

Therapeutic Foster Care is not considered a qualifying encounter for purposes of case rate billing. Costs associated with Therapeutic Foster Care are included in the mental health child monthly case rate and are received when a billable service is provided.

### DOCUMENTATION REQUIREMENTS

Brief monthly summary of individual response and ongoing need for continued intervention.

Requires submissions of encounters to document service delivery.

The living arrangement must be documented in the Individualized Plan of Care.

### STAFF QUALIFICATIONS

The DA/SSA retains responsibility for coordinating access to services and oversight of treatment approaches and plans of care for all youth placed in licensed TFC homes. The DA/SSA will have contractual arrangements that delineate clear roles and responsibilities for the family, foster home and DA/SSA.

## 3.18 SHARED LIVING HOME PROVIDERS

Target Group: Individuals in CRT

### DEFINITION

These are individualized shared-living arrangements for adults, offered within a home provider's home. Home providers are contracted workers and are not considered staff of the host agency in their role as contracted provider.

### CONDITIONS OF COVERAGE

Shared living arrangements may be prior authorized by DMH as a part of an enhanced funding plan (see also section 5.1 regarding outlier payments) and may be included in individually calculated outlier rates. Shared living arrangements that are provided by a DA/SSA at its discretion, through use of earned revenue, are not subject to prior authorization by DMH.

Providing a shared living arrangement is not considered an encounter for purposes of case rate billing or reporting. Costs associated with prior authorized shared living arrangements may be included in the monthly outlier case rate and are received when a billable service is provided.

### DOCUMENTATION REQUIREMENTS

Choice of this living arrangement and continued need must be documented in the Individualized Plan of Care and included in at least the monthly summary note.

### STAFF QUALIFICATIONS

Individuals who, based on their education, training, or experience, are determined competent to provide the service by the Medical Director of the DA/SSA.

## 3.19 STAFFED LIVING

## CHILDREN YOUTH AND FAMILIES STAFFED LIVING

Target Group: Children receiving IHCBS

### DEFINITION

Staffed living for children and youth (formerly referred to as micro-residential programs) are community-based homes for 3-4 children with significant mental health/behavioral needs. These arrangements are targeted to children and adolescents who are at risk of institutional care, are transitioning to home from psychiatric inpatient or intensive residential treatment, and/or adolescents with significant mental health needs who are transitioning to adulthood.

### CONDITIONS OF COVERAGE

Children and youth must meet criteria for Intensive Home and Community Based Services (IHCBS) to be eligible for staffed living services. *See IHCBS Conditions of Coverage in Section 2.2 of this manual.

Staffed Living settings are required to be licensed by the Department of Children and Families as a Residential Treatment Facility. They are staffed 24/7 with intensive mental health services and supports.

Each community setting serves no more than 4 children or youth.

Triaging for admissions beyond 7 days shall be done in consultation with DMH and DCF. A CANS completed within the last 6 months must be provided to the staffed living placement.

Costs related to Staffed Living arrangements are included in the case rate. Staffed living arrangements in and of themselves do not qualify as an eligible service for the case load count. Additional qualifying mental health services are required for the individual to be counted towards the caseload.

### DOCUMENTATION REQUIREMENTS

Choice of this living arrangement and continued need must be documented in the Individualized Plan of Care and included in at minimum the weekly summary note. Communication between staffing shifts is needed for best clinical practice and specific content is at the discretion of the DA/SSA.

The Staffed Living service encounter must be submitted as 1 unit per day of service. Encounter data for additional qualifying mental health services (Service Coordination, Community Supports, Therapy and Med Management) must be entered by the staff providing the service. Service Coordination and Community Support encounter data may be aggregated if provided by the same staff for the same client in the same day.

Clinical documentation to support the encounter submission for therapy codes shall be documented in accordance with the service guidelines (See Sections 3.4 -3.6 of this Provider Manual.)

Service Coordination and Community Support clinical documentation provided throughout the week is not required per service submitted, and shall be summarized through a weekly note, identifying interventions used, progress towards goals and continuing treatment needs.

### STAFF QUALIFICATIONS

Individuals who, based on their education, training, or experience, are determined competent to provide the service by the Medical Director of the DA/SSA.

### STAFFED LIVING ADULTS

Target Group: Individuals in CRT

### DEFINITION

This service consists of residential living arrangements for one or two people, staffed full-time by employees of a provider agency.

### CONDITIONS OF COVERAGE

Staffed living arrangements may be prior authorized by DMH as a part of an enhanced funding plan (see also section 5.1 regarding outlier payments) and may be included in individually calculated outlier rates. Staffed living arrangements that are provided by a DA at its discretion, through use of earned revenue, are not subject to prior authorization by DMH.

Staffed living is not considered an encounter for purposes of case rate billing or reporting. Costs associated with staffed living may be included in the monthly outlier case rate and are received when a billable service is provided.

### DOCUMENTATION REQUIREMENTS

Choice of this living arrangement and continued need must be documented in the Individualized Plan of Care and included in at least the monthly summary note.

### STAFF QUALIFICATIONS

Individuals who, based on their education, training, or experience, are determined competent to provide the service by the Medical Director of the DA/SSA.

## 3.20 GROUP LIVING

Target Group: Individuals in CRT

### DEFINITION

This service consists of group living arrangements for three or more people, owned and/or staffed full-time by employees of a provider agency. These arrangements are designed to provide individualized, recovery-oriented treatment plan services in either transitional or longer term residential rehabilitation settings. Group Living arrangements are licensed as residential treatment programs[26]; and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with their treatment plan.

[26] Link to DAIL licensing website.

### CONDITIONS OF COVERAGE

Group living is not considered an encounter for purposes of case rate billing or reporting. Costs associated with group living are included in the monthly case rate and are received when a billable service is provided.

### DOCUMENTATION REQUIREMENTS

Choice of this living arrangement and continued need must be documented in the Individualized Plan of Care and included in at least the monthly summary note.

### STAFF QUALIFICATIONS

A Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider.

## 3.21 INTENSIVE RESIDENTIAL RECOVERY (IRR)

Target Group: Individuals in CRT

### DEFINITION

This residential treatment setting consists of specialized group arrangements for three or more people, staffed full-time by employees of a provider agency. These arrangements are designed to be recovery oriented and treatment focused programs for individuals frequently stepping down from hospital level of care. Eligibility thresholds for entrance to these transitional support and treatment programs anticipate individuals who continue to require ongoing supervision by skilled mental health staff and in an environment focused on safety and further harm reduction and mitigation work as part of aftercare in the community and access to more permanent, stable living options. IRR arrangements are also licensed as residential treatment programs[27] and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with their treatment plan.

### CONDITIONS OF COVERAGE

Intensive residential recovery is not considered an encounter for purposes of case rate billing or reporting. Costs associated with intensive residential recovery are included in the monthly case rate and are received when a billable service is provided.

### DOCUMENTATION REQUIREMENTS

Choice of this living arrangement and continued need must be documented in the Individualized Plan of Care and included in at least the monthly summary note.

[27] DAIL licensing weblink here.

### STAFF QUALIFICATIONS

A Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider.

## 3.22 MENTAL HEALTH PROGRAMS NOT IN CASE RATE

The following DA/SSA programs and fund sources are not paid through the child or adult mental health case rates:

- Reach up
- Eldercare
- DCF funds for services and supports beyond those indicated by the individualized plan of care
- Private Non-Medical Institutions
- Success Beyond Six/C.E.R.T.
- General Fund (state only funds)
- Global Commitment Investments[28]
- Federal Grants

# 4. DA/SSA DELIVERY SYSTEM REQUIREMENTS

## 4.1 ELIGIBLE PROVIDERS

Providers eligible to receive child and/or adult mental health case rate payments are limited to DMH Commissioner-Designated Agencies (DA's) and other DMH Commissioner-designated entities such as Specialized Services Agencies (SSA's) that are established for the purpose of providing community based mental health care and are Medicaid-enrolled providers.

In order for a Commissioner-designated agency, specialized services agency, or entity to be eligible for participation under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards, procedures, and this manual's requirements as set by the Commissioner of the Department of Mental Health[29].

### RENDERING PROVIDER ELIGIBILITY

Billing is allowed when the staff qualifications for the service delivered and conditions of coverage are met, and the rendering provider is a

- a qualified staff person employed by a DA/SSA, or
- qualified sub-contractor hired by the DA/SSA, or

[28] See exception for individuals receiving services through CRT at or above 185% of FPL at section 2.3

[29] 18 VSA, Chapter 177, Section 7401(2), (4), and (15); and 18 VSA, Chapter 207, Sections 8907 through 8913.

- students/interns supervised by qualified staff of the DA/SSA and subject to all DA/SSA policies and procedures. The DA/SSA assumes responsibility for the work performed.

## SUB-CONTRACTORS

All sub-contractual arrangements must be in writing and specify procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims. No subcontract will terminate the legal responsibility of the DA/SSA to assure that all DMH requirements are met as described in the executed Master Agreement.

Sub-contracts for services must

- specify the amount, duration, and scope of services to be provided,
- allow evaluation by DVHA and the U.S. Department of Health and Human Services, through inspection or other means, of the quality, appropriateness and timeliness of services performed under the contract;
- require that the contractor maintain an appropriate record system for services to the service recipient,
- require that the contractor safeguards information about the individual, and
- allow for inspection and auditing of any financial records of the contractor/ subcontractor.

If a DA/SSA elects to sub-contract for behavioral health services from a non-DA/SSA provider, the DA/SSA may enter into a contract only if the non-DA/SSA provider

- accepts the contract conditions and reimbursement rates outlined,
- meets the DA/SSA's established credentialing requirements,
- has proof of adequate clinical supervision, and
- is willing to coordinate care with the DA/SSA, including sharing clinical information (with appropriate consent from the service recipient).

## ENROLLEE ACCESS TO NON-DA MEDICAID-ENROLLED LICENSED PROVIDERS

Any enrollee may access services from a Medicaid-enrolled licensed provider if they so choose. In the event that a person wants to access behavioral health services from a provider who is not employed by or under contract to the DA/SSA, that provider must be an enrolled Vermont Medicaid provider and must

- be willing to coordinate care with the DA/SSA, including sharing clinical information (with appropriate consent); and
- accept the DVHA-established Medicaid reimbursement rates.

Non-DA/SSA Medicaid-Enrolled Licensed Providers may bill Medicaid at the DVHA-established Medicaid reimbursement rates for Medicaid State Plan services. The DA/SSA is not obligated to find a Medicaid-

enrolled provider willing to serve the individual if the DA/SSA is offering to provide the clinically indicated covered service.

### HOME PROVIDERS AND RESPITE WORKERS - PEGGY'S LAW (18 V.S.A. § 7103)

The DA/SSA must ensure that contracted home providers and respite workers have relevant information about enrolled clients so that they can make an informed decision about providing care for such persons in their own home. Specifically, the DA/SSA is required to give home and day/overnight respite providers paid by the DA/SSA information about a person's history of violent or predatory behaviors, any potential predictors of such behaviors, and any prescribed medications they are using. This must be done with the individual's authorization. The home/respite provider has the option to choose to care for the individual even if the person refuses to disclose relevant information[30].

## 4.2 MEMBER GRIEVANCE AND APPEALS

DA/SSAs receiving Medicaid funding and responsible for providing DMH funded specialized programs for persons in CRT and IHCBS must maintain compliance with Vermont's Medicaid Managed Care grievance and appeals rules[31]. DA/SSAs must have processes and agreements in place to ensure that all necessary notices are provided to beneficiaries and that quarterly grievance and appeal reporting to the State is timely and accurate.

The Global Commitment to Health Medicaid Grievance and Appeal Technical Assistance Manual is located here: http://dvha.vermont.gov/ga-manual-2017-.pdf/view?searchterm=grievance and appeal manual

### GRIEVANCE AND APPEAL REPORTING

**For all Medicaid beneficiaries, the DA/SSA shall populate the DVHA grievance and appeals database (**https://www.ahsnet.ahs.state.vt.us/GCAppeal/gc_pword.cfm**) on a case-by-case basis. This is a Global Commitment requirement: it is not an optional activity.**

This action automatically notifies DMH of grievances and appeals. DMH reviews the reports to identify trends that may require further investigation and/or corrective action, and to ensure that grievances and appeals are being resolved in a timely manner. The External Quality Review Organization also does a periodic, federal audit of the data base to insure this requirement is fulfilled by DAs/SSAs and DMH.

### SUBCONTRACTOR GRIEVANCES AND APPEALS

Subcontractors to the DA/SSA must follow all required DA/SSA grievance and appeals rules, including assisting the service recipient, with the DA/SSA regarding service denials or reductions. Each DA/SSA Grievances and Appeals Coordinator is responsible for ensuring timely processing and resolution of all grievances and appeals.

[30] http://mentalhealth.vermont.gov/reports-forms-and-manuals/forms

[31] http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view

Each DA/SSA is expected to have a mechanism in place for timely resolution of subcontractor grievances with the DA/SSA or its staff members. All subcontractor appeals on behalf of individuals will be processed in accordance with the Grievance and Appeals Process.

Issues pertaining to denial of Medicaid eligibility should be directed to DVHA and not the DA/SSA.

## 4.3 ACCESS TO CARE

General access standards for DA/SSA services:

- The DA/SSA is responsible for making information available to individuals, family members, other service providers, and the general community about the array of services available.
- The DA/SSA must offer an easy screening and intake process.
- The DA/SSA will triage referrals based on the clinical assessment of acuity and the applicant's service needs. Routine care must be available in a timely manner consistent with the individualized treatment plan.
- Waiting times for scheduled appointments must not exceed one hour. Exceptions to the one-hour standard must be justified and documented in writing if requested by DMH.

Emergency Services Access Standards:

- Emergency Services shall be available 24 hours a day, 7 days a week, with telephone availability within an average of five minutes. Face-to-face Emergency Services must be available within an average of thirty minutes of identified need.
- Emergency Services shall be closely and routinely coordinated with all necessary community emergency resources, including medical and law enforcement support.

## CONSIDERATION FOR CHILDREN AND FAMILIES

The DA shall provide or secure access to services for all Vermont children and adolescents with Severe Emotional Disturbance (SED) or at risk of SED in its region in need of mental health assessment and/or treatment. Family support activities and treatment services will be

- available year-round (unless part of a specific seasonal approach such as summer or after school therapeutic programs);
- available 24 hours a day, 7 days a week if required by the individual's plan of care;
- provided in the natural environment (i.e., home or an early child care setting) to the maximum extent possible or a community setting that supports the family, child or youth's inclusion with typically developing peers;
- provided through a centralized intake and referral process either by "one door" (a single centralized point of entry) or "no wrong door" (a consistent intake and shared triage process used by all providers); and
- identified as medically necessary if they are treatment-related under Vermont Medicaid.

To assist in efficient use of intensive home and community-based service referrals the following shall be prioritized

- children who require an intensive level of mental health treatment in order to maintain safely in their home,
- children who currently reside out of their home and will require intensive level of mental health treatment in order to return safely to their family,
- children who require short term out of home stabilization in therapeutic foster care,
- children who require intensive amounts of mental health treatment as they transition to adulthood.

### CONSIDERATIONS FOR ADULTS

The DA/SSA is responsible for evaluating all referrals for CRT enrollment. Urgent care requests for eligibility shall be assessed within two business days and include individuals who are currently served in inpatient hospital settings, crisis beds, and Emergency Departments. Non-urgent requests for assessment to determine CRT eligibility shall be completed within 30 days of referral, contingent on the individual's participation.

The DA/SSA and its providers and subcontractors are prohibited from denying access to CRT for qualifying individuals who relocate to their catchment area. CRT enrollees have the right to move within Vermont and the DA/SSA shall make reasonable efforts to assist relocation. Assisting relocation does not require the receiving DA/SSA to provide housing. The receiving DA/SSA is responsible for working with the sending DA/SSA to support an individual's choice and goals, providing reasonable assistance in identifying resources for individuals choosing to relocate to their catchment area. For more information see Person/Family Centered Care, Section 4.5 of this manual.

The adult mental health case rate also covers adults of any age who are experiencing emotional or behavioral distress severe enough to disrupt their lives but do not meet coverage criteria for CRT services. The Agency shall address outpatient mental health needs of its communities to the extent that resources allow. To assist in efficient use of services the following shall be prioritized:

- individuals admitted to involuntary inpatient care who are not eligible for CRT services,
- individuals committed to the care and custody of the Commissioner of Mental Health in either inpatient or outpatient commitment who are not eligible for CRT services, and
- individuals and/or families in or transitioning from other intensive/high priority services funded by AHS including individuals served by the Department of Corrections (DOC), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department for Children and Families (DCF).

## 4.4 SCREENING AND ASSESSMENT

### CLINICAL ASSESSMENT SERVICE DELIVERY EXPECTATIONS

The DA/SSA is required to perform an assessment at intake[32] and periodically reassess the status of all children and adults enrolled in services. Comprehensive diagnostic and treatment reassessment is

[32] See section 3.1 Clinical Assessment

required at least every two years to closely re-examine diagnostic profiles and on-going service needs. Reassessments should also occur with significant events such as

- a substantial improvement that results in a long-term recovery or loss of disability, affecting eligibility determination,
- major transitions including developmental milestones (for example, child-adult transition, Major impairments or injury whereby needs change and other primary support programs are better able to meet those changed needs;
- prolonged pattern of non-participation in services,
- change or clarification of diagnosis that impacts treatment plan and/or eligibility,
- significant changes in family dynamics, make-up, support, or functioning; and/or
- significant escalation in patterns of behavior that impact placement, activities of daily living or ability to maintain in their current placement or safety in the community.

Reassessment should also consider ongoing clinical criteria for CRT and IHCBS services. Reassessment findings and planned services should reflect consideration of all pertinent clinical and psychosocial variables resulting in continuation or disenrollment from intensive services.

Reassessments for all individuals should include working with the individual and family (if appropriate) to update their goals and Plan of Care.

## SCREENING AND ASSESSMENT TOOLS

The use of standardized screening and/or evaluation tools is expected as part of the intake process and as clinically indicated to direct treatment decisions. At least one standardized screening and/or assessment tool will be used in order to develop the plan of care. The most appropriate tools for the presenting issue and age should be used; it is not expected that every tool listed by the State is used for every assessment. However, if serving a child or youth, all assessments should address family needs as well as the identified child or youth.

The DA/SSA will ensure that referrals for specialized consultation are provided as needed for individuals, children and families who have complex needs. The DA/SSA is responsible for covering the cost of specialized consultations through the child mental health case rate for individuals who are eligible for Intensive Home and Community Based Services (IHCBS). For individuals who are not found to need IHCBS, the DA/SSA can request funds via Special Services Funding.

## STANDARDIZED TOOLS FOR CHILDREN

The Department of Mental Health is moving to use of standardized tools for functional status and progress monitoring. Standardized tools should be used to prioritize interventions, direct treatment planning, and inform decision making at the direct service level. The aggregate data from these standardized tools will help guide policy, measure outcomes, and inform planning at the systems level. The CANS (Child and Adolescent Needs and Strengths) is the tool that has been selected for children's services 0-22.

In future years of payment reform, the CANS will be used as one of the quality measures. Designated Agencies shall continue to train and certify staff in the CANS (0-22) so that when the CANS data is linked to a value-based purchasing performance measure, the DAs are trained and certified appropriately.

The CANS is a multiple-purpose, information-integration tool that is designed to be the output of an assessment process. The purpose of the CANS is to accurately represent the shared vision of the child serving system, including the child and their family. As such, completion of the CANS allows for effective communication of this shared vision for all levels of the system.

### STANDARDIZED TOOLS FOR ADULTS

The Department of Mental Health is moving to standardized tools for functional status and progress monitoring. Standardized tools should be used to prioritize interventions, direct treatment planning, and inform decision making at the direct service level. The aggregate data from these standardized tools will help guide policy, measure outcomes, and inform planning at the systems level. DMH requires use of a standardized tool as part of the assessment process.

## 4.5 CARE PLANNING

### PERSON/FAMILY CENTERED PLANNING

Person-centered planning is a way to assist individuals needing services and supports to construct and describe what they want and need to help facilitate good treatment and recovery. In mental health programs, a person-centered plan is required for treatment and must meet the requirements described below.

The person-centered planning process must

- be driven by the individual, and
    - include people chosen by the individual or family/guardian,
    - provide necessary information and support to ensure that the individual or family/guardian directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
    - be timely and occur at times and locations of convenience to the individual or family/guardian,
    - for home and community-based settings (HCBS) reflect that the setting in which the individual resides is chosen by the individual or family/guardian;
    - offer informed choices to the individual or family/guardian regarding the services and supports they receive and from whom,
    - be finalized and agreed to, with the informed consent of the individual or family/guardian in writing, and signed by all individuals and providers responsible for its implementation;[33]
- Be strengths-based, and

[33] This requirement is specific to home and community-based services settings and may exceed signature requirements outlined elsewhere in this manual.

    - include individually identified goals and desired outcomes,
    - reflect the individual's strengths and preferences;
- Be clear and understandable, and
    - reflect cultural considerations of the individual or family/guardian and be conducted by providing information in plain language. All services must also be accessible to individuals with disabilities and persons who have limited English proficiency;
    - be understandable to the individual receiving services and supports, as well as to the individuals important in supporting them (written in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency);
- Reflect the options explored, and
    - for HCBS, record the alternative home- and community-based settings that were considered by the individual,
- Be proactive, and
    - include a method for the individual or family/guardian to request updates to the plan as needed,
    - reflect needs identified through functional assessments,
    - reflect the services and supports (both natural and professional) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports;
    - reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
    - identify the individual and/or entity responsible for monitoring the plan,
    - be distributed to the individual and other people involved in the implementation of the plan, and
    - prevent the provision of unnecessary or inappropriate services and supports.

In addition to the requirements described above person-centered planning processes must also include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. Person-centered planning processes should also consider the separation of functions between development and delivery of the plan, such that the service provider who is developing the plan is not the provider who is also rendering services.

## INDIVIDUALIZED PLANS OF CARE (IPC) TIMELINES AND REQUIRED COMPONENTS

IPCs reflect the person-centered planning partnership between providers and the enrolled individual. The IPC identifies service expectations, collaborations, and outcomes in support of the individual's goals. It includes all planned services to address the individual's treatment goals.

The services included in the IPC are a subset of the total available array of program services, depending on clinical need and individual choice. Individuals are only entitled to the clinically appropriate services that are included in their IPC. DMH requires the DA/SSA to issue written notices to the service recipient with information about the right to appeal a decision at least ten calendar days prior to making any

decision to deny a service, or to authorize a service in an amount, scope or duration less than had been clinically prescribed in the IPC.

An IPC shall be created and completed with the individual within thirty (30) days of initial assessment. At a minimum, the treatment plan must be signed by the individual served and a licensed master's-level clinician, a physician or an authorized advanced practice psychiatric nurse practitioner (APRN)[34]. Signature of a psychiatrist/psychiatric nurse practitioner is only required if any of the following conditions are present:

- medication management is a service on the plan
- the individual is discharging from psychiatric hospitalization, and/or
- the supervising clinician feels the individual's treatment issues warrant psychiatric review or consult.

Absence of the individual's signature should be an exception and explained in the clinical record.

## COMPONENTS OF THE IPC

The IPC must contain the following components:

Goals: A statement of the overall, long term desired results of service interventions, expressed in the individual's words as much as possible. In addition

- the goals should reflect evaluation and/or other assessments, and
- at least one goal must reflect mental health treatment needs.

Objectives: The action steps that help people move toward realizing their long-term goals and

- describe the specific changes in behavior, function and/or status that would indicate progress toward the long-term goal;
- are observable, measurable and achievable, using language that is understandable for the person served;
- include specific time frames for achieving/assessing progress.

Interventions: A description of the actions used to achieve each objective. For each intervention identify

- who- The responsible person or role providing the intervention. This could include staff, family and/or natural support network;
- what- The specific service to be provided;
- when- The frequency and duration. It is acceptable to identify a range of treatment frequency for planned services or interventions. PRN or "as needed" frequency should be reserved for emergent or episodic service delivery.

[34] Per 26 V.S.A. § 1616, an APRN signature may be obtained in place of a physician signature.

Crisis plan: When indicated, a proactive crisis plan or WRAP (using Copeland's Wellness Recovery Action Plan) will be developed with the individual in collaboration with their identified family or support persons as requested.

Emergency treatment needs and services may be delivered PRN or "as needed" and do not need to be identified as planned services. IPCs should identify the services that will be provided (not every possible option).

An Individual Plan of Care (IPC) must be authorized at least every 12 months

If an individual's circumstances/needs change significantly or the individual requests a review during the authorized IPC period, the IPC must be reviewed.

- If a review determines service plan changes are needed, the IPC will be updated. The updated IPC represents a new authorized IPC period.
- If a review determines that no service plan changes are indicated, an addendum to the IPC will outline supporting clinical rationale for no change and the IPC remains in effect for the balance of the authorized IPC period.

An authorized or updated IPC must have required signatures (see section on required components, above) for approval. Absence of the individual's signature should be an exception and explained in the clinical record.

## 4.6 PROVIDER OWNED AND CONTROLLED RESIDENTIAL SETTINGS

Home and community-based settings must have all the following qualities[35], based on the needs of the individual, as indicated in their person-centered service plan. The setting must

- be integrated in the greater community and support full access to that community by individuals receiving services,
- be selected by the individual or family/guardian from among setting options, including non-disability specific settings or a private unit in an out-of-home setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and resources available for room and board;
- ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact;
- facilitate individual or family/guardian choice regarding services and supports, and who provides them.

Residential program designs may be initially restrictive, based upon an individual's need. To be HCBS-compliant, individuals must be evaluated on a regular basis for safety, and as an individual's psychiatric

[35] 42 CFR 441.710(a)(1)

symptoms improve, their ability to access the community should expand with supports as needed. Any restrictions of the program must be detailed in the admissions agreement and any modifications to the HCBS rule requirements must be made using a person-centered plan that documents interventions and supports used prior to making modifications.

See Attachment A for additional information regarding federal regulations for HCBS.

## SETTING REQUIREMENTS

Corresponding with the needs identified in the person-centered plan, provider-owned or -controlled settings described in the previous section must meet certain requirements, which are described below.

While residential program designs may be initially restrictive, as based upon the individual's need, they must have an admissions agreement and any restrictions of the program must be detailed in the admissions agreement. Individuals must be evaluated on a regular basis for safety and as individual's psychiatric symptoms improve, they can access the community, with supports as needed.

It is important that residential settings are selected by the individual from among setting options recommended by treatment need as part of the person-centered planning process. Non-disability specific settings and options for private units should be considered if therapeutically appropriate. The setting options are identified, documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

The following list are requirements for provider-owned or controlled settings. These requirements may be modified or restricted due to clinical acuity and developmental age. Such modification or restrictions must be documented in the person's individual plan of care and/or in the admissions agreement.

Provider owned or controlled settings will:

- be integrated in and support full access to the community to the same degree of access as individuals not receiving Medicaid home and community-based services, consistent with the individualized treatment plan
- be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
    - The plan of care is the written agreement which includes client rights within the setting as well as grievance and appeal rights for all services in the plan of care. These settings uphold individual privacy rights through developmentally and clinically appropriate means.
- For settings in which landlord tenant laws do not apply, that the individual has a lease, residency agreement or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    - While tenancy rights do not have application in treatment programs that are transitional and short-term in nature, similar protections honoring the intent of residency rights through planful transitions must be afforded within the individualized, person-centered plan of care.

- be physically accessible to the individual
- have unit entrance doors lockable by the individual, with only appropriate staff having keys to doors
- ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint
- optimize individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact
- facilitate individual choice regarding services and supports, and who provides them
- allow privacy in sleeping or living units
- allow a choice of roommates for individuals sharing units
- allow individuals to have the freedom to furnish and decorate their sleeping or living units
- allow individuals to have the freedom and support to control their own schedules, activities, and have access to food at any time
- allow individuals to have visitors of their choosing at any time

### MODIFICATIONS TO HCBS SETTING REQUIREMENTS

In the event that an individual's treatment needs prevent a setting requirement from being met, the person-centered plan must reflect the need for the restriction. Additionally, if a setting must implement a more restrictive measure than is typically allowable for a setting, the setting provider must:

- identify the specific and individualized assessed need for modification
- document the positive interventions and supports used prior to any modifications to the person-centered service plan
- document less intrusive methods of meeting the need that have been tried but did not work
- include a clear description of the condition that is directly proportionate to the specific assessed need
- include a regular collection and review of data to measure the ongoing effectiveness of the modification
- include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
- include informed consent of the individual
- include an assurance that interventions and supports will cause no harm to the individual

## 4.7 DOCUMENTATION REQUIREMENTS

### GENERAL REQUIREMENTS

Electronic documentation of services provided is required. Documentation must be of sufficient clarity (i.e., acronym free or clearly defined) and clinical content to ensure eligibility for payment. Auditors must be able to read documentation, especially any documentation kept in paper format. The DA/SSA and/or any subcontractor must be able to produce specific encounter data from the EHR using MSR coding if requested by the State. All electronic records must be HIPAA compliant and retained for 10 years from the date of service.

## ELECTRONIC HEALTH RECORDS

For individuals or families who require treatment intervention or support beyond consultation, education and population-based strategies, the following items must be present in the client file:

- participant name & Medicaid ID,
- referral & intake information,
- screening tools or information,
- evaluation tools & on-going assessment information (including assessment provider name and dates completed);
- individual plan of care (including time frame of the plan, service type and frequency, responsible providers name, individual or parent/guardian and licensed clinician signature, dates completed);
- progress notes,[36] which include
    - a summary of major content or intervention themes consistent with treatment goals;
    - a clear relationship to assessment data,
    - a description of services and interventions that reflect those listed in the treatment plan,
    - observations made of the individual or responses to interventions,
    - an assessment of progress toward treatment goals,
    - signature by lead service coordinator,
- ongoing needs for continued intervention and next steps,
- performance goals/outcomes for individual clients served,
- a log of services provided and dates (this log may be electronically available as part of the EHR and does not need to be duplicated as a separate document each month); and
- a transition or discharge plan.

## CLINICAL DOCUMENTATION

Clinical Documentation is the foundation of all other documentation requirements. Meeting ongoing patient needs, such as furnishing and coordinating necessary services, is impossible without documenting each patient encounter completely, accurately, and in a timely manner. Documentation is often the communication tool used by and between professionals. Records not properly completed with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. The outcome can cause unintended complications.

Please see below, a table which inventories the *minimum standards* for documentation of each service included in the child and adult mental health case rates. Providers may exceed minimum standards according to preferred professional practice. Specifications for clinical documentation are also included with each service description in Section 3 of this manual.

[36] According to or exceeding the minimum frequency described in the table of minimum standards for documentation of services at the end of this section.

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| **A01 --SERVICE PLANNING AND COORDINATION** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**15 min** accumulated in one day<br>**Billable Encounter:**<br>Yes | **Monthly Summary Note**<br>-Clinical intervention used<br>-Summary of major content or intervention themes<br>consistent with treatment goals;<br>-Observations made of the individual or<br>responses to interventions;<br>-Assessment of progress toward treatment goal;<br>-Ongoing Needs for continued intervention and<br>plan.<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | **Chronological log of all Service Planning and Coordination services provided**<br>Multiple service coordination contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br><u>All encounter data must include:</u><br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **B01 --COMMUNITY SUPPORTS** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**15 min** accumulated in one day<br>**Billable Encounter:**<br>Yes | **Monthly Summary Note**<br>-Clinical intervention used<br>-Summary of major content or intervention themes<br>consistent with treatment goals;<br>-Observations made of the individual or<br>responses to interventions;<br>-Assessment of progress toward treatment goal;<br>-Ongoing Needs for continued intervention and<br>plan.<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | **Chronological log of all Community Support services provided**<br>Multiple Community Support contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br><u>All encounter data must include:</u><br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **B02 - GROUP COMMUNITY SUPPORTS** | | | |
| **Target Population:** | **Monthly Summary Note**<br>-Clinical intervention used | **Chronological log of all Group Community Support services provided** | Vermont Medicaid enrolled provider consistent with their |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**15 min** accumulated in one day<br>**Billable Encounter:**<br>Yes | -Summary of major content or intervention themes consistent with treatment goals;<br>-Observations made of the individual or responses to interventions;<br>-Assessment of progress toward treatment goal;<br>-Ongoing Needs for continued intervention and plan.<br>*Must have at most a 1:4 ratio of staff to clients<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | Multiple Group Community Support contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **B03 –FAMILY EDUCATION & CONSULTATION** | | | |
| **Target Population:**<br>EFT/IHCBS<br>**Minimum Duration for Payment**<br>N/A<br>**Billable Encounter**<br>No | DA's/SSA's are responsible for ensuring that all sub-contractors provide documentation of the consultation they provide to families or treatment teams.<br><br>Documentation must cover each individual service provided and meet all applicable standards for that service. | **Chronological log of all Community Support services provided**<br>Multiple Family Education contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Specialized practitioners sub-contracted by the DA/SSA. Sub-contractors must be licensed, working within their professional scope of practice, and have the appropriate credentialing or evidence of successfully completing a nationally recognized training program in the specialty area. The sub-contractor must also be authorized by the DA/SSA's Medical Director as competent to provide the service based on their education, training or experience. |
| **C01 - EMPLOYMENT ASSESSMENT** | | | |
| **Target Population:** | | | |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| Adults in CRT and JOBS Eligible individuals.<br>*Other individuals may access these services as resources allow*<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>-Describe the purpose, content, and outcome of each activity<br>-Describe individual's response and staff's observations<br>-Describe overall progress for the month in relation to the individual's plan of care<br>-Identify next steps determined through shared-decision making with individual.<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | **Chronological log of all Employment Assessment services provided**<br>Multiple Employment Assessment contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **C02 - EMPLOYER AND JOB DEVELOPMENT** | | | |
| **Target Population:**<br>Adults in CRT and JOBS Eligible individuals<br>*Other individuals may access these services as resources allow*<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>-Describe the purpose, content, and outcome of each activity<br>-Describe individual's response and staff's observations<br>-Describe overall progress for the month in relation to the individual's plan of care<br>-Identify next steps determined through shared-decision making with individual.<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | **Chronological log of all Employer and Job Development services provided**<br>Multiple Employer and Job Development contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **C03 - JOB TRAINING** | | | |
| **Target Population:** | | | |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| Adults in CRT and JOBS Eligible individuals<br>*Other individuals may access these services as resources allow*<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>-Describe the purpose, content, and outcome of each activity<br>-Describe individual's response and staff's observations<br>-Describe overall progress for the month in relation to the individual's plan of care<br>-Identify next steps determined through shared-decision making with individual.<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | **Chronological log of all Job Training and Coordination services provided**<br>Multiple Job Training contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **C04 - ONGOING SUPPORT TO MAINTAIN EMPLOYMENT** | | | |
| **Target Population:**<br>Adults in CRT and JOBS Eligible individuals<br>*Other individuals may access these services as resources allow*<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>-Describe the purpose, content, and outcome of each activity<br>-Describe individual's response and staff's observations<br>-Describe overall progress for the month in relation to the individual's plan of care<br>-Identify next steps determined through shared-decision making with individual.<br><br>*If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required* | **Chronological log of all Ongoing Support to Maintain Employment services provided**<br>Multiple Ongoing Support to Maintain Support contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **D01 - Respite (by hour)** | | | |
| **Target Population:**<br>EFT-IHCBS Population | **Monthly Summary Note**<br>Brief summary of client response and ongoing need for continued intervention | **Chronological log of all Respite services provided** | Licensed by DCF or child placing agency |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| **Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | *If more than one service is provided during the month, only one progress note containing the summary information is required. Documentation may be completed by respite providers or lead service coordinators and is at the discretion of the DA/SSA.* | Multiple Respite contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | |
| **D02 - Respite (by day/overnight)** | | | |
| **Target Population:**<br>EFT-IHCBS Population<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>Brief summary of client response and ongoing need for continued intervention<br><br>*If more than one service is provided during the month, only one progress note containing the summary information is required. Documentation may be completed by respite providers or lead service coordinators and is at the discretion of the DA/SSA.* | **Chronological log of all Respite services provided**<br>Multiple Respite contacts in one day by the same provider for the same client can be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Licensed by DCF or child placing agency |
| **E01 - CLINICAL ASSESSMENT** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:** | **Psychosocial Evaluation**<br>-Identifying information<br>-Presenting Issue<br>-History: Psych/Medical/Family/<br>-Trauma/Education/Development<br>-Supports and Strengths<br>-Functional Status | **Chronological log of all Clinical Assessment services provided**<br>Qualified providers only may use this code to document time spent face-to-face or telemedicine providing clinical assessment services to an individual.<br>All encounter data must include: | Rostered MA level; Rostered intern providing clinical services through a formal internship as part of a clinical master's level program; Or licensed provider |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| **15 min**<br>**Billable Encounter:**<br>Yes | -Mental Status Exam<br>-Diagnosis<br>-Interpretive Summary<br>-Treatment/Service Recommendations<br><br>*See Section 4.4 for further guidelines | -Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service<br><br>*Any information gathering by a non-qualified provider for clinical assessment purposes should be coded as community support B01* | *Supervised Billing Requirements Apply* |
| **E02 - INDIVIDUAL THERAPY** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment**<br>**16 minutes**<br>**Billable Encounter**<br>Yes | **Hit Note/SOAP Note**<br>-Clinical intervention used;<br>-Current issues discussed or addressed;<br>-Observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment;<br>-If indicated, the involvement of family and/or significant others in treatment;<br>-The clinician's assessment of the issues;<br>-Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and<br>-Specific plan for ongoing treatment or follow-up | **Chronological log of all Individual Therapy services provided**<br><u>All encounter data must include:</u><br>-Client Identification<br>-Service Provided<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Rostered MA level; Rostered intern providing clinical services through a formal internship as part of a clinical master's level program; Or licensed provider<br><br>*Supervised Billing Requirements Apply* |
| **E03 - FAMILY THERAPY** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**30 minutes** | **Hit Note/SOAP Note**<br>-Clinical intervention used;<br>-Current issues discussed or addressed;<br>-Observations made of the individual and family (the individual or family system response to the treatment session) or any significant factors affecting treatment; | **Chronological log of all Family Therapy services provided**<br><u>All encounter data must include:</u><br>-Client Identification<br>-Service Provided<br>-Staff Providing Service<br>-Date of Service | Rostered MA level; Rostered intern providing clinical services through a formal internship as part of a clinical master's level program; Or licensed provider |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| **Billable Encounter:**<br>Yes | -If indicated, the involvement of family and/or significant others in treatment;<br>-The clinician's assessment of the issues;<br>-Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and<br>-Specific plan for ongoing treatment or follow-up | -Duration of Service<br>-Location of Service | *Supervised Billing Requirements Apply* |
| **E04 - GROUP THERAPY** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**45 minutes**<br>**Billable Encounter:**<br>Yes | **Hit Note/SOAP Note**<br>-Clinical intervention used;<br>-Current issues discussed or addressed;<br>-Observations made of the individual (the individual's response to the group dynamic in the treatment session) or any significant factors affecting treatment;<br>-If indicated, the involvement of family and/or significant others in treatment;<br>-The clinician's assessment of the issues;<br>-Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and<br>-Specific plan for ongoing treatment or follow-up | **Chronological log of all Group Therapy services provided**<br>All encounter data must include:<br>-Client Identification<br>-Service Provided<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service<br>*If two or more clinicians lead a group, only one may submit encounter data per client.*<br>**Group Therapy sessions may not exceed a 1-to-10 clinician ratio.* | Rostered MA level; Rostered intern providing clinical services through a formal internship as part of a clinical master's level program; Or licensed provider<br><br>*Supervised Billing Requirements Apply* |
| **E05 - MEDICATION AND MEDICAL SUPPORT** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**15 min** accumulated in one day<br>**Billable Encounter:**<br>Yes | **Hit Note**<br>-Changes in medication (addition, deletion or change in dosage)<br>-Efficacy and management of the medication being prescribed or continued, and/or monitoring of the individual's reaction to the medication<br>-Mental status change at which the medication is being aimed<br>-Documentation of discussion with | **Chronological log of all Medication and Medical Support services provided**<br>All encounter data must include:<br>-Client Identification<br>-Service Provided<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Services | Physician certified in psychiatry, APRN, PA operating within the scope of their respective professions.<br><br>*Supervised Billing Requirements Apply* |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| | client, as well as family and other providers as releases allow. | | |
| **G01 - EMERGENCY/CRISIS ASSESSMENT, SUPPORT AND REFERRAL** | | | |
| **Target Population:**<br>All Global Commitment to Health Enrollees<br>**Minimum duration for payment:**<br>**15 min** accumulated in one day<br>**Billable Encounter**<br>Yes: | **Crisis Note**<br>-Identified issue or precipitant to crisis contact;<br>-Issues addressed or discussed;<br>-Collateral contact information as solicited or available;<br>-Observations made by the clinician;<br>-The clinician's assessment of the issues/situation including mental status and lethality/risk potential;<br>-Disposition or plan resulting from the crisis intervention;<br>-Psychiatric consultation, as clinically indicated. | **Chronological log of all Emergency Services provided**<br>Multiple Emergency Services contacts in one day by the same provider for the same client may be gathered into one service encounter log.<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **G02 - EMERGENCY/CRISIS BEDS** | | | |
| **Target Population:**<br>Adults<br>**Minimum duration for payment:**<br>Completion of the intake assessment<br>**Billable Encounter:**<br>Yes | Admission Documentation<br>- Assessment of needs and plan for treatment<br>- Intake LOCUS<br>Shift note/8 hour note<br>- Observations<br>- Interventions and client response<br>- Clinicians assessment of issues/situation/risks<br>- Ongoing plan for crisis stabilization<br>Discharge Summary<br>-Issues addressed, skills developed, follow up plan<br>-Discharge LOCUS | **Chronological log of all Crisis Bed Services provided**<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service **Crisis Bed encounters are documented in days*<br>-Location of Service<br><br>*Services provided during a Crisis Bed stay that have supervised billing requirements must be documented by the qualified clinician providing that service, and follow the appropriate service documentation guidelines (ie:* | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| | | *Medication Consultation, Individual Therapy, etc.)* | |
| **H02 - STAFFED LIVING ADULTS** | | | |
| **Target Population:**<br>Adults in CRT<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>Brief summary of client response and ongoing need for continued intervention<br><br>*If more than one service is provided during the month, only one progress note containing the summary information is required.* | **Chronological log of all Staffed Living services provided**<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service *Staffed Living encounters are documented in days (1 day = individual assigned to program at 11:59 pm)<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **H02 – STAFFED LIVING CHILDREN** (Formerly known as Micro Residentials) | | | |
| **Target Population**<br>Children in IHCBS<br>**Minimum duration for payment**<br>N/A<br>**Billable Encounter**<br>No | **Weekly Summary Note**<br>Summary of interventions used, client response, progress towards goals and ongoing need for continued intervention | **Chronological log of all Staffed Living services provided**<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service *Staffed Living encounters are documented in days (1 day = individual assigned to program at 11:59 pm)<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **H03 - GROUP LIVING** | | | |
| **Target Population:** | | | |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| Adults in CRT<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>Brief summary of client response and ongoing need for continued intervention<br><br>*If more than one service is provided during the month, only one progress note containing the summary information is required.* | **Chronological log of all Group Living services provided**<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service *Group Living encounters are documented in days<br>-Location of Service | Vermont Medicaid enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **H04 - LICENSED HOME PROVIDERS/FOSTER FAMILIES** | | | |
| **Target Population:**<br>EFT/IHCBS Population<br>**Minimum duration for payment**<br>N/A<br>**Billable Encounter**<br>No | **Monthly Summary Note**<br>Brief summary of client response and ongoing need for continued intervention.<br><br>If more than one service is provided during the month, only one progress note containing *the summary information is required.* | **Chronological log of all Licensed Home Provider services provided**<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service *Licensed Provider encounters are documented in days<br>-Location of Service | Must be licensed by DCF or child placing agency. DCF approved foster homes with license pending may be included |
| **I01 - TRANSPORTATION** | | | |
| **Target Population:**<br>Adults in CRT<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:** | **Monthly Summary Note**<br>Indication in Monthly Summary Note that client received a transportation service<br><br>*Transportation services are only for the necessary transportation of individuals covered* | **Chronological log of all Transportation Services provided**<br>Multiple Transportation Services contacts in one day by the same provider for the same client may be gathered into one service encounter log. | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined |

| Billing Criteria | Minimum Clinical Documentation Required | Encounter Data to Support Clinical Documentation | Provider Qualifications |
|---|---|---|---|
| No | *by Medicaid to and from an agency facility in order to receive Medicaid- reimbursable services.* | All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |
| **L01 - DAY SERVICES** | | | |
| **Target Population:**<br>Adults in CRT<br>**Minimum duration for payment:**<br>N/A<br>**Billable Encounter:**<br>No | **Monthly Summary Note**<br>Brief summary of client response and ongoing need for continued intervention.<br><br>If more than one service is provided during the month, only one progress note containing *the summary information is required.* | **Chronological log of all Day Services provided**<br>All encounter data must include:<br>-Client Identification<br>-Name of Service<br>-Staff Providing Service<br>-Date of Service<br>-Duration of Service<br>-Location of Service | Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider. |

## 4.8 COLLABORATION AND INTEGRATION WITH OTHER PROVIDERS

### COORDINATED CARE:

The system of care is guided by the philosophy that individuals achieve better outcomes when they receive coordinated community-based treatment and support services. Coordinated service planning is expected to continue during any residential or inpatient stays to provide a more seamless transition back into the community. Clear coordination between residential or inpatient staff and community providers, as well as with schools, health care providers, case workers, out of home providers, individuals and family members is essential for comprehensive care and is expected whenever releases allow.

For early childhood mental health, designated agencies provide services to help to improve the early childhood mental health of children aged 0-6 and their families; increase access to early childhood mental health services and improve those children's readiness for school. To achieve this, the DA's early childhood mental health administrators and field workers must coordinate with early care and education providers, health care providers, family representatives and advocates, and the broader community (including special target groups).

The delivery model for early childhood mental health also requires the designated agency to participate in the ongoing development and operation of a regional Children's Integrated Services (CIS) Resource Team. This team is convened to assure the integration and delivery of high-quality prevention and early intervention services for pregnant women, children aged 0-6, and their families. The team consists of at least representatives from Early Childhood and Family Mental Health, Part C/Early Intervention, and Health/Healthy Babies Kids &Families in the region served by the DA.

### LEAD SERVICE COORDINATOR

The lead service coordinator will be the staff member responsible for documenting and tracking a person's overall goals and for coordinating and monitoring the provision of needed services and supports for a specific individual. If a service coordinator is away, this oversight must be reassigned to an "acting" service coordinator. The lead service coordinator is responsible for ensuring that appropriate documentation of all services is included in the client's EHR.

### COORDINATION WITH PRIMARY CARE PROVIDERS

Each DA/SSA is responsible for making every effort to secure the individual's release of information (ROI) to support sharing appropriate clinical information between the primary healthcare provider and the DA/SSA.

Additionally, DA/SSA service coordinators are encouraged to develop and maintain joint comprehensive treatment plans when possible to provide for maximum integration of physical and mental health services. Toward this end, the following requirements must be met:

- Each clinical record at the DA/SSA must contain the name of the primary care provider (PCP).
- For those individuals without a primary healthcare provider, the DA/SSA must make every effort to assist with the selection of a PCP. The service coordinator or other DA/SSA designee must

also take steps to assure that enrollees are seen by their PCPs at least once annually or to document the efforts made and ongoing barriers preventing this.

For individuals with Service Coordination as part of their treatment plan

- the DA/SSA service coordinator or designee must also take steps to assure that individual's psychotropic medication management including changes in medications or dosage is, with consent, routinely shared with the primary healthcare physician; and if not, to document the ongoing efforts made and barriers preventing this coordination of care;
- individuals enrolled in the adult or child case rate are eligible for physical healthcare or medical hospitalization services apart from case rate funding. The DA/SSA service coordinator or designee will make every effort to promptly advise the individual's PCP and the DA/SSA psychiatrist of any significant changes in physical health or significant health concerns. Significant changes or health concerns include chronic healthcare conditions that are untreated and deteriorating, acute changes in health care status that require immediate or emergency care, and hospitalization.

The DA/SSA prescribing psychiatrist is ultimately responsible for insuring coordination of care with the primary healthcare provider for any individual to whom they are prescribing medication.

## CONTINUITY OF CARE

### COORDINATION WITH INPATIENT PSYCHIATRIC PROVIDERS - ACUTE HOSPITAL SERVICES

Enrollees are eligible for psychiatric inpatient hospitalization services to stabilize an acute exacerbation of their mental health illness. The DA/SSA service coordinator or designee will make every effort to prevent an acute exacerbation or decompensation of illness, and will promptly advise the DA/SSA psychiatrist of any significant changes in mental health condition that might warrant hospitalization of the person. Significant changes or concerns could include: a person's decision to not follow agreed upon medication regimen or abrupt and/or unplanned discontinuation of medication; marked or significantly changed psychiatric symptomology; acute potential for harm to self or others; and crisis presentation for psychiatric inpatient hospitalization.

If a person is hospitalized, the DA/SSA Service Coordinator or designees are expected to

- collaborate actively with the DMH Care Managers and psychiatric inpatient providers;
- contribute to the development of the inpatient treatment plan, supporting maximum coordination and continuity of mental health services;
- develop timely coordinated aftercare and follow-up plans, and
- the DA/SSA psychiatrist is ultimately responsible for the overall efforts on the part of the DA/SSA to coordinate care with the psychiatric inpatient provider.

## TRANSITIONS AND DISCHARGE PLANNING

Transition planning is critical for the support of the individual's ongoing treatment, recovery or well-being. If for any reason a transition or discharge plan cannot be developed in the timelines below, the circumstances prohibiting the planning will be documented.

A transition plan must be developed for any individual who requires treatment intervention and/or family support who is transitioning to other services or providers outside the local network or moving to another region including but not limited to a transition from one level of care to another or a transition from one programming area to another. A **transition plan** must be developed with the individual and/or family/guardian prior to transition date.

**A discharge plan must** be developed anytime an individual or child and family have completed services, chosen to discontinue services, or for whom services have been terminated. A **discharge plan** must be developed with the individual and/or family/guardian prior to discharge date for all individuals where the discharge is planned.

Plans should include the following components and be developed with the individual and other appropriate participants, such as the family, whenever possible:

- progress towards goals during program participation,
- reason for discharge or transition.
- condition at last contact, and
- referrals made, if clinically indicated.

For a child or adult who is in an out-of-home treatment setting, the local team supports the facility or out of home treatment provider for discharge planning.

This includes settings such as

- out-of-home community home provider placements,
- private non-medical institutions/residential programs (in and out of state);
- hospital diversion/emergency beds;
- inpatient psychiatric hospitalization, and
- arrangements with other providers.

### SHARED CARE PLANS: CONFIDENTIALITY (PRIVACY AND SECURITY)

Providers will follow federal and State law relating to privacy and security of individually identifiable health information as applicable; including AHS rule No. 08-048; the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations; V.S.A. Title 9, Ch. 62 pertaining to social security numbers; and 42 CFR Part 2 for alcohol and substance use disorder treatment information. Providers will assure that all of its employees and subcontractors understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

# 5. REIMBURSEMENT AND FINANCIAL REPORTING

## 5.1 ESTABLISHING AND MONITORING CASE RATES

### CASE RATE MODEL

DMH pays for Adult and Child Mental Health Services listed in section 3 of this manual through two separate monthly case rates, one for children and one for adults. Each case rate is calculated per person, per month (PMPM), and is paid monthly on a prospective basis using an annual budget and target

caseload for each DA/SSA. The prospective payment is paid in lump sum at the same point each month and the entire case rate allocation is received through equal distribution over 12 months.

One child and one adult case rate is paid to each DA/SSA for all case rate services, regardless of type of service and the acuity or specialized program assignment of the individual served with the exception of prior approved outlier payments described in this section, below. The prospective case rate payments are reconciled at least annually against actual caseload served. If target caseloads are not met, the case rate is recouped on a PMPM basis. There is no recoupment of funds if ≥90% of the annual caseload has been reached.

## CASELOAD COUNTS

Caseload numbers are created using the most complete and available Monthly Service Report (MSR) data. The Adult and Child caseloads counts are based on a weighted average of monthly caseload over 36 months (first month is 0.5 through last month at 1.5). People are counted if the following three conditions are met:

1. Program Service includes child, adult, emergency or CRT values in the Program/Service field. Adults are counted using the "adult" and "CRT" Program/Service field and children are counted with "child" in the Program/Service field. People with the "Emergency" Program/Service Field are counted using age (21 and under are counted as Child).
2. Services are listed in any of the following cost centers (all cost centers included for CRT):
   - 
   - Access
   - Clinical Intervention
   - Crisis Services
   - Community Support and Service Planning (MH)
3. Payer values for Child, Adult, or Emergency recipients include any of the following values: Medicaid, Medicaid Waiver, or Medicaid Managed Care in any of the "Responsible for Fee" fields. Any payer is counted for CRT.

Example: SFY 2019 monthly caseload base will start in the first month of SFY 2015 (weighted at 50%) and end with the last month of SFY 2017 (weighed at 150%). The SFY 2020 caseload base will start in the first month of SFY 2015 (weighted at 50%) and end with the last month of SFY 2017 (weighed at 150%).

| | **14-Jul** | **14-Aug** | **. . .** | **15-Dec** | **16-Jan** | **. . .** | **17-May** | **17-Jun** |
|---|---|---|---|---|---|---|---|---|
| **Weight (SFY 2019)** | 0.5 | 0.528 | . . . | 0.986 | 1.014 | . . . | 1.472 | 1.5 |
| | **15-Jul** | **15-Aug** | **. . .** | **16-Dec** | **17-Jan** | **. . .** | **18-May** | **18-Jun** |
| **Weight (SFY 2020)** | 0.5 | 0.528 | . . . | 0.986 | 1.014 | . . . | 1.472 | 1.5 |

## RATE SETTING METHODOLOGY

The individual case rate is derived from the DA/SSAs expected annual allocation and 90% of a DA/SSA's projected caseload.

Example:

| **Program/Service Area** | **"XYZ" DA/SSA** |
|---|---|
| Outpatient Service | $110,000 |
| Emergency Services | $200,000 |
| CRT | $3,410,000 |
| DVHA Funds* | $320,000 |
| **Adult Total** | **$4,040,000** |
| Average Monthly Adults | 400 |
| 90% of Average Monthly Adults | 360 |
| Case Rate | $935.19 |

* The portion of DVHA funds included in the case rate are calculated based on a weighted, 3-year, "rolling" average, with the most recent three years of experience used to derive the next CY case rate calculations. The first part of the calendar year will use actual spending from the most recent state fiscal year and after that it will use the best available service utilization data.

Example:

| CY 2019 DVHA Funds Weighted Average | CY 2020 DVHA Funds Weighted Average |
|---|---|
| SFY 2016 DVHA Funds – 90% | SFY 2017 DVHA Funds – 90% |
| SFY 2017 DVHA Funds – 100% | SFY 2018 DVHA Funds – 100% |
| SFY 2018 DVHA Funds – 110% | SFY 2019 DVHA Funds – 110% |

## CASE RATE MONITORING AND ADJUSTMENTS

DMH will use encounter data to monitor utilization trends, unanticipated reductions in services, and to support DMH budget development in future years.

Caseload Certification and Reconciliation: caseload counts of individuals served will be calculated monthly based on billable services provided to individuals and submitted as encounter claims to the MMIS. Each child and adult caseload will be certified by DMH and the DA/SSA on at least a quarterly basis to ensure that counts of people served and unexpected trends are understood. All qualifying services should be submitted as "0" paid encounter claim beginning on 1/1/2019 aside from CRT services. "0" paid encounter claims for CRT services will begin on 4/1/2019. From 1/1/2019 through 3/31/2019 MSR encounters will be used to calculate caseload counts.

Target Caseload Calculation: In addition to the 10% discount applied to the calculation of the annual caseload target there is an upper limit to target caseload calculation of 15% annual growth within a fixed allocation. The cap on caseload growth is not a cap to the actual number of individuals a DA/SSA serves. It is a cap on the caseload numbers that are used to calculate the case rate payment each year. The purpose of the growth cap is to not penalize a DA/SSA if they are able to serve more people within a fixed allocation because of payment reform.

Example:

> A DA/SSA has an average caseload over three years of 100 people and a case rate of $1000 ($100,000 total allocation per month). If the DA/SSA increases its average caseload to 160 for the latest year of the 3 year baseline then its average caseload would increase to 120 people. The next year the DA/SSA would receive $833/case without a cap (assuming the same $100,000 a month allocation). The 115% cap would limit the increase in the average case rate to 115, resulting in a case rate of $870/case.
>
> Also, the cap would mean the DA/SSA would reach their full allocation serving 115 people instead of 120 people without the cap.

The target caseload calculation may exceed 15% annual growth based on policy, legislative and budget changes that are outside of the prior three years of experience used to develop the caseload targets and PMPM case rates for each DA/SSA.

## OUTLIER PAYMENTS

There may be individual outliers that are not accounted for in the trends that went into the design of the case rate and who significantly impact utilization. In these circumstances, the provider and DMH may review and revise the contractual cap and create an enhanced case rate on an individual basis.

Requirements:

- The rate must be approved by DMH prior to expenditures occurring.
- The rate must be documented through use of a cost-effective alternative worksheet or enhanced funding evaluation method.
- If the individual moves out of the DA/SSA case rate, the enhanced rate follows the individual (as applicable) and may be changed according to changes in the plan of care.
- If an existing outlier case (a case used in case rate development) moves out of the DA/SSA catchment area there will be a reduction in the case rate of the originating DA/SSA.

## UNFORESEEN CIRCUMSTANCES

Separate from individual outlier payments and from changes made as a result of the annual case mix review, a mid-year adjustment may be made to the case rate in catastrophic circumstances. Should unforeseen circumstances significantly impact utilization, the DA/SSA and DMH may review and revise the contractual cap and case rate or make a one-time adjustment through general funds. Unforeseen circumstances may include, but are not limited to, natural disaster, facility closure, or adverse community events on such a scale that they are not accounted for in the trends that went into design of the case rate.

### COST CENTERS

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## 5.2 GENERAL PAYMENT PROVISIONS

### MINIMUM REQUIREMENTS

Provider Number: a single provider number is used for both the adult and child mental health case rates. This provider number shall not be used for any MMIS claim submission unrelated to the adult or child mental health case rates.

The monthly case rate will serve as the form of payment for all eligible case rate services that are described in this manual and provided to the beneficiary. A complete listing of DMH covered case rate services is found at section 3 of this manual. A complete listing of procedure codes and modifiers that must be used for submission of MMIS encounter claims is included at Appendix E. Claims will indicate the DA/SSA provider number responsible for the service and will be $0-paid by the MMIS vendor.

Because case rate payments are made on a monthly, prospective basis 0-paid encounter claims must be submitted for caseload tracking purposes. Encounter claims may be submitted when any member of the target population receives an allowable service, defined as one encounter. Medicaid eligibility must be checked on a monthly basis[37]. Supported employment, transportation, respite, family education/consultation, day services or residential services provided as the sole service in a single month are not counted toward the annual caseload target; these services must be provided in combination with a clinical treatment, service coordination, or community support.[38].

All qualifying services should be submitted as 0-paid encounter claim beginning on 1/1/2019 aside from CRT services. 0-paid encounter claims for CRT services will begin on 4/1/2019. From 1/1/2019 through 3/31/2019 MSR encounters will be used to calculate caseload counts.

Vermont Medicaid requirements regarding timely filing and timely filing reconsideration requests are located at section 8.2 of this link:
http://vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf.

### THIRD PARTY LIABILITY (TPL)

The DA/SSA rate and caseload calculations include members with private coverage and associated residual claims payments. For individuals who have private coverage, third party payers must be billed for all services covered in the commercial payers covered benefit plan. If all services provided by DA/SSA are covered by the third party, then, no claim should be submitted for that beneficiary for reimbursement under the monthly case rate. However, if a service allowable under the Global Commitment to Health Medicaid demonstration is delivered to an eligible Medicaid beneficiary in any

[37] See also section 2.1 – Medicaid Eligibility and Enrollment

[38] A summary of claims conditions is included in the minimum standards documentation table at section 4.7.

month and is not covered or is only partially covered under the beneficiary's private coverage benefits package, then the case rate may be billed in the month that service is provided.

### MEDICARE COVERAGE

The DA/SSA rate and caseload calculations include dual eligible members and crossover claims. The DA/SSA may submit a case rate claim for dual eligible members. For CRT, MMIS encounter claims may not be submitted until April 1, 2019.

For Medicare-only CRT participants, the DA/SSA must bill Medicare for all Medicare eligible covered services. If all services provided by DA/SSA are covered by Medicare, then no claim should be submitted for that beneficiary for reimbursement under the monthly case rate. However, if a CRT service allowable under the Global Commitment to Health Medicaid demonstration is delivered to an eligible CRT member in any month and is not covered, or is only partially covered, then the case rate may be billed in the month that service is provided starting April 1, 2019.

## CONCURRENT BILLING

The child and adult mental health case rates are built using a weighted, three-year average count of services, and counts of unique individuals as well as historical allocations to DA/SSAs. The case rates are not built based on attribution of specific individuals. This means that one individual accessing mental health services may on occasion receive those services from more than one DA/SSA and/or other mental health practitioner(s)[39] based on individual choice and location of services best meeting the individual's needs. The DA/SSA-specific case rates, correspondingly, include the costs of services delivered to an individual by the specified DA/SSA and exclude the costs of services delivered to the individual by another DA/SSA or mental health practitioner. DA/SSA case load counts are also built on counts of unique (to the DA/SSA) individuals served, and do not exclude individuals that may have been seen by another DA/SSA or mental health practitioner in the same month. This means that total, statewide caseload counts are not-deduplicated.

Mental Health case rate billing is allowable as long as a billable service has been provided in the month, regardless of the individual's living situation or receipt of services from another provider. DA/SSAs manage services and caseloads within an annually fixed allocation based on historic expenditures. This promotes coordination and delivery of timely and effective services. There are allowances for certain unanticipated expenditures in the case rate model. However, historically, overlap of service between providers for the same individual within the same month is limited. The current model provides no financial incentive for duplication or a high volume of services. Examples of allowable scenarios are provided below and are also described at sections 3.8 Service Planning and Coordination, and 4.8 Collaboration and Integration with Other Providers.

### COORDINATED SERVICES

[39] Other mental health practitioners include but are not limited to: independent mental health clinicians, Federally Qualified Health Centers, Blueprint Community Health Teams and Outpatient Hospital clinics.

Example 1: One DA/SSA may provide a residential service to an individual while another DA/SSA is providing Service Planning and Coordination to the same individual. The intent is for the residential service of the one DA/SSA to end and for the home DA/SSA to assume responsibility and coordination of ongoing community services, this requires ongoing coordination of care planning and transition planning.

Example 2: A child is served in a residential setting in one DA/SSA catchment areas during the week and returns to their home DA/SSA catchment area on the weekends. This arrangement results in both DA/SSAs appropriately billing the case rate and submitting multiple encounters for the same or similar services. Only the costs of services provided have been built into each DA/SSA's respective case rate.

### MEMBER CHOICE

Example 1: An individual starts therapy with one DA/SSA and is not satisfied with the relationship or progress. The individual chooses to initiate therapy with another DA/SSA or independent practitioner.

Example 2: An individual may have an established relationship with a therapist and then move to another catchment area. The individual may choose to retain the prior therapist relationship while receiving other services from the new DA/SSA.

### COMPLEX CARE NEEDS

There is no limit on the number of mental health services that may be received by an individual. An individual may engage in different types of therapy within or across DA/SSA catchment areas depending on the availability and specialties of each DA/SSA or mental health practitioner. For example, a member may receive weekly services that involve multiple individual therapy sessions (e.g., for complex or worsening conditions); individual psychiatry sessions (e.g. medication check and vital signs); and group and family therapy sessions. These services may be delivered by the same agency or by multiple mental health providers. Service expectations, for each member, are described in their person-centered plan of care and encounters are expected to align with the plan of care.

### SUCCESS BEYOND SIX AND C.E.R.T.

Children who receive services through the mental health child case rate are eligible for Success Beyond Six and C.E.R.T. case rate school based mental health services if the services delivered in the educational setting are separate and delivered distinct from the treatment services provided through the IPC for the mental health child case rate.

### TRANSITION AND DISCHARGE PLANNING

Transition and discharge planning is expected to be performed by the local DA/SSA team for a child or adult who is in an out-of-home treatment setting such as private non-medical

institutions/residential programs (in and out of state), hospital diversion/emergency beds and inpatient psychiatric hospitalization[40].

Note: An individual receiving mental health services is not required to disclose treatment in accordance with protections under 42 CFR part 2. DMH expects that services are coordinated and that this is reflected in individual chart notes, however, DMH does not consider a case that is uncoordinated to be a finding in the instance that an individual has chosen not to disclose receipt of other mental health treatment.

## 5.3 VALUE-BASED PAYMENTS

Through its multi-year reform plan, DMH is transitioning away from traditional reimbursement mechanisms (such as program-specific budgets and Fee-For-Service payments) and has established the following framework of value-based payments that are focused on the value rather than the volume of services provided.

Direct services are paid through the monthly child and adult case rate. Value-based payments are made through a separate quality payment. The Designated Agency's ability to earn value-based payments is subject to the Designated Agency's complete and timely satisfaction of its obligations.

### MEASURES, TARGETS AND VALUE-BASED PAYMENT STRUCTURE

The Designated Agency has two types of value-based payment measures: reporting, and performance.

- Reporting Measures are those measures that are used to establish a baseline and/or gather data. Reporting Measures are retrieved by the Designated Agency and do impact the distribution of value-based payments according to a Designated Agency's ability to meet specific criteria (as outlined in the Master Agreements).
- Performance Measures are those measures that assess an agency's work and/or outcomes of work. Performance Measures may be retrieved by the Designated Agency or the State of Vermont and do impact the distribution of value-based payments according to the Designated Agency's ability to meet specific criteria.

Measure specifications for calendar year 2019 value-based performance measures are listed at Attachment G.

### SPECIFICATIONS

During each measurement year, the DMH will withhold a portion of the approved adult and child case rate allocations for value-based payments. The measures, reporting criteria, targets, benchmarks and value-based payment opportunities are set forth in Master Agreements. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement.

The Designated Agency's performance shall be calculated based on care delivered during the time frame of the executed Master Agreement.

[40] See sections 3.8, Service Planning and Coordination and 4.8, Collaboration and Integration with Other Providers, for additional detail.

The Designated Agency shall submit information to DMH, in the format and detail specified by DMH, with respect to each performance measure set forth in the Master Agreement.

### 5.4 GLOBAL COMMITMENT INVESTMENT FUNDS

Adults in CRT who: (1) meet target population criteria at section 2.1, (2) are not Medicaid eligible, and (3) have incomes above 185% of the Federal Poverty Level (FPL), may receive mental health services as a part of the adult mental health case rate. The Medicaid waiver describes these individuals and program expenditures as an approved Global Commitment Investment for "Mental Health CRT Community Support Services".

All qualifying services should be submitted as 0-paid encounter claim beginning on 1/1/2019 aside from CRT services. 0-paid encounter claims for CRT services will begin on 4/1/2019. From 1/1/2019 through 3/31/2019 MSR encounters will be used to calculate caseload counts.

The adult case rate may be billed for services provided to individuals under this category. The Medicaid Management Information System (MMIS) will attribute the claim to the Global Commitment Investment fund source based on person-level information associated with the claim.

### 5.5 OTHER STATE AND FEDERAL FUNDS

No other state or federal fund sources are currently included in the child or adult mental health case rates.

## 6. REPORTING, PROGRAM INTEGRITY AND QUALITY OVERSIGHT

### 6.1 REPORTING REQUIREMENTS

#### MSR ENCOUNTER DATA

MSR Encounter Data refers to individual-level records of DA/SSA services provided and submitted to DMH via the Monthly Service Report (MSR). MSR data includes all services provided to individuals regardless of the fund source of the specific services. Encounters covered by Medicare or any other insurer must be reported to DMH if the DA/SSA shares in any liability.

The MSR is due no later than the last day of the month following the reporting month, i.e. encounter data for February is due by the last day of March. MSR files must be complete, accurate and loaded without critical errors. Reports that are submitted with critical errors and not corrected by the due date will be considered delinquent and subject to penalty. DMH may grant, on behalf of the State, a waiver of penalty upon the presentation of good faith effort on the part of the DA/SSA to comply with the intent of this provision.

Encounter data submissions are reviewed by DMH for accuracy, timeliness, correctness, and completeness. Any encounter-data submission failing established parameters will be rejected and must be resubmitted. Amendments to encounter data may be submitted at any time but the DAs/SSA should recognize that this may affect billing and payment. Encounter-data submissions must represent all services provided to individuals under the adult and child case rates.

DMH will perform clinical records audits for the purposes of comparing submitted data to the clinical record. Additionally, clinical records will be audited by DVHA (or its contractor) on an annual basis. The DA/SSA must cooperate with these audits and must make records available upon request. DMH and DVHA will notify the DA/SSA in advance of the audits.

Additional specifications for MSR encounter documentation are included in the table of minimum standards for documentation of services in section 4.7, in the Monthly Service Report Submission Specifications[41], and may also be described in connection to performance evaluation activities in section 5.3 of this manual and in any DA/SSA and DMH Agreements.

### MMIS ENCOUNTER DATA

In addition to mental health adult, child and outlier case rate encounter claims, DA/SSAs will submit encounter claims to the MMIS. The encounter claims will be submitted as follows

- billed under the mental health case rate provider ID,
- either listed on the mental health case rate claim or submitted separately,
- billed without any modifiers, and
- paid at "$0.00" for each provider ID/procedure code combination.

Exception: Programs and services that do not use MMIS encounter claims or have assigned MMIS procedure codes as of 12/31/2018 are not required to submit MMIS encounter claims.

All qualifying services should be submitted as 0-paid encounter claim beginning on 1/1/2019 aside from CRT services. 0-paid encounter claims for CRT services will begin on 4/1/2019. From 1/1/2019 through 3/31/2019 MSR encounters will be used to calculate caseload counts.

## 6.2 PROGRAM INTEGRITY

### DETECTION AND INVESTIGATION OF POTENTIAL FRAUD AND ABUSE

DMH is responsible for monitoring activities of providers and members, for the purpose of detecting potential fraud and abuse of Title XIX of the Social Security Act. If an instance of possible fraud or abuse is identified, DMH must explore the concern, notify DVHA Program Integrity and notify the Medicaid Provider Fraud and Abuse Unit if it believes actual fraud or abuse has been detected.

[41] http://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/MSR-DataSubmissionDefinition_v51.5_061917.pdf

In accordance with the Medicaid Waiver and its managed care delivery model[42], the State uses the following terms in defining fraud and abuse:

> *Medicaid Managed Care Fraud*: any type of intentional deception or misrepresentation made by an entity or person in a capitated program, or other managed care setting with knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.
>
> *Medicaid Managed Care Abuse:* practices in a capitated MCO, PCCM program, or the managed care setting, that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards of contractual obligations for health care.

Identification of Potential Provider Fraud and Abuse: The most common type of provider fraud consists of billing for services not actually furnished to clients. To protect against potential fraud, periodic audits will be conducted to verify that all billed services and service encounters reported to DMH are adequately reported and documented in the client records. Additionally, contracted providers will be evaluated monthly to identify any unusually high costs or utilization. Suspected fraud cases will be investigated further through detailed audits of client records and/or verifying with the client that services were provided.

As part of the regular Clinical Care Reviews, a DMH Quality Management team will compare provider clinical documentation to encounter data to verify that all billed services are documented and adequately recorded in the patient's record. DMH may conduct a more detailed audit of provider's records if necessary.

Reporting of Detected Fraud and Abuse: Suspected cases of client or provider fraud will be reported immediately to the DMH along with all supporting documentation.

## 6.3 QUALITY OVERSIGHT

DMH supports the practice of quality management at each DA and SSA and requires that processes are in place. Services and assessment of client needs shall undergo ongoing quality review for improvement opportunities. Quality management practices typically consist of three types of activities: Quality Assurance, Quality Monitoring, and Quality Improvement.

### QUALITY ASSURANCE

Quality Assurance is the process of oversight of services provided within the system of care, where deficiencies and/or weaknesses are identified, while ensuring that services meet minimum standards. DA/SSA's will generate data internally to review use of their resources. Each DA/SSA will provide documented evidence of its internal monitoring, review, and utilization of service data and outcomes to better meet the needs of those individuals served and fulfill minimum standard requirements.

### QUALITY MONITORING

[42] Described in section 1.2 of this manual.

Quality Monitoring consists of the collection and review of data and analysis and aggregate reporting.

The Department of Mental Health requires the management of service utilization data and corresponding outcomes to ensure provision of quality services. To ensure compliance with this standard, programs are required to have a utilization and outcomes management practices for measuring and responding to the needs of those receiving services described in this manual and evaluating practice outcomes.

Each DA/SSA shall maintain utilization review activities to assess, monitor, and maintain effective, efficient, and appropriate utilization of resources. The utilization review process will include consideration of service use for potential patterns of underutilization, overutilization, or inefficient use of services and to assure that they are delivered in an appropriate, and effective and efficient manner, that individual. Individual service documentation must meet DMH minimum standards, requirements and ensure that DA/SSA resources are used efficiently. Review of monitoring activities and achievements must occur at least quarterly and will be reviewed by DMH during the Minimum Standards Chart Review, Agency Review, and Redesignation processes.

## QUALITY IMPROVEMENT

Quality Improvement (QI) is a systematic approach to improve and enhance the way care is delivered. A variety of approaches—or QI models—exist to help collect and analyze measurable data and test change to achieve desired outcomes and goals, while utilizing best practices.

The DA/SSA shall employ a continuous evaluation process coupled with coordinated plans to improve and build meaningful and effective services. DA/SSA structures a measurable quality management or improvement plan to make changes that will lead to better care. DA/SSA's identify individual needs and preferences, collect information through needs assessments, monitor quality, and manage outcomes to promote improved quality of service. Community collaboration and systems improvement can likewise be forged through greater levels of individual and service provider participation in the Quality Improvement process.

Program effectiveness, efficiency, and satisfaction by service users are priority objectives for system measurement. Agency structures must support monitoring of priority initiatives through timely information and review activities. Review activities must include consideration of service quality, appropriateness of service, and service trends.

The DA/SSA will generate and review service use data internally and review use of their resources. Each DA/SSA will provide documented evidence of its internal monitoring, review, and utilization of service data and outcomes to better meet the needs of those individuals served. Review of outcomes management activities and achievements must occur at least quarterly and will be reviewed by DMH during Agency Reviews.

DA/SSA requirements regarding Quality Improvement and Quality Management are found in the Administrative Rules on Agency Designation.

## MONITORING OF STANDARDS

The DA/SSA is responsible for monitoring its compliance with access to care standards described in this manual. Compliance should be monitored through a variety of mechanisms, including review of appointment availability, surveys by service users, review of grievances and appeals, coverage and enrollment logs, incident logs, etc.

DMH will monitor DA/SSA compliance with the standards through the following methods:

- Routine, urgent, and emergency services will be evaluated as part of the Clinical Care and Minimum Standards Reviews and Program Reviews, each completed at regular intervals to be determined by DMH Agency Designation Procedures dependent on the CRT Program size and pattern of service delivery of the DA/SSA.
- Emergency services telephone availability may also be tested during the intervening period through after-hours calls to the 24-hour hotline number.
- Urgent care referrals to CRT will be evaluated using electronic health records to determine if clients with urgent problems were treated within the required two business days window.
- Referral appointments will be evaluated using electronic health records to determine if referral appointments occurred within the required 30-day window.
- Routine care will be evaluated using electronic health records to determine if individuals received services in a timely manner consistent with their treatment plans through an examination of appointment records, appointment availability through periodic calls requesting to know when the next routine appointment slot would be available, and on-site random interviews of enrollees.
- Travel time will be evaluated as part of the Program Review process. Network capacity and staffing patterns will be examined to determine if travel time to all provider types is within what is usual and customary in the geographic area.
- Waiting times for appointments will be evaluated during comprehensive program reviews. DMH reviewers may observe patients in waiting rooms to ascertain whether they are seen within one hour of their scheduled appointment time, and on-site random interviews of people receiving services will be conducted.
- Focused Individual Consultation visits will be conducted as needed for high cost/ high utilizers of services, individuals with complicated or complex profiles and service needs, or other individuals as determined by the DA/SSA and/or DMH.
- It is expected that the DA/SSA will initiate contact with individuals within 24 hours of notification of hospital discharge for any psychiatric admission and assess for impact on well-being for all hospital discharges.

## AUDITS AND MONITORING

A departmental team will be assigned to each region to monitor outcomes and program integrity to oversee quality improvement monitoring. The monitoring team will conduct at least one site visit and chart review for each DA/SSA on a rolling four-year basis and as needed participate in check in calls or meetings with providers to assess progress and provide technical assistance. The team will employ

consistent methodologies for tracking the utilization of intensive services provided to determine shared savings incentives across all regions of the State.

### MEDICAID AUDITS

Each provider must keep written documentation for all medical services, actual case record notes for any services performed, or business records that pertain to members for services provided and payments claimed or received. All documentation must be legible, contain complete and adequate information and applicable dates. Providers must submit information upon request of the State Agency of Human Services, Office of the Vermont Attorney General or U.S, Secretary of Health and Human Services and at no charge to the requester. The documentation for any service that was billed must be kept for ten years from the date of service. This information must also be available at any time for on-site audits. Records of any business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request, must be submitted within 35 days of the request. DMH conducts reviews which are intended to assure that quality services are provided to members and that providers are using the program properly. The reviews are generally an examination of records, known as a desk audit, although they may also include an on-site visit from the utilization review unit.

## OUTCOME MEASUREMENT

DAs and SSAs must report on performance and provide information for monitoring purposes as described in the Master Agreement between each DA or SSA and the Department of Mental Health. Information regarding reporting and performance measures related to value-based payments is described at section 5.5 and measure specifications for value-based payments are attached to this manual at section F.

## POPULATION BASED EXPECTATIONS

Through its multi-year reforms, DMH is implementing progressively advanced payment models that encourage population-based approaches toward delivery of services. The initial delivery and payment model encourages DAs and SSAs to focus on prevention, early intervention and promising approaches that are expected to reduce acuity and intensive service needs over time. DMH has identified DA/SSA performance measures that are supportive of the population-based outcomes in the following tables.

*Table 1- Children's Population Based Outcomes and Indicators*

| **Children's Mental Health Outcomes** | Pregnant women and young children are thriving | Families/Communities are safe, stable, nurturing, and supported |
|---|---|---|
| **Population Indicators** | Demonstrates Resilience / Flourishing<br><br>Prevalence of Emotional, mental or behavioral conditions<br><br>Level of severity of Emotional, mental or behavioral conditions<br><br>How often have these conditions affect child's ability to do things, severity of impact | Family Strengths<br><br>Child involvement in Community Activities<br><br>Parent's physical health, mental/emotional health |

*Table 2- Adult Population Based Outcomes and Indicators*

| **Adult Mental Health Outcomes** | All Vermonters are healthy. |
|---|---|
| **Population Indicators**[43] | a. Rate of suicide deaths per 100,000 Vermonters<br><br>b. % of Vermont adults with any mental health conditions receiving treatment<br><br>c. Rate of community services utilization per 1,000 Vermonters |

[43] Act 186 of the 2014 legislative session: https://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT186/ACT186%20As%20Enacted.pdf

# ATTACHMENT A

## STATE AND FEDERAL RULES

DA/SSA must follow all applicable state and federal rules as described in the Medicaid provider enrollment agreement and the Master Agreement. The following rules are excerpted for convenience of reference.

### HOME AND COMMUNITY BASED SETTINGS (HCBS)

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based services (HCBS). More information can be found here: https://www.medicaid.gov/medicaid/hcbs/guidance/index.html

The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS's intent to ensure that individuals receiving services and supports within two Medicaid waiver programs: Community Rehabilitation and Treatment (CRT) and Children's Enhanced Family Treatment (EFT) (titled "Mental Illness Under 22" in the Medicaid waiver) have full access to the benefits of community living and can receive services in the most integrated setting.

As part of the Medicaid Global Commitment to Health 1115 waiver, both the Community Rehabilitation and Treatment (CRT) and Enhanced Family Treatment (EFT) programs are HCBS-like programs and must ensure that their person-centered planning processes and settings meet the requirements of the rule.

### HCBS FEDERAL REQUIREMENTS

HCBS rule specifics can be found in the Code of Federal Regulations at 42 CFR 441.301(c) and 42 CFR 441.710(a)(1)(2).

### EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

#### BACKGROUND

All services for Medicaid eligible children ages 0 to 21 that are coverable under the Federal Medicaid program and found to be medically necessary must be provided under Vermont Medicaid whether the service is authorized through the currently approved Vermont Medicaid State Plan. Mental health services for children provided under the waiver that would not otherwise be allowable under the Medicaid State Plan may have limits on the amount duration and scope of services, as described in this manual.

More information regarding medical necessity and EPSDT can be found at the following links:

1. Federal Medicaid resources: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html
2. Vermont Medicaid Covered Services Rule 7103: http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view

#### DEFINITION[44]

[44] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

**Early:** Assessing and identifying problems early

**Periodic:** Checking children's health at periodic, age-appropriate intervals. Vermont's EPSDT periodicity schedule is defined by law and maintained by VDH at: http://www.healthvermont.gov/children-youth-families/health-care-children-youth/health-care-and-screening-guidelines

**Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

**Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and

**Treatment:** Control, correct or reduce health problems found.

## EPSDT EARLY AND PERIODIC SCREENING

EPSDT Early Screening Services require assessment of the child's needs through initial and periodic examinations and evaluations before they become more complex and their treatment more costly.

Providers are expected to promote surveillance, early identification and screening for Medicaid eligible and Medicaid enrolled children. The following definitions adopted by the State of Vermont AHS in 2010 should guide activities. All providers are expected to adhere to the EPSDT (Bright Futures) Periodicity scheduled for screenings as published by VDH.

1. Surveillance/Early Identification is the ongoing, longitudinal, cumulative process of recognizing children who may be at risk of developmental delays. Surveillance may occur in primary care practices, childcare settings or other environments applying population-based strategies for early detection of risk or problems.
2. Screening is use of brief and objective standardized tools to identify children at risk of developmental delay. It is a formal process that occurs at defined intervals and points of entry into services and any time a child is identified at risk through surveillance. Screening may occur at a primary care practice, mental health or other early childhood or provider settings.
3. Evaluation is a more complex process aimed at identifying and refining the specific nature of a particular client problem and related complex or confounding factors. Together, this information forms the foundation for specific recommendations and, if appropriate, leads to an individualized integrated treatment plan. An evaluation consists of gathering key information, exploring problem areas, formulating diagnoses, identify disabilities and strengths, and assessing the client's readiness for change.

## STAFF QUALIFICATIONS

Screening services may be provided by any licensed provider working within the scope of his or her practice. This includes authorized individuals working under the supervision of another provider.

## DIAGNOSTIC AND TREATMENT SERVICES

Diagnostic and Treatment services assure that identified health problems are diagnosed and treated early and are described throughout Section 3.

# ATTACHMENT B

## STATE RESOURCES AND REQUIRED FORMS

### CREDENTIALING AND RE-CREDENTIALING

A Designated Agency (DA) or Specialized Services Agency (SSA), must re-certify with DXC (DXC Technology) Enrollment every year. DXC will send a letter at both 60 and 30 days prior to the enrollment recertification due date. The next step is to complete the Recertification Agreement, available online at: http://vtmedicaid.com/, under "provider enrollment."

All providers receiving payments from DMH through the Child or Adult case rates must be Medicaid providers in good standing or must meet the DA/SSA minimum credentialing standards. Each DA/SSA is required to conduct credentialing and re-credentialing activities for employed and sub-contracted providers as directed by Medicaid. Minimum standards for credentialing and re-credentialing are available from the DVHA website.

### MEDICAID ENROLLMENT RESOURCES

Providers must confirm Medicaid eligibility and other insurance information. Medicaid enrollment information is available through:

1. The Vermont Medicaid Provider Portal at www.vtmedicaid.com; or,
2. The automated Voice Response System (VRS) at 802-878-7871.

The Department of Vermont Health Access (DVHA) determines an individual's eligibility for Medicaid. Applications for Medicaid benefit eligibility can be made online at:

- https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action.

Other public benefit determinations can be made as follows:

- Online at http://dcf.vermont.gov/mybenefits/apply
- BY phone through the DCF Benefits Service Center (800) 479-6151
- At a DCF district office listed here: http://dcf.vermont.gov/esd/contact-us/districts

Statewide beneficiary support is available through the Green Mountain Care Member Services Unit at (1-800-250-8427)

### MEDICAL NECESSITY REQUEST FORMS

Individuals enrolled in CRT who require equipment that is not customarily covered by Medicaid but related to their physical or medical condition may qualify for coverage using a Medical Necessity Form, available on DVHA's website at http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms. The form must be completed by a Medicaid-enrolled physician who certifies that the equipment is necessary for a client's medical condition. Items such as wheelchairs, adaptive equipment, air conditioners, or other health products that are identified as needed due to a CRT enrollee's medical condition, if medically necessary, should be eligible for coverage.

NOTE: If coverage has already been provided by Medicaid for a similar item previously, it is unlikely that coverage will be duplicated.

# ATTACHMENT C

## MEDICAID STATE PLAN COMMUNITY MENTAL HEALTH CENTER SERVICES

### DESCRIPTION

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Developmental and Mental Health Services. These services may be provided by physicians, psychologists, MSWs, psychiatric nurses, and qualified mental health professionals carrying out a plan of care approved by a licensed physician or licensed psychologist. Services may be provided in any setting; however, services will not be duplicated.

### RESTRICTIONS

All Global Commitment to Health Enrollees, except, beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under the 1115 waiver are ineligible for these State Plan services.

| COVERED SERVICE | MSR CODE |
|---|---|
| **DIAGNOSIS AND EVALUATION** | |
| A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client's attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to the family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole. | **E01 Clinical Assessment** |
| **EMERGENCY CARE** | |
| A method of care provided for persons experiencing an acute mental health crisis as evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources. | **G01 Emergency Care and Assessment Services/Mobile Crisis** |

### PSYCHOTHERAPY

A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes client-centered family therapy.

**E02 Individual Therapy**
**E03 Family Therapy**

### GROUP THERAPY

A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptational skills involving social interaction and emotional reactions to reality situations.

**E04 Group Therapy**

### CHEMOTHERAPY (MED-CHECK)

Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs.

**E05 Medication Evaluation, Management and Consultation Services**

### SPECIALIZED REHABILITATIVE SERVICES

#### 1. BASIC LIVING SKILLS

Restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills.

**B01 Community Supports**

#### 2. SOCIAL SKILLS

Redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.

**B01 Community Supports**

#### 3. COUNSELING

Counseling services directed toward the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community.

**B01 Community Supports**

#### 4. COLLATERAL CONTACT

Meeting, counseling, training or consultation to family, legal guardian, or significant others to ensure effective treatment of the recipient. These services are only provided to, or directed exclusively toward, the treatment of the Medicaid eligible person.

**A01 Service Planning and Coordination**

## ATTACHMENT D

### GLOBAL COMMITMENT TO HEALTH MEDICAID DEMONSTRATION SERVICES

| COVERED SERVICE | MSR CODE |
|---|---|
| **SERVICE COORDINATION**<br>Target Population: Children under 22 with Mental Illness & CRT<br>Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions. | **A01 Service Planning and Coordination** |
| **COMMUNITY SUPPORTS (INDIVIDUAL OR GROUP)**<br>Target Population: Children under 22 with Mental Illness & CRT<br>Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth. | **B01 Community Supports** |
| **SKILLED THERAPY SERVICES**<br>Target Population: Children under 22 with Mental Illness<br>Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy or specialized behavioral and health services. | **E01 - Clinical Assessment;**<br>**E02 - Individual Therapy;**<br>**E03- Family Therapy;**<br>**E04 - Group Therapy;**<br>**E05 - Medication and Medical Support** |
| **SKILLED THERAPY SERVICES**<br>Target Population: CRT<br>Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; individual, group, and family therapy or diagnosis-specific practices; medication evaluation, management and consultation with Primary Care; inpatient behavioral health services; partial hospitalization. | **E01 - Clinical Assessment;**<br>**E02 - Individual Therapy;**<br>**E03- Family Therapy;**<br>**E04 - Group Therapy;**<br>**E05 - Medication and Medical Support** |
| **RESIDENTIAL TREATMENT**<br>Target Population: IHCBS<br>Out of home treatment services that include:<br>• Transitional Living: Short-term out of home care for adolescents requiring intensive supports in order to transition to independent living.<br>• Therapeutic Foster Care: Short-term out-of-home care to assist in skill development and remediation of intensive mental health issues to support a return to the family. | **H04 - LICENSED HOME PROVIDERS/FOSTER FAMILIES**<br>H02 Staffed Living |

• Residential Treatment: Intensive out of home care for mental health treatment, skill building, family reintegration and/or specialized assessment services to assist recovery and skill building that supports return to the family home.

### RESIDENTIAL TREATMENT

**H02 - STAFFED LIVING**

**H03 - GROUP LIVING**

Target Population: CRT

Residential Treatment: Intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, but not provided in institutions for mental disease (IMD). Treatment may include the use of approved peer supported and peer run alternatives.

Housing and Home Supports: Mental Health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement).

### FLEXIBLE SUPPORT

**B03 - Family Education & Consultation**

Target Population: IHCBS

• Family Education: In home support and treatment for the purpose of enhancing the family's ability to meet their child's emotional needs.

• Specialized Rehabilitation or Treatment Plan Services: Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, treatment plan and/or prior approval.

### FLEXIBLE SUPPORT

**L01 - Day Services**

Target Population: CRT

Day Recovery/Psychoeducation, Including Recovery Education: Group recovery activities in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self- advocacy.

### COUNSELING

**B01 Community Supports**

Target Population: Children under 22 with Mental Illness /CRT

Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. Services may include approved peer supported and recovery services.

### RESPITE

**D01 - Respite**

Target Population: IHCBS

Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.

### SUPPORTED EMPLOYMENT

Target Population: Youth who meet criteria at section 3.10/CRT

Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.

**C01 - Employment Assessment**
**C02 - Employer and Job Development**
**C03 - Job Training**
**C04- Ongoing Support to Maintain Employment**

## CRISIS SUPPORTS

Target Population: Children under 22 with Mental Illness /CRT

Time limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 Availability, one to one support, and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.

**G01 - emergency care and assessment**

## ENVIRONMENTAL SAFETY DEVICES

Target Population: IHCBS/CRT

Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.

**G01 - emergency care and assessment**

## ATTACHMENT E

### MMIS PROCEDURE CODES AND MODIFIERS

| Billable (Caseload Qualifying) MSR Category | Associated Zero Paid Encounter Claims (Red = non case rate qualifying encounter) | Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4 | Notes |
|---|---|---|---|---|---|---|
| **A01** | H2017 | HA or HB or V1 | 76 or 77 or GY | GY | | |
| | T1017 | HA | 76 or 77 or GY | GY | | Howard Center provider ID only. |
| **B01** | H2017 | HA or HB or V1 | 76 or 77 or GY | GY | | H2017 maps to both A01 and B01. Would leave no distinction b/w Community Support and Service Coordination |
| | H2014 | HA or HB or V1 | 76 or 77 or GY | GY | | |
| **B02** | H2014 | HA or HB or V1 | 76 or 77 or GY | GY | | H2014 maps to both B01 and B02. These MSR services have different policies and utilization expectations |
| **E01 - E05** | 90791 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 90792 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90832 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90834 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90837 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90846 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90847 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90853 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99201 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | 10 min clinical assessment. Not qualifying. |
| | 99202 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99203 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99204 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99205 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99211 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | 5 min med code.Not qualifying. |
| | 99212 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | 10 min med code. Not qualifying. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 99213 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99214 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99215 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99241 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99242 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99243 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99244 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 99245 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | H0031 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | H2010 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90833 | HA or HB or V1 | AH or AJ or HO or HN, | 76 or 77 or GY | GY | |
| | 90836 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90838 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | |
| | 90785 | HA or HB or V1 | AH or AJ or HO or HN | 76 or 77 or GY | GY | add on code for therapy with no time duration. Not qualifying. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 97151 | HA | AH or AJ or HO or HN | 76 or 77 | GY | Howard Center provider ID only. |
| | 97152 | HA | 76 or 77 | GY | | Howard Center provider ID only. |
| **G01** | H2011 | HA or HB or V1 | 76 or 77 | GY | | |
| **G02** | H0046 | HA or HB or V1 | 76 or 77 | GY | | |
| **DVHA FFS Codes** | 90839 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | 60-minute crisis psychotherapy session |
| | 90840 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | add-on used for each additional 30 minutes of crisis psychotherapy. |
| | 96101 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Psychological testing |
| | H0001 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Alcohol and/or drug assessment |
| | H0004 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Behavioral health counseling and therapy, per 15 minutes |
| | H0005 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Alcohol and/or drug services; group counseling by a clinician |
| | H0040 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Assertive community |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | treatment program, per diem |
| | H2000 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Comprehensive multidisciplinary evaluation |
| | H2019 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Therapeutic behavioral services, per 15 minutes |
| | H2020 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Therapeutic behavioral services, per diem |
| | H2032 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Activity therapy, per 15 minutes |
| | S9485 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Crisis intervention mental health services, per diem |
| | T2038 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | Community transition, waiver; per service |
| | 99366 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | |
| | 99367 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | |
| | 99368 | HA or HB or V1 | AH or AJ or HO or HN, or 76 or 77 or GY | 76 or 77 or GY | GY | |

## ATTACHMENT F

### CASE RATE DA/SSA PROGRAM MATRIX

| | | | NKHS | | NCSS | | HC | | CSAC | | WCMH | | LCMS | | CMC | | RMHC | | HCRS | | UCS | | Pathways | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** |
| **DMH Child Case Rate** | | | X | | IFS | | X | | IFS | | X | | X | | X | | X | | X | | X | | | X |
| Exh B Investment (includes non-cat) | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Exh B FFS (Including New Leaf at WCMH and CHIP) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| Exh C: Respite Investment | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Exh C: Access[i] Investment | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Exh B: Access FFS | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | | |
| Waiver (Global Commitment/FFS) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | | |
| Waiver R&B[ii] (Global Commitment/Invest) | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Non-Categorical (Medicaid) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| Special Services[iii] | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| JOBS (Jump on Board for Success) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | | |
| Medical Assistance Program[iv] | | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | | |
| DCF ISB (Other than transitional living) | | X | | X | X | | | X | X | | | X | | X | | X | | X | | X | | X | | X |
| Transitional Living (waiver and ISB) | X | | | X | | X | X | | | X | X | | | X | | X | | X | | X | | X | | X |
| DCF Waiver (Global Commitment) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | | |
| Youth In Transition (YIT) FFS | X | | | | X | | X | | X | | | | | | X | | | | X | | X | | | |
| YIT Capacity and GF | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Kids Substance Abuse (FFS outside Exhibit B) | X | | | | | X | | | X | | | | | | | | | | | | | | | |

| | | | NKHS | | NCSS | | HC | | CSAC | | WCMH | | LCMS | | CMC | | RMHC | | HCRS | | UCS | | Pathways | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** | **In** | **Out** |
| **DMH Adult Case Rate** | | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| Exh B Investment | | **X** | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Exh B FFS Including Nursing) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| Emergency | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | | |
| Emergency Capacity | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Adult Substance Abuse | X | | | | X | | X | | X | | X | | | | | | X | | X | | | | | |
| Adult SA Capacity | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| CRT Case Rate and Capacity | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| CRT Emergency Support Fund | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Community Initiatives – Hill House (CSAC) | X | | | | | | | | X | | | | | | | | | | | | | | | |
| Kirby House WCMH | X | | | | | | | | | | X | | | | | | | | | | | | | |
| START | X | | | | | | X | | | | | | | | | | | | | | | | | |
| CRT Residential Recovery | X | X | | X | | X | | X | | X | | X | | X | | X | X | | X | | | X | | X |
| CSIP | X | | | | | | | | | | X | | | | | | | | | | | | | |
| Elder Care | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Severely Functionally Impaired | X | | | | | | | | | | X | | | | | | | | | | | | | |
| SFI Investment | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Case Management and Supported Housing (C4C) | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Safe Haven (CMC only) | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |
| Street Outreach | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X |

[i] These are funds in addition or in lieu of PMPM funding when children have an emergency (behavioral or medical).

[ii] This includes any fee for service that is not part of the PMPM rate. Investment not FFS- CL

[iii] This includes services outside of the bundle or fee for service (FFS) billing which can be provided to children at the D.A.'s discretion.

[iv] This is not a program; rather, it is NCSS's code for designating funds for its PCC services.

# ATTACHMENT G

## VALUE-BASED PERFORMANCE MEASURE SPECIFICATIONS

| Measure | Required By | |
|---|---|---|
| | Children | Adult |
| 1. Number of children/youth (0-17) served. | X | |
| 2. Number of Medicaid-eligible children/youth (0-17) served. | X | |
| 3. Number of eligible children/youth (0-17) served per 1,000 age-specific population. | X | |
| 4. Number of young adults (18-21) served. | X | |
| 5. Number of Medicaid-eligible young adults (18-21) served. | X | |
| 6. Number of eligible children/youth (18-21) served per 1,000 age-specific population. | X | |
| 7. Number of adults (18+) served. | | X |
| 8. Number of Medicaid-covered adults (18+) served. | | X |
| 9. Number of adults (18+) served per 1,000 age-specific population. | | X |
| 10. Percentage of clients indicate services were "right" for them. | X | X |
| 11. Percentage of clients indicate they received the services they "needed." | X | X |
| 12. Percentage of clients indicate they were treated with respect. | X | X |
| 13. Percentage of clients indicate services made a difference. | X | X |

### STANDARDS DEFINITIONS

Unless otherwise stated in the measure definition or specifications for calculation, standards apply to all clients served at the agency.

Following are specifications for each measure describing:

- **Measure definition**: Describes and defines the measure.
- **Rationale for the measure:** Explains why this measure is important, and should describe how the measure
  - focuses on outcomes;
  - increases the quality and value of the programs and services provided; and/or
  - produces meaningful data for CQI efforts.
- **Data Source:** Defines the source or location of the data (Consumer Satisfaction Survey, Monthly Service Report, Agency Electronic Health Record).
- **Data Retrieved By:** The party responsible for retrieving the data (State, Agency, or authorized third party).
- **Data Schedule:** The frequency and/or the dates the data is due. The frequency the data is analyzed.
- **Measure Type:** Indicates if a measure examines the Process, Delivery System, Patient Experience, or Outcome.
- **Measure Category:** Indicates the Results-Based Accountability category (How Much / How Well / Better Off)
- **Specifications for calculation:** Defines how the measure will be assessed.
- **Population:** Indicates the applicable population for the measure (Children and/or Adult)
- **Value-Based Payment Performance Target:** Defines the target for value-based payment.
- **Rationale for Performance Target:** Explains why this target was selected. May list any comparable national, state, or local benchmarks, if available.
- **Scoring:** Provides the scoring methodology to determine how points are earned for value-based payment.
- **On Time:** Monthly MSR submissions are "On Time" if received on/before the last day of the following month (approx. 30 days after last reporting day)
- **Timely Annual:** Annual submissions are "timely" if received on/before March 31st (approx. 90 days after last reporting day)
- **Standard:** Received in the format and standard as defined in the Master Agreements and/or in the Provider Manual
- **Complete:** Accepted by the MSR or the identified contact as defined in the Master Agreements and/or in Provider Manual
- **Other:** Includes additional information about the standard, including references, if there are other notable corresponding measures (e.g., Center of Excellence, National HEDIS measures, evolving ACO measures).

### MEASURES

| 1. Number of children/youth (0-17) served | |
|---|---|
| Measure Definition | The total non-duplicated number of children/youth (0-17) served by Designated Agencies regardless of payer. |
| Rationale for Measure | This measure is used to monitor the total number of clients served by the Designated Agency, and to further the State's understanding of changes and/or variations in the mental health needs of the catchment area. By acting as the denominator in other |

| | |
|---|---|
| | measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Pull MSR services<br>• Calculate age of client from the midpoint of the service year (June 30, XXXX)<br>• Select clients who are aged 0-17<br>• Aggregate to clinic client level, with flag for total services during fiscal year<br>• Select clients who have a least 1 unit (as defined in the *Provider Manual*)<br>Report figure on a designated agency level basis |
| Population | Children |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>• 1 point for "on time"<br>• 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates. |

| 2. Number of Medicaid-enrolled children/youth (0-17) served | |
|---|---|
| Measure Definition | The total non-duplicated number of Medicaid-enrolled children/youth (0-17) served by the Designated Agencies. Includes individuals with full or partial coverage. |
| Rationale for Measure | This measure is used to monitor the access to care, by examining total number of Medicaid beneficiaries served by the Designated Agency. The Agency of Human Services is the Single State Medicaid Authority and must be able to account for numbers of individuals served through Medicaid. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Pull MSR services<br>• Match service records to MSR client services on clinic-client no.<br>• Calculate age of client from the midpoint of the service year (June 30, XXXX)<br>• Select clients who are aged 0-17<br>• Select clients who are reported as Medicaid enrolled (from client file)<br>• Aggregate to clinic client level, with flag for total services during fiscal year<br>• Select clients who have a least 1 unit (as defined in the *Provider Manual*)<br>Report figure on a designated agency level basis |
| Population | Children |
| Value-Based Payments Benchmarks | N/A |

| | |
|---|---|
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates. |

| 3. Number of eligible children/youth (0-17) served per 1,000 age-specific population | |
|---|---|
| Measure Definition | Number of children/youth (0-17) served by Designated Agencies per 1,000 age-specific population. |
| Rationale for Measure | This measure is used to monitor the penetration rate of a catchment area for an age-specific population, and to provide information about the population health. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Follow steps for measure 1 (Number of children/youth (0-17) served).<br>• Request most recent demographic data from VDH on a catchment level basis<br>• Calculate per capita rate based on formula below<br><br>The rates of clients served per 1,000 population are presented as a comparable standardized measure of the proportion of the residents of specified geographical regions who are served by specified programs. This utilization rate is computed according to the formula:<br>$$R = \frac{1{,}000\ C}{P}$$<br>where R is the rate of clients served per 1,000 population, C is the number of clients served, and P is the age-specific population of the geographic area in question.<br>Report figure on a designated agency level basis |
| Population | Children |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |

| | |
|---|---|
| Other | The denominator in this measure is supplied by the Vermont Department of Health from Vital Statistics. *Please note*: the denominator provided to DMH is calculated using catchment area, which is different than the public denominator which is broken out by county. |

| 4. Number of young adults (18-21) served | |
|---|---|
| Measure Definition | The total non-duplicated number of young adults (18-21) served by the Designated Agency, regardless of payer. |
| Rationale for Measure | This measure is used to monitor the total number of clients served by the Designated Agency, and to further the State's understanding of changes and/or variations in the mental health needs of the catchment area. By acting as the denominator in other measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Pull MSR services<br>• Calculate age of client from the midpoint of the service year (June 30, XXXX)<br>• Select clients who are aged 18-21<br>• Aggregate to clinic client level, with flag for total services during fiscal year<br>• Select clients who have a least 1 unit (as defined in the *Provider Manual*)<br>Report figure on a designated agency level basis |
| Population | Children |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates. |

| 5. Number of Medicaid-enrolled young adults (18-21) served | |
|---|---|
| Measure Definition | The total non-duplicated number of Medicaid-enrolled young adults (18-21) served by the Designated Agencies. Includes individuals with full or partial coverage. |
| Rationale for Measure | This measure is used to monitor the access to care, by examining total number of Medicaid beneficiaries served by the Designated Agency. The Agency of Human Services is the Single State Medicaid Authority and must be able to account for numbers of individuals served through Medicaid. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |

| | |
|---|---|
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Pull MSR services<br>• Match service records to MSR client services on clinic-client no.<br>• Calculate age of client from the midpoint of the service year (June 30, XXXX)<br>• Select clients who are aged 18-21<br>• Select clients who are reported as Medicaid enrolled (from client file)<br>• Aggregate to clinic client level, with flag for total services during fiscal year<br>• Select clients who have a least 1 unit (as defined in the *Provider Manual*)<br>Report figure on a designated agency level basis |
| Population | Children |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates. |

| 6. Number of eligible young adults (18-21) served per 1,000 age-specific population | |
|---|---|
| Measure Definition | Number of children/youth (18-21) served by Designated Agencies per 1,000 age-specific population. |
| Rationale for Measure | This measure is used to monitor the penetration rate of a catchment area for an age-specific population, and to provide information about the population health. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Follow steps for measure 4 (Number of children/youth (18-21) served).<br>• Request most recent demographic data from VDH on a catchment level basis<br>• Calculate per capita rate based on formula below<br><br>The rates of clients served per 1,000 population are presented as a comparable standardized measure of the proportion of the residents of specified geographical regions who are served by specified programs. This utilization rate is computed according to the formula:<br>$$R = \frac{1{,}000\ C}{P}$$<br>where R is the rate of clients served per 1,000 population, C is the number of clients served, and P is the age-specific population of the geographic area in question.<br>Report figure on a designated agency level basis |
| Population | Children |
| Value-Based Payments Benchmarks | N/A |

| | |
|---|---|
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The denominator in this measure is supplied by the Vermont Department of Health from Vital Statistics. *Please note*: the denominator provided to DMH is calculated using catchment area, which is different than the public denominator which is broken out by county. |

| 7. Number of adults (18+) served | |
|---|---|
| Measure Definition | The total non-duplicated number of adults (18+) served by the Designated Agency, regardless of payer. |
| Rationale for Measure | This measure is used to monitor the total number of clients served by the Designated Agency, and to further the State's understanding of changes and/or variations in the mental health needs of the catchment area. By acting as the denominator in other measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Pull MSR services<br>• Calculate age of client from the midpoint of the service year (June 30, XXXX)<br>• Select clients who are aged 18 or older<br>• Aggregate to clinic client level, with flag for total services during fiscal year<br>• Select clients who have a least 1 unit (as defined in the *Provider Manual*)<br>Report figure on a designated agency level basis |
| Population | Adult |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates. |

| 8. Number of Medicaid-enrolled adults (18+) served | |
|---|---|
| Measure Definition | The total non-duplicated number of Medicaid-enrolled adults (18+) served by the Designated Agencies. Includes individuals with full or partial coverage, as well as non-Medicaid CRT clients. |
| Rationale for Measure | This measure is used to monitor the access to care, by examining total number of Medicaid beneficiaries served by the Designated Agency. The Agency of Human Services is the Single State Medicaid Authority and must be able to account for numbers of individuals served through Medicaid. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Pull MSR services<br>• Match service records to MSR client services on clinic-client no.<br>• Calculate age of client from the midpoint of the service year (June 30, XXXX)<br>• Select clients who are aged 18 and older<br>• Select clients who are reported as Medicaid enrolled (from client file)<br>• Aggregate to clinic client level, with flag for total services during fiscal year<br>• Select clients who have a least 1 unit (as defined in the *Provider Manual*)<br>Report figure on a designated agency level basis |
| Population | Adult |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates. |

| 9. Number of adults (18+) served per 1,000 age-specific population | |
|---|---|
| Measure Definition | Number of adults (18+) served per 1,000 age-specific population. |
| Rationale for Measure | This measure is used to monitor the penetration rate of a catchment area for an age-specific population, and to provide information about the population health. |
| Data Source | MSR |
| Data Retrieved By | State of Vermont – Department of Mental Health |
| Data Schedule | Monthly Submission by Designated Agencies, Annual Calculation by DMH |
| Measure Type | Delivery System |
| Measure Category | How Much |
| Specifications for Calculations | For any given year of service (Jan - Dec):<br>• Follow steps for measure 8(Number of Adults (18+) served)<br>• Request most recent demographic data from VDH on a catchment level basis<br>• Calculate per capita rate based on formula below<br><br>The rates of clients served per 1,000 population are presented as a comparable standardized measure of the proportion of the residents of specified geographical regions |

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|---|---|
| | who are served by specified programs. This utilization rate is computed according to the formula:<br>$$R = \frac{1{,}000\ C}{P}$$<br>where R is the rate of clients served per 1,000 population, C is the number of clients served, and P is the age-specific population of the geographic area in question.<br>Report figure on a designated agency level basis |
| Population | Adult |
| Value-Based Payments Benchmarks | N/A |
| Rationale for Benchmark (if available) | N/A |
| Scoring | • This measure is scored together with all delivery system measures submitted through the MSR;<br>• Each MSR submission is eligible for 2 points:<br>  • 1 point for "on time"<br>  • 1 point for "standard and complete"<br>• A total of 24 points are available for MSR submissions per calendar year.<br><br>**Agency only needs to score 22 of the 24 points available to achieve 100% points for Delivery System measures.** |
| Other | The denominator in this measure is supplied by the Vermont Department of Health from Vital Statistics. *Please note*: the denominator provided to DMH is calculated using catchment area, which is different than the public denominator which is broken out by county. |

| 10. Percentage of clients indicate services were "right" for them | |
|---|---|
| Measure Definition | The percentage of clients who indicate via satisfaction survey that they agree that services provided were "right" for them |
| Rationale for Measure | Provides agency with client feedback about their perception of whether services were the "best fit" for their needs. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency's ability to meet the client's needs. |
| Data Source | Consumer Satisfaction Surveys |
| Data Retrieved By | Designated Agency |
| | |
| Data Schedule | Annual. At the time of review, agencies are required to submit their most recent, complete survey results. |
| Measure Type | Patient Experience |
| Measure Category | How Well |
| Specifications for Calculations | • Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)<br>• Denominator = Total # of responses |
| Population | Children, Adult |
| Value-Based Payments Benchmarks | (N/A for CY2019, will be set for CY2020) |
| Rationale for Benchmark (if available) | None Available |
| Scoring | Eligible for 2 points (1 point for "timely annual" submission, 1 point for "standard and complete" submission) |
| Other | This measure was taken from the Centers Of Excellence's *Certification Manual* Measures. |

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|---|---|
| | Known Biases: possible duplications (clients may be surveyed multiple times, particularly if they receive different services or participate in multiple programs); parents/guardians may be filling out the surveys for some clients; young adults transitioning into adult services may be surveyed in both children's and adults; may include incomplete surveys; feedback from persons with intellectual disabilities has indicated that they may not understand the question (due to an array of services received and/or the absence of context during the surveying); and surveys only provided in English, unless by request (may decrease the number of ESL clients responding) |

| 11. Percentage of clients indicate they received the services they "needed" | |
|---|---|
| Measure Definition | The percentage of clients who indicate via satisfaction survey that they agree that services provided were what they "needed" |
| Rationale for Measure | Provides agency with client feedback about their perception of whether services were the "best fit" for their needs. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency's ability to meet the client's needs. |
| Data Source | Consumer Satisfaction Surveys |
| Data Retrieved By | Designated Agency |
| Data Schedule | Annual. At the time of review, agencies are required to submit their most recent, complete survey results. |
| Measure Type | Patient Experience |
| Measure Category | How Well |
| Data Source | Consumer Satisfaction Surveys |
| Specifications for Calculations | • Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)<br>• Denominator = Total # of responses |
| Population | Children, Adult |
| Value-Based Payments Benchmarks | (N/A for CY2019, will be set for CY2020) |
| Rationale for Benchmark (if available) | None Available |
| Scoring | Eligible for 2 points (1 point for "timely annual" submission, 1 point for "standard and complete" submission) |
| Other | This measure was taken from the Centers Of Excellence's *Certification Manual* Measures.<br><br>Known Biases: possible duplications (clients may be surveyed multiple times, particularly if they receive different services or participate in multiple programs); parents/guardians may be filling out the surveys for some clients; young adults transitioning into adult services may be surveyed in both children's and adults; may include incomplete surveys; feedback from persons with intellectual disabilities has indicated that they may not understand the question (due to an array of services received and/or the absence of context during the surveying); and surveys only provided in English, unless by request (may decrease the number of ESL clients responding) |

| 12. Percentage of clients indicate they were treated with respect | |
|---|---|
| Measure Definition | The percentage of clients who indicate via satisfaction survey that agree that they were treated with respect |
| Rationale for Measure | Provides agency with client feedback about their perception of whether staff were respectful. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency's ability to meet the client's needs. |
| Data Source | Consumer Satisfaction Surveys |
| Data Retrieved By | Designated Agency |
| Data Schedule | Annual. At the time of review, agencies are required to submit their most recent, complete survey results. |

| | |
|---|---|
| Measure Type | Patient Experience |
| Measure Category | How Well |
| Data Source | Consumer Satisfaction Surveys |
| Specifications for Calculations | • Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)<br>• Denominator = Total # of responses |
| Population | Children, Adult |
| Value-Based Payments Benchmarks | (N/A for CY2019, will be set for CY2020) |
| Rationale for Benchmark (if available) | None Available |
| Scoring | Eligible for 2 points (1 point for "timely annual" submission, 1 point for "standard and complete" submission) |
| Other | This measure was taken from the Centers Of Excellence's *Certification Manual* Measures.<br><br>Known Biases: possible duplications (clients may be surveyed multiple times, particularly if they receive different services or participate in multiple programs); parents/guardians may be filling out the surveys for some clients; young adults transitioning into adult services may be surveyed in both children's and adults; may include incomplete surveys; feedback from persons with intellectual disabilities has indicated that they may not understand the question (due to an array of services received and/or the absence of context during the surveying); and surveys only provided in English, unless by request (may decrease the number of ESL clients responding) |

| 13. Percentage of clients indicate services made a difference | |
|---|---|
| Measure Definition | The percentage of clients who indicate via satisfaction survey that agree that services made a difference |
| Rationale for Measure | Provides agency with client feedback about their perception of whether services made an impact on their wellbeing. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency's ability to meet the client's needs. |
| Data Source | Consumer Satisfaction Surveys |
| Data Retrieved By | Designated Agency |
| Data Schedule | Annual. At the time of review, agencies are required to submit their most recent, complete survey results. |
| Measure Type | Patient Experience |
| Measure Category | Better Off |
| Data Source | Consumer Satisfaction Surveys |
| Specifications for Calculations | • Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)<br>• Denominator = Total # of responses |
| Population | Children, Adult |
| Value-Based Payments Benchmarks | (N/A for CY2019, will be set for CY2020) |
| Rationale for Benchmark (if available) | None Available |
| Scoring | Eligible for 2 points (1 point for "timely annual" submission, 1 point for "standard and complete" submission) |
| Other | This measure was taken from the Centers Of Excellence's *Certification Manual* Measures.<br><br>Known Biases: possible duplications (clients may be surveyed multiple times, particularly if they receive different services or participate in multiple programs); parents/guardians may be filling out the surveys for some clients; young adults transitioning into adult services may be surveyed in both children's and adults; may include incomplete surveys; feedback from persons with intellectual disabilities has indicated that they may not understand the question (due to an array of services received and/or the absence of context during the surveying); and surveys |

| | |
|---|---|
| | only provided in English, unless by request (may decrease the number of ESL clients responding) |