Community-Based
Mental Health Services for
Children and Adults

Integrating Family Services

School Mental Health:
Success Beyond Six

Vermont Department of Mental Health

Provider Manual

December 2023 Update

CONTENTS

Section 1:Community-Based Mental Health Services for Children and Adults

1. DEPARTMENT OF MENTAL HEALTH DELIVERY SYSTEM AND PAYMENT REFORM

1.1 BACKGROUND AND REFORM GOALS

In 2019, the Department of Mental Health (DMH) changed 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 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 the Department of Mental Health's (DMH) overall annual allocation for each provider including funds from the Department for Children and Families and the Department of Vermont Health Access.

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]

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 Members 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.

1.2 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:

2 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.

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

1 18 V.S.A. § 7204

2 18 V.S.A. § 7201

4 18 V.S.A. § 7202

Provider Manual Part 2 describes the additional scope and requirements of the Integrating Family Services payment and delivery reform model. Part 3 of this manual includes information on DMH School-based Mental Health Services.

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

In 2019, DMH began a multi-year reform plan and continues to expect 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.

A standard process for making edits and revisions to the Mental Health Provider Manual is found at:

https://mentalhealth.vermont.gov/document/mental-health-provider-manual-revision-protocol

2. COVERED POPULATIONS

2.1 GLOBAL COMMITMENT TO HEALTH ENROLLEES

Medicaid Members 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.

Medicaid eligibility can be checked at https://vtmedicaid.com/secure/logon.do or providers can access member eligibility and other information using the Voice Response System (VRS) by calling 800.925.1706 (select option 1).

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.

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: Meet Community Rehabilitation and Treatment (CRT) criteria at section 2.2 of this manual, and are not Medicaid eligible or enrolled may receive mental health services paid for using the adult mental health case rate.

2.2 POPULATION SERVED

Medicaid Members 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.

CHILDREN, YOUTH AND YOUNG ADULTS

5 In accordance with the provisions of 33 V.S.A. chapter 43.

6 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 Home and Community Based 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.

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). To establish IHCBS eligibility the following criteria should be considered and included in the client's record:

7 Refer to attachment A regarding EPSDT for additional information.

8 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.

- 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.

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.

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

Children and youth who have been identified as requiring IHCBS level of care shall be identified and tracked for reporting at the state and federal level. To meet this requirement, all services provided to those eligible for IHCBS shall be submitted under cost center 99 until the need for IHCBS services is resolved.

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, diagnosed 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 following:

- 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 for at least 6 months, 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.

When the Designated Agency submits an enrollment form in a certain month, the person will be added to the CRT list as of the first of that month of enrollment.

Example: If a client is determined to be eligible on February 15th, they will be enrolled in CRT for February 1st and any case rate qualifying claim submitted in that month will be counted toward the DAs annual caseload target for the Adult Mental Health case rates.

Individuals may be added to the CRT list up to three months prior to the first month of enrollment if the individual had no other source of coverage and a case load qualifying service was provided.

Example: A client is determined to be eligible on February 15th, but the person received a mental health case load qualifying service on November 10th. The individual may be enrolled in CRT with an effective date of November 1st as long as there was no other source of coverage for the *service.*

CRT ENROLLMENT

The CRT Program Enrollment and the Checklist for Eligibility must be completed for all new enrollees and is available at https://mentalhealth.vermont.gov/reports-forms-and-manuals/forms#C .

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 https://mentalhealth.vermont.gov/reports-forms-and-manuals/forms#C).

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 for a period of 2 years.

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 https://mentalhealth.vermont.gov/reports-forms-and-manuals/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, choosing the transfer section on the drop-down;
- submission to DMH by the sending DA/SSA a CRT Dis-enrollment Form to DMH, choosing the transfer option in the drop down;;
- 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.

ADVANCE DIRECTIVES

An Advance Directive is a written document, signed by an individual and two witnesses, that outlines the individual's wishes for medical treatment in the future when he or she no longer can (or wishes to) make decisions about what to do. The use of Advance Directives replaces what used to be referred to as a "living will," or a "durable power of attorney (DPOA) for healthcare."

The DMH requires all designated agencies to have written policy statements describing their procedure for handling an Advance Directive. The DA/SSA must inform all CRT enrolled clients of their right to accept treatment or to refuse treatment and of their right to initiate an Advance Directive. The DA/SSA will inform individuals about Advance Directives, including who to contact for assistance in developing one and in communicating one's preference about future medical treatment, constraints on the use of an Advance Directive, family involvement in planning, and standards for proxy decision making. If an individual has provided the DA/SSA with specific instructions about health care through a valid Advance Directive, and the Advance Directive is in effect, the instructions and terms will be followed according to federal and state law, unless the terms conflict with a Court order.

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.

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

Clinical Assessment or reassessment must be a face-to-face contact, in-person or through Telemedicine[12]. The Initial Clinical Assessment must be completed within 45 days of first scheduled appointment attended.

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

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 Psychiatry and Neurology 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 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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
    - Licensed Alcohol and Drug Counselor
- 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

12 See *Telemedicine*, *Section 5.3.53*, of the Vermont Medicaid General Billing and Forms Manual for specific requirements related to the provision of telemedicine services: http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf

rules apply. For more information refer to Section 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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 provided 24-hours-a-day, 7-days-a-week. They are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources such as screening for involuntary hospital admissions, or referrals to other appropriate levels of care. 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

Emergency Services typically include assessment of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization or emergency placement, assessment of need for mental health and other services, referral and follow-up. The role of the Designated Agency (DA) crisis screener is to identify and access the least restrictive intervention that will help to resolve or stabilize the immediate crisis.

The following Emergency Services shall be provided[13]:

Designated Agency emergency telephone numbers shall be prominently and currently listed in all telephone directories in the local service area.

A Designated Agency shall have the capacity to provide services in accordance with their Provider Agreement and Administrative Rules for Agency Designation, including:

- Consultation and coordination for mental health crisis until the immediate crisis is resolved, all available and appropriate resources have been utilized, or responsibility is transferred to another agency or appropriate person;
- Follow-up, where possible and if appropriate, to emergency contacts to ensure that linkages were appropriate, and referrals were made if needed;

[13] See also section 4.3 Access to Care.

- Documentation of all contacts and their disposition;
- Emergency screening on a face-to-face basis in accordance with a Designated Agency's policies and procedures; and
- 24/7 face-to-face Qualified Mental Health Professional (QMHP) and psychiatric assessment for involuntary inpatient admissions.

In addition to meeting the requirements above, nothing within these standards shall prevent an Agency from seeking compensation for routine mental health response and support capacities over and above those mandated by their DA Provider Agreement (see *Inpatient screening above)* with individual community mental health providers or facilities serving the community.

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. If a psychiatrist is not available, a warrant can be used.

A Designated Agency's transport protocol will be in accordance with the current statute *(Title 18 V.S.A.§7511). A complete description of the DMH standards surrounding transportation can be found on the DMH website at* https://mentalhealth.vermont.gov/reports-forms-and-manuals/manuals

COURT SCREENINGS

A Designated Agency QMHP is the 'mental health professional', referenced in *Title 13 V.S.A. § 4815*[14]*,* 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.

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

Emergency Services will have the capacity to be mobile, in addition to seeing people in the office, clinic, and emergency departments. ES will provide services 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.

For information on enhanced two-person response services, please review the Community-Based Mobile Crisis program manual:

Community-Based Mobile Crisis Services Provider Manual | Department of Mental Health (vermont.gov)

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

[14] *http://legislature.vermont.gov/statutes*

15 See *Telemedicine*, *Section 5.3.53*, of the Vermont Medicaid General Billing and Forms Manual for specific

requirements related to the provision of telemedicine services:
http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf

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.

FOR TELEPHONE INTERVENTIONS

Emergency Services shall include 24-hour, seven-days-a-week (24/7) direct personal telephone response which shall:

- respond to all calls within an average of five minutes of the initial telephone contact with a Designated Agency;
- triage calls and provide information, referral, or immediate access to services to assist the caller in resolving the crisis; and
- document all telephone contacts and their disposition.

FOR FACE-TO-FACE INTERVENTIONS

Emergency services shall include the capacity for 24/7, face-to-face evaluation and treatment. Face-to-face services shall:

- Provide on-site services by a qualified screener, within an average of 30 minutes from the identified need or request for emergency examination screening.
- Be closely and routinely coordinated with all necessary community emergency resources, including medical and law enforcement support.
- Travel time to services shall not exceed what is usual and customary in the geographic region.
- Coordinate urgent care appointments within 48 hours of initial crisis intervention.
- Designated Agencies, working in conjunction with their local hospitals, will determine when a face-to-face versus telemedicine response is most appropriate.

DOCUMENTATION REQUIREMENTS

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.

Designated Agency crisis staff shall be qualified to assess and provide intervention to individuals presenting with mental health and substance use symptoms.

The clinical supervisor of a Designated Agency's crisis program(s) shall be a Commissioner designated qualified mental health professional (QMHP) as described in the QMHP Manual

Staffing shall be sufficient to meet the response times required in this section. Exceptions to the standards for staffing and response time shall be reviewed by the clinical supervisor of the Designated Agency's crisis program(s).

Support services (e.g. phone answering, clerical services) to crisis programs may be delivered by non-DA staff with training and supervision by a QMHP.

All staff providing emergency services shall have the opportunity to receive clinical training, including, but not limited to, crisis assessments and de-escalation, at least annually.

Clinical staff with specific expertise in intellectual disabilities and child/adolescent services shall be available to crisis staff.

A Designated Agency shall have guidelines approved by their Medical Director indicating when to contact a supporting psychiatrist.

A Designated Agency shall have a system approved by their Medical Director to screen for physical health problems in people receiving emergency services.

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 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 address acute mental health crises, including adults dually diagnosed 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)

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

- 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

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 1 unit of service. Please refer to AMA guidelines for establishing billing thresholds for 1 unit of service.

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.

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17 See *Telemedicine*, *Section 5.3.53*, of the Vermont Medicaid General Billing and Forms Manual for specific requirements related to the provision of telemedicine services: http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf

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

STAFF QUALIFICATIONS

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

- Licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology 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,
- A non-licensed Psychiatric Nurse Practitioners refer to *Section* 3.6 – *Supervised Billing for Behavioral Health Services* in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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
    - Licensed Alcohol and Drug Counselor
- 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* 3.6 – *Supervised Billing for Behavioral Health Services* in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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.

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

The minimum duration for family therapy and couples therapy is 1 unit. . Please refer to AMA guidelines for establishing billing thresholds for 1 unit of service.

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

DOCUMENTATION REQUIREMENTS

Each session needs 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 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.

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

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

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 Psychiatry and Neurology 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 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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
    - Licensed Alcohol and Drug Counselor
- 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 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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 1 unit of service. Please refer to AMA guidelines for establishing billing thresholds for 1 unit of service.

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

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

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

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

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 Psychiatry and Neurology 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 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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
    - Licensed Alcohol and Drug Counselor
- 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 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.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 telehealth 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 Medical Evaluation, Management and Consultation encounter to be allowable for case rate billing is 1 unit of service. Please refer to AMA guidelines for establishing billing thresholds for 1 unit of service.

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 or telehealth 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

Psychiatric Medication Evaluation, Management and Consultation Services may only be provided by a board-eligible or board-certified physician in Psychiatry by the American Board of Psychiatry and Neurology or an authorized Advanced Practice Provider who is licensed in Vermont and directly affiliated with the Designated Agency/Specialized Services Agency and operating within their scope of practice. Agencies must retain at least one board-certified psychiatrist on staff or available for consultation and supervision.

Board-certified or board-eligible Primary Medical Specialty Providers (such as Family Medicine, Pediatrics, Neurology, etc.), including Advanced Practice Providers, may provide care within the scope of their practice.

Designated Agencies/Specialized Service Agencies will conduct performance reviews of all prescribing providers annually at a minimum. Reviews may be completed by a peer evaluation process or by the Designated Agency Medical Director to ensure providers are rendering care that is efficacious, efficient and within the standards of care. It is expected that any deficiencies be addressed via performance improvement plans.

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 encounter to be allowable for case rate billing is 1 unit of service. Please refer to AMA guidelines for establishing billing thresholds for 1 unit of service.

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;
- 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.

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

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. A Registered Nurse may provide these services to CRT enrollees, only.

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

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

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

The minimum duration for a group community support encounter to be allowable for case rate billing is 1 unit of service. Please refer to AMA guidelines for establishing billing thresholds for 1 unit of service.

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.

Progress notes for community supports must include:

- 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.

3.10 SUPPORTED EMPLOYMENT

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

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)*

   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 job search techniques.

Integrated competitive employment is defined as a community-based job that pays at least minimum wage and is available to any person regardless of disability or no disability, and belongs to the worker and not the rehabilitation agency. Further examples:

- If the job is not posted to allow any member of the public to apply and is a job set aside for the person/worker, that is not considered competitive employment.
- Self-employment is considered competitive if the person has registered their business, pays taxes, reports to the Social Security Administration, and earns at least minimum wage from their business income.
- Temporary jobs through a Temp Agency/Staffing Agency are considered competitive.
- Seasonal work for a company, such as a resort, is considered competitive.
- Work performed for a payment that is unreported to the Internal Revenue Service and/or Social Security Administration (commonly referred to as “Under the Table” and is typically a cash payment) is not considered competitive.

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 are required, however this service alone does not qualify to draw down the case rate regardless of duration. Please refer to AMA guidelines for coding units of Supported Employment services.

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

Day 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.

Day services should be coded in the MMIS based on time, per 15 minutes, per half day or per day. Half Day of service would equal 3 hours and a Full day would be more than 3 hours of time spent at the Day Program.

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. Transportation claims should only be entered into the MMIS for Designated Agencies that have their own dedicated vehicles that transports clients to day services. This should be coded per one-way trip.

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 GUARDIANSHIP EVALUATION

Target Group: All Global Commitment to Health Enrollees 18 years of age and older without a developmental disability.

DEFINITION

Evaluations for persons in need of guardianship without a developmental disability.

CONDITIONS OF COVERAGE

Title 14 of Vermont statute[26] requires the evaluation be completed by someone who is trained and competent to do guardianship evaluations. DMH evaluations for persons in need of guardianship without developmental disabilities shall be completed by an Eligible Provider.

- An eligible Provider shall bill Medicare or private insurance if available prior to billing Medicaid.
- An eligible Provider may bill Medicaid under the Mental Health Case Rate Provider ID

[26] https://legislature.vermont.gov/statutes/fullchapter/14/111

• The difference in the insurance or the value of the service listed in the FFS Medicaid rate sheet, and the balance of uncompensated reasonable expenditures up to $800.00 per evaluation, may be invoiced to DDAIL using the Guardianship Evaluation Invoice Form at this link: https://mentalhealth.vermont.gov/document/guardianship-evaluation-invoice-form-court-ordered

• Any request for evaluation compensation exceeding $800.00, must be accompanied with the extenuating circumstances and will be approved or denied by DAIL (see above).

• Medicaid cannot be billed for DMH CRT program clients; please invoice DAIL.

DOCUMENTATION REQUIREMENTS

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

Per Statute the evaluation shall:

1) describe the nature and degree of the respondent's disability, if any, and the level of respondent's intellectual, developmental, and social functioning.

2) Contain Recommendations, with supporting data, regarding:

> (A) those aspects of his or her personal care and financial affairs which the respondent can manage without supervision or assistance;
>
> (B) those aspects of his or her personal care and financial affairs which the respondent could manage with the supervision or assistance of support services and benefits;
>
> (C) those aspects of his or her personal care and financial affairs which the respondent is unable to manage without the supervision of a guardian;
>
> (D) those powers and duties as set forth in sections 3069 and 3071 of this title which should be given to the guardian, including the specific support services and benefits which should be obtained by the guardian for the respondent.

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

STAFF QUALIFICATIONS

The statute requires that the evaluation be completed by someone who is trained and competent to do guardianship evaluations

Guardianship Evaluations must be delivered by one of the following:

- Licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology directly affiliated with the Designated Agency/Specialized Services Agency
- Licensed psychiatric nurse practitioner directly affiliated with the Designated Agency/Specialized Services Agency
- 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

- 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.

3.15 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.

Family Education/consultation encounter claims should be submitted to the MMIS per 15 minutes for the IHCBS population.

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 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

DAs 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.

3.16 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 a Case Rate Supporting Service and 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.

For IHBCS clients, Respite claims should be billed either per 15 min unit for clients receiving hourly respite, or per diem for clients receiving overnight respite services.

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.

3.17 THERAPEUTIC FOSTER CARE

Target Group: Children receiving IHCBS

DEFINITION

These arrangements provide short-term individualized support for children in the home of a licensed DCF 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.

Therapeutic Foster Care should be billed per diem.

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 enhanced funding plan payments) and may be included in individually calculated enhanced funding plan 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 enhanced funding plan 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. Staffed Living services are to be documented 1 unit per day. Additional qualifying mental health services should be documented separately and 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.

STAFFED LIVING ADULTS

Target Group: Individuals in CRT identified for an enhanced funding plan

DEFINITION

This service consists of residential living arrangements for individuals approved for an enhanced funding plan 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 enhanced funding plan payments) and may be included in individually

calculated enhanced funding plan 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.

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. Staffed Living services are to be documented 1 unit per day. Additional qualifying mental health services should be documented separately and 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 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.

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.

3.20 GROUP LIVING

Target Group: Individuals in CRT

DEFINITION

Group Living will provide support and skill building so to allow client to reach their highest potential of independence to live in the least restricted environment in the community. This service consists of group living arrangements 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[28]; and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with their treatment plan.

CONDITIONS OF COVERAGE

Costs related to group residential arrangements are included in the case rate. Group living arrangements in and of themselves do not qualify as an eligible service for the case load count. Staffed Living services are to be documented 1 unit per day. Additional qualifying mental health services should be documented separately and are required for the individual to be counted towards the caseload.

28 https://dlp.vermont.gov/survey-cert

Group Living encounter claims should be billed to MMIS per diem.

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, with a goal of transitioning back to the individual's community. 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[29] 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.

Intensive Residential Recovery encounter claims should be billed per diem.

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.

29 https://dlp.vermont.gov/survey-cert

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 INTERPRETER SERVICES

Target Group: All Global Commitment to Health Enrollees

DEFINITION

Providers are required under federal and State laws to provide interpreters for patients with limited English proficiency (LEP) and for those who are deaf or hard of hearing. This includes interpreter services that accompany mental health services included in the case rate.

CONDITIONS OF COVERAGE

Interpreter Services are billable through the case rate but are not considered Case Rate Qualifying services. When an agency uses Interpreter Services for client with limited English proficiency of for those who are deaf or hard of hearing, the agency is expected to follow the guidelines set forth in the Vermont Medicaid Provider Manual Section 9.8[30]

3.23 MENTAL HEALTH PROGRAMS NOT IN THE CASE RATES

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[31]
- Federal Grants

4. DA/SSA DELIVERY SYSTEM REQUIREMENTS

[30] http://www.vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf

[31] See exception for individuals receiving services through CRT at or above 139% of FPL at section 2.3

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[32].

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
- 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 Provider 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.

32 18 VSA, Chapter 177, Section 7401(2), (4), and (15); and 18 VSA, Chapter 207, Sections 8907 through 8913.

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[33].

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[34]. DA/SSAs must have processes and agreements in place to ensure that all necessary notices are provided to Medicaid Members and that quarterly grievance and appeal reporting to the State is timely and accurate.

33 https://mentalhealth.vermont.gov/reports-forms-and-manuals/forms

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

The Global Commitment to Health Medicaid Grievance and Appeal Technical Assistance Manual is located here: https://dvha.vermont.gov/sites/dvha/files/documents/Members/global-commitment-manual-2017-.pdf

GRIEVANCE AND APPEAL REPORTING

For all Medicaid Members, 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 database to ensure 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.

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.
- The DA/SSA should provide timely supports as necessary to manage urgent needs and/or to facilitate engagement as they work toward completing a comprehensive, person-centered clinical assessment. Services provided prior to the completion of the assessment, including support by non-MA level clinicians gathering information and supporting an individual's entrance into care may be documented as an encounter and submitted as a qualifying service. If a full assessment has not been completed, a provisional diagnosis reporting the signs/symptoms

may be used for these services only until the assessment is completed or the time maximum for assessment completion has lapsed, whichever comes first.

- 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. Referrals from inpatient, crisis beds, and ED should be considered priority referrals. Those settings should make the referral to the DA as soon as is feasible during the patient/client stay (discharge planning). Those settings can make urgent requests for CRT eligibility when a patient is receptive to referral and early engagement and discharge from those settings would be delayed without a CRT eligibility determination. Urgent requests for eligibility shall be assessed within two business days. Other eligibility requests should be reviewed within 7 business days, or an alternative date that has been agreed to by the referring party. DAs should evaluate eligibility by having at minimum a master's-level clinician review relevant history, documentation, and have some face-to-face or telehealth contact with the client in order to complete the CRT eligibility form. Comprehensive clinical assessments may further inform this process and ongoing enrollment after initial eligibility has been determined. 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 a psychosocial assessment within 45 days of the first scheduled appointment attended[35] and periodically reassess the status of all children and adults enrolled in services. Comprehensive diagnostic and treatment reassessment is 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 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 will be 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.

35 See section 3.1 Clinical Assessment

STANDARDIZED TOOLS FOR CHILDREN

The Department of Mental Health has moved to the 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.

SCREENING

Screening tools are intended to be utilized universally to inform later assessment and treatment planning, to be implemented before or during the initial clinical assessment process. All children and youth served are required to have use of at least one standardized tool. Starting at age 12, youth are required to be screened for:

- Depression – agencies may choose whether to implement the PHQ-2/9 or PHQ-A
- Substance use -- agencies may choose whether to implement the CAGE-AID or CRAFFT

ASSESSMENT

The Child and Adolescent Needs and Strengths (CANS) Assessment is the tool that has been selected for children's services 0-22. All agencies should be transitioned to the latest version of the CANS (2.0). Updated CANS manuals and scoresheets can be found here: https://ifs.vermont.gov/content/child-and-adolescent- needs-and-strengths-cans-0.

Use of the CANS is one of the quality measures for payment reform. Designated Agencies shall continue to train and certify staff in the CANS (0-5 and 5-22 2.0 version) 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 DA and system level.

SCREENING

Screening tools are intended to be utilized universally to inform later assessment and treatment planning, to be implemented before or during the initial clinical assessment process. All adults served are required to be screened for:

- Depression – using the PHQ-2/9
- Substance use – using the CAGE-AID
- Trauma – using the PC-PTSD-5

ASSESSMENT

The Adult Needs and Strengths Assessment (ANSA) is the tool that has been selected for adult services and is required 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 support 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;[36]
- Be strengths-based, and
    - 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.

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

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)[37]. 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.

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

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.

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[38], 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 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.

38 42 CFR 441.710(a)(1)

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

If 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,[39] 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.

39 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: All Global Commitment to Health Enrollees **Minimum duration for payment:** **1 unit (*15 min)** accumulated in one day **Qualifying Encounter:** Yes	**Monthly Summary Note** -Clinical intervention used -Summary of major content or intervention themes consistent with treatment goals; -Observations made of the individual or responses to interventions; -Assessment of progress toward treatment goal; -Ongoing Needs for continued intervention and plan. *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** Multiple service coordination contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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: All Global Commitment to Health Enrollees **Minimum duration for payment:** **1 unit (*15 min)** accumulated in one day **Qualifying Encounter:** Yes	**Monthly Summary Note** -Clinical intervention used -Summary of major content or intervention themes consistent with treatment goals; -Observations made of the individual or responses to interventions; -Assessment of progress toward treatment goal; -Ongoing Needs for continued intervention and plan. *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** Multiple Community Support contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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** -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 **Minimum duration for payment:** **1 unit (*15 min)** accumulated in one day **Qualifying Encounter:** Yes	-Summary of major content or intervention themes consistent with treatment goals; -Observations made of the individual or responses to interventions; -Assessment of progress toward treatment goal; -Ongoing Needs for continued intervention and plan. *Must have at most a 1:4 ratio of staff to clients *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. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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: EFT/IHCBS **Minimum Duration for Payment** N/A **Qualifying Encounter** 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. Documentation must cover each individual service provided and meet all applicable standards for that service.	**Chronological log of all Community Support services provided** Multiple Family Education contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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. *Other individuals may access these services as resources allow* **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** -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 -Identify next steps determined through shared-decision making with individual. *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** Multiple Employment Assessment contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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: Adults in CRT and JOBS Eligible individuals *Other individuals may access these services as resources allow* **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** -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 -Identify next steps determined through shared-decision making with individual. *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** 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. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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 *Other individuals may access these services as resources allow* **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** -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 -Identify next steps determined through shared-decision making with individual. *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** Multiple Job Training contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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: Adults in CRT and JOBS Eligible individuals *Other individuals may access these services as resources allow* **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** -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 -Identify next steps determined through shared-decision making with individual. *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** 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. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -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: EFT-IHCBS Population	**Monthly Summary Note** 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: N/A **Qualifying Encounter:** 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. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	
D02 - Respite (by day/overnight)			
Target Population: EFT-IHCBS Population **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** Brief summary of client response and ongoing need for continued intervention *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** Multiple Respite contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	Licensed by DCF or child placing agency
E01 - CLINICAL ASSESSMENT			
Target Population: All Global Commitment to Health Enrollees **Minimum duration for payment:**	**Psychosocial Evaluation** -Identifying information -Presenting Issue -History: Psych/Medical/Family/ -Trauma/Education/Development -Supports and Strengths -Functional Status	**Chronological log of all Clinical Assessment services provided** Qualified providers only may use this code to document time spent face-to-face or telemedicine providing clinical assessment services to an individual. 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
1 unit (*15 min) **Qualifying Encounter:** Yes	-Mental Status Exam -Diagnosis -Interpretive Summary -Treatment/Service Recommendations *See Section 4.4 for further guidelines	-Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service *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: All Global Commitment to Health Enrollees **Minimum duration for payment** **1 unit (*30 min)** **Qualifying Encounter** Yes	**Hit Note/SOAP Note** -Clinical intervention used; -Current issues discussed or addressed; -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	**Chronological log of all Individual Therapy services provided** All encounter data must include: -Client Identification -Service Provided -Staff Providing Service -Date of Service -Duration of Service -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 *Supervised Billing Requirements Apply*
E03 - FAMILY THERAPY			
Target Population: All Global Commitment to Health Enrollees **Minimum duration for payment:** **1 unit (*50 min)**	**Hit Note/SOAP Note** -Clinical intervention used; -Current issues discussed or addressed; -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** All encounter data must include: -Client Identification -Service Provided -Staff Providing Service -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
Qualifying Encounter: Yes	-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	-Duration of Service -Location of Service	*Supervised Billing Requirements Apply*
E04 - GROUP THERAPY			
Target Population: All Global Commitment to Health Enrollees **Minimum duration for payment:** **1 unit (*50 min)** **Qualifying Encounter:** Yes	**Hit Note/SOAP Note** -Clinical intervention used; -Current issues discussed or addressed; -Observations made of the individual (the individual's response to the group dynamic in 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	**Chronological log of all Group Therapy services provided** All encounter data must include: -Client Identification -Service Provided -Staff Providing Service -Date of Service -Duration of Service -Location of Service *If two or more clinicians lead a group, only one may submit encounter data per client.* **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 *Supervised Billing Requirements Apply*
E05 - MEDICATION AND MEDICAL SUPPORT			
Target Population: All Global Commitment to Health Enrollees **Minimum duration for payment:** **1 unit (*15 min)** accumulated in one day **Qualifying Encounter:** Yes	**Hit Note** -Changes in medication (addition, deletion or change in dosage) -Efficacy and management of the medication being prescribed or continued, and/or monitoring of the individual's reaction to the medication -Mental status change at which the medication is being aimed -Documentation of discussion with	**Chronological log of all Medication and Medical Support services provided** All encounter data must include: -Client Identification -Service Provided -Staff Providing Service -Date of Service -Duration of Service -Location of Services	Physician certified in psychiatry, APRN, PA, RN operating within the scope of their respective professions.

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: All Global Commitment to Health Enrollees **Minimum duration for payment:** **1 unit (*15 min)** accumulated in one day **Qualifying Encounter** Yes:	**Crisis Note** -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.	**Chronological log of all Emergency Services provided** Multiple Emergency Services contacts in one day by the same provider for the same client may be gathered into one service encounter log. <u>All encounter data must include:</u> -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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: Adults **Minimum duration for payment:** Completion of the intake assessment **Qualifying Encounter:** Yes	<u>Admission Documentation</u> - Assessment of needs and plan for treatment - Intake LOCUS <u>Shift note/8 hour note</u> - Observations - Interventions and client response - Clinicians assessment of issues/situation/risks - Ongoing plan for crisis stabilization <u>Discharge Summary</u> -Issues addressed, skills developed, follow up plan -Discharge LOCUS	**Chronological log of all Crisis Bed Services provided** <u>All encounter data must include:</u> -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service **Crisis Bed encounters are documented in days* -Location of Service *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: Adults in CRT **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** Brief summary of client response and ongoing need for continued intervention *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** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service *Staffed Living encounters are documented in days (1 day = individual assigned to program at 11:59 pm) -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 Children in IHCBS **Minimum duration for payment** N/A **Qualifying Encounter** No	**Weekly Summary Note** Summary of interventions used, client response, progress towards goals and ongoing need for continued intervention	**Chronological log of all Staffed Living services provided** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service *Staffed Living encounters are documented in days (1 day = individual assigned to program at 11:59 pm) -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 **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** Brief summary of client response and ongoing need for continued intervention *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** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service *Group Living encounters are documented in days -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: EFT/IHCBS Population **Minimum duration for payment** N/A **Qualifying Encounter** No	**Monthly Summary Note** Brief summary of client response and ongoing need for continued intervention. 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** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service *Licensed Provider encounters are documented in days -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: Adults in CRT **Minimum duration for payment:** N/A **Qualifying Encounter:**	**Monthly Summary Note** Indication in Monthly Summary Note that client received a transportation service *Transportation services are only for the necessary transportation of individuals covered*	**Chronological log of all Transportation Services provided** 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.*	<u>All encounter data must include:</u> -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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: Adults in CRT **Minimum duration for payment:** N/A **Qualifying Encounter:** No	**Monthly Summary Note** Brief summary of client response and ongoing need for continued intervention. 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** <u>All encounter data must include:</u> -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -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.

New Additions July 2023:

Billing Criteria	Minimum Clinical Documentation Required	Encounter Data to Support Clinical Documentation	Provider Qualifications
B01 – Adult Needs and Strengths Assessment (ANSA)			
Target Population: Adults Receiving Mental Health Case Rate Services **Minimum duration for payment:** **N/A (session based / untimed)** **Qualifying Encounter** Yes -	**Vermont ANSA Requirements** - Life Functioning - Strengths - Cultural Factors - Behavioral/Emotional Needs - Risk Behaviors - Caregiver Resources and Needs **Required at:** - Initial Assessment - Annually while the client remains enrolled in services.	**Chronological log of all assessment services provided.** Qualified providers may only use this code to document time spent face-to-face or telemedicine providing clinical assessment services to an individual. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	PRAED Foundation Certified Provider
B01 – Child and Adolescent Needs and Strengths Assessment (CANS 0-5 & CANS 5-22)			
Target Population: Children, Ages 0-22 **Minimum duration for payment:** **N/A (session based / untimed)** **Qualifying Encounter** Yes	**Vermont CANS Requirements** - Resiliency - Anxiety - Depression - Oppositional - Anger Control - Family / Family Relationships - Impulsivity / Hyperactivity - Adjustment to Trauma - Caregiver Knowledge - Suicidal Thought / Behaviors - Self-Injury **Required at:** - Initial Assessment - Every 6 months while the client remains enrolled in services.	**Chronological log of all assessment services provided.** Qualified providers may only use this code to document time spent face-to-face or telemedicine providing clinical assessment services to an individual. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	PRAED Foundation Certified Provider

Billing Criteria	Minimum Clinical Documentation Required	Encounter Data to Support Clinical Documentation	Provider Qualifications
REGISTERED NURSING			
Target Population Adults enrolled in CRT **Minimum Duration for payment:** **1 unit (*15 min)** accumulated in one day **Qualifying Encounter** No	**Hit Note/SOAP Note** -Clinical services or education provided; -Current issues discussed or addressed; -Observations made of the individual or any significant factors affecting treatment; -If indicated, the involvement of family and/or significant others in treatment; -The nurse's assessment of the issues; -Movement or progress toward the treatment plan -Documentation of discussion with client, as well as family and other providers as releases allow -Specific plan for ongoing treatment or follow-up; and - Requirements for E05, as above when applicable.	**Chronological Log of all Nursing Services Provided.** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	Registered Nurse, Licensed by the Vermont Board of Nursing.

The following services may be provided to CRT enrollees by a Registered Nurse when included in the treatment plan in either residential treatment settings or as part of skilled therapy services.

Nursing Service	MSR Category
Injection	E05- medication, medical support, and consultation services
IV push or Infusion	E05- medication, medical support, and consultation services
Blood Draws	E05- medication, medical support, and consultation services
Medication Management	E05- medication, medical support, and consultation services
Nursing Assessment and Observation	E05- medication, medical support, and consultation services
Wound Care and Other Nursing Procedures	E05- medication, medical support, and consultation services

Teaching and Education (ex: diabetes, asthma, tobacco cessation)	F01- education, consultation, and advocacy
Transition and Discharge Planning	A01 – service planning and coordination

*The CPT code book indicates that a unit of time is obtained when mid-point is passed. Please follow CPT coding guidelines for all MMIS Encounter Data. For more information, please see page 84, MMIS Encounter Data

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 enhanced funding plan payments described in this section, below.

The case rate is comprised of two types of services: Case Rate Qualifying Services and Case Rate Support Services.

- **Case Rate Qualifying Services** are those services that can draw down a case rate as a standalone service.
- **Case Rate Support Services** are those services that cannot draw down a case rate as a standalone service.

Both Case Rate Qualifying Services and Case Rate Support Services are calculated services in the case rate PMPM development. Case Rate Support Services cannot pull down the case rate as a standalone either because they are service add-ons or because they are services that should not be the only service provided in a month.

Examples of Case Rate Support Services and rationale:

- T1013, Interpreter Services
    - The case rate qualifying service would be the mental health service provided that needed an interpreter. The interpreter service is an add-on that would not be billed as a standalone. The value of providing the interpreter services would be considered in the PMPM rate development.

- S5150, Respite Services
    - Respite services can only be billed for IHCBS. Children receiving IHCBS are a priority population and should be receiving other mental health services in the month. Classifying respite as support code ensures that providers are delivering other mental health services to draw down the case rate for the client.

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 up to the minimum threshold for payment. There is no recoupment of funds if the minimum threshold for payment has been reached

or surpassed. Any recoupment as a result of caseload reconciliation will be communicated by DMH memo.

Minimum threshold for payment is 96% of the caseload target.

Agencies should always consult the current, approved Alternative Payment Model (APM) for the most recent minimum threshold for payment.

CASELOAD COUNTS

Caseload numbers are created using the most complete and available Medicaid Management Information System (MMIS) 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). Caseloads are attributed when a Medicaid beneficiary has at least one encounter of a qualifying service, regardless of the number of days or quantity of services received in that month. Caseloads are not attributed in a month in which a Medicaid beneficiary did not access a Medicaid-covered service.

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 Review 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 reviewed 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 claims.

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.

EENHANCEDD FUNDING PLAN (EFP) PAYMENTS

An Enhanced Funding Plan payment is identified as funding to support a person receiving higher level of care and needs enhanced funding to create a safe and stable community setting that optimizes recovery. There is a significant cost for treatment and supports. Historically, enhanced funding plans are less than 1% of the population.

Important funding note: EFP requests from the Children's Programs are possible. However, Children's EFT (or waiver) funds -- which is the equivalent of adult EPP -- went into the children's case rate. Therefore, outlier requests for children should be even more rare, as funding for enhanced plans is already included in their case rate.

The criteria to determine if an Enhanced Funding Plan payment is warranted is as follows:

1. Clinical need: DA submits clinical form to Adult Care Management Director or Children's Mental Health Operations Chief
    a. DA needs to complete Proposal Request for Enhanced Funding Plan form. This request form may be used for any enrolled CRT Program or Children's program client who requires intensive treatment services/associated costs in excess of overall Case Rate revenues. The DA must provide a clinical analysis of client complexity. Submitting a proposal request for funding does not guarantee an outlier approval.

2. Dollar threshold: use expected costs from clinical form
    a. After the outlier request meets the Clinical Need criteria the approved request would need to meet a dollar threshold. EFP requests expected to cost below the threshold would not be considered large enough to be considered a true EFP. The dollar threshold is different for each DA. The annualized threshold is $80,000 plus 1% of total annual case rate payment for child and adult programs combined.
3. Financial need: Evaluation by DMH of DA fiscal
    a. If the clinical criteria as well as the dollar threshold are met, the DA must provide an internal financial analysis demonstrating an existing financial need within the Case Rate. This analysis could contain KPI information and/or demonstration of a potential loss position within the case rate or overall MH financial situation. The review of the information provided will take place within the DMH Business Office in partnership with the DMH division director depending on whether the request is for a child or adult.

UNFORESEEN CIRCUMSTANCES

Separate from individual Enhanced Funding Plan 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 Vermont Medicaid provider ID is used in billing for both adult and child mental health services. This Vermont Medicaid provider ID shall not be used for any MMIS claim submission unrelated to the adult or child mental health payments.

The monthly payments will serve as the form of reimbursement for all eligible services that are described in this manual and provided to the beneficiary. A complete listing of DMH covered services is found at Section 3 of this manual. A complete listing of procedure codes that are available for submission of MMIS encounter claims is included at Appendix E. Eligible claims will indicate the DA/SSA provider number responsible for the service and will be paid $0 regardless of the charge indicated on the claim. 0-paid encounter claims must be submitted for PMPM calculation and to support volume of services reported to the MSR. Encounter claims may be submitted when any member of the target population receives an allowable service, defined as one encounter. Encounters may be submitted on the same date and time by different providers if the service is distinct. For example, a case manager providing case management during a medication check, or a therapist engaging in a treatment team

meeting with a case manager. Medicaid eligibility must be checked on a monthly basis[40]. 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.[41].

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 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.

PAYMENTS AND CONDITIONS OF REIMBURSEMENT

The following conditions of reimbursement shall apply to all mental health Medicaid services.

- Payment for mental health Medicaid services will be made at the lower of the actual charge or the Medicaid rate on file. The agency must accept, as payment in full, the amounts received from Medicaid.
- According to Federal Law, all clients must be treated similarly in terms of billing for all services. For example, if a non-Medicaid client is being transported with other clients whose services are being reimbursed by Medicaid, the non-Medicaid client must also be billed. (This does not preclude the use of sliding fee scales.)
- The Federal Government (Medicaid – Title XIX) will not reimburse for services to a Medicaid eligible individual if a non-Medicaid individual receives the same service free of charge. This does not preclude the use of sliding fee scales.
- DMH retains sole authority to set payment rates.

MEDICARE COVERAGE

40 See also section 2.1 – Medicaid Eligibility and Enrollment

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

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 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.

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)[42] 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

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.

42 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 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[43].

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

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. Value-Based Payments are established for Designated Agencies (DA) and Specialized Service Agencies (SSA).

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

MEASURES, TARGETS AND VALUE-BASED PAYMENT STRUCTURE

DAs and SSAs have 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 DA or SS and do impact the distribution of value-based payments according to a DA's or SSA' ability to meet specific criteria (as outlined in the Provider Agreements).
- Performance Measures are those measures that assess an agency's work and/or outcomes of work. Performance Measures may be retrieved by the DA, the SSA or the State of Vermont and do impact the distribution of value-based payments according to the DA's or SSA's ability to meet specific criteria.

SPECIFICATIONS

During each measurement year, DMH allocates funds for value-based payments. If an agency serves the minimum threshold for payment of both the child and adult case load and meets performance goals, the agency can earn up to 103% of their adult and child case rate payments The measures, reporting criteria, targets, benchmarks and value-based payment opportunities are set forth in Provider 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.

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

The most current measure specifications can be found in the reporting template and the DMH website.

5.4 GLOBAL COMMITMENT INVESTMENT FUNDS

The Vermont Comprehensive Flexible Payment is designed to provide access of quality mental health care to the uninsured, underinsured, and for unique programs and services to Vermonters that cannot

be covered by other funding sources.

DMH pays the Vermont Comprehensive Flexible Payment as a single, fixed quarterly payment. The payment is not subject to recoupment, unless it is determined by the State that the use of funds did not meet the requirements.

Requirements:

A. Costs must not duplicate payment for activities that are already being offered or should be provided by other entities, or paid through other programs, including Medicaid.

B. Costs may not supplant funding obligations from other sources.

C. Costs must be supported by adequate documentation.

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, 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 MSR encounter reporting, DA/SSAs will submit encounter claims to the MMIS for mental health adult, child and Enhanced Funding Plan case rate encounter claims. The encounter claims will be submitted as follows

- billed under the mental health case rate provider ID,
- billed with required modifiers as described below, and
- paid at "$0.00" for each eligible provider ID/procedure code combination.

MODIFIERS

Encounter claims submitted to the MMIS for Mental Health Payment Reform require the use of certain modifiers. Providers should refer to the current alphanumeric HCPCS file posted by the Centers for Medicare and Medicaid Services (CMS) for current modifier information.

The modifiers selected for use in Mental Health Payment Reform are listed below with definitions from OPTUM360. Modifier placement information should be used as general guidance. Agencies should consult with their Gainwell Technologies Provider Representative for questions on correct modifier placement and use.

HA – Case Rate, Child Program. Always first modifier placement, when applicable.

HB – Case Rate, Adult Program. Always first modifier placement, when applicable.

V1 – Enhanced Funding encounter. Always first modifier placement, when applicable.

AH – Clinical Psychologist. Second modifier placement, when applicable.

AJ – Clinical Social Worker. Second modifier placement, when applicable.

HO – Master's Degree Level. Second modifier placement, when applicable.

HN – Bachelor's Degree Level. Second modifier placement, when applicable.

XE – Separate encounter, a service that is distinct because it occurred during a separate encounter. Second or third modifier placement when applicable.

XP – Separate practitioner, a service that is distinct because it was performed by a different practitioner. Second or third modifier placement when applicable.

GY – Item or service statutorily excluded does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit. Typically, last modifier placement, when applicable.

93 – Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system; defined by DVHA. Always last modifier placement, when applicable.

CORRECT CODING AND ACCURATE REPORTING OF TIME-BASED PROCEDURE CODES

The Department of Mental Health follows correct coding guidelines outlined in the Vermont Medicaid General Provider Manual [45]. Correct coding practices are based on AMA, Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), the most recent International Classification of Diseases Clinical Modification (ICD-10_CM), and International Classification of Diseases Procedure Coding System (ICD-10-PCS).

With regards to time-based procedure code billing, the chart below outlines the minimum threshold billing based on units per service.

Units of Service	Minimum Threshold for reporting
1 unit=15 minutes	
1 unit	8 minutes
2 units	23 minutes
3 units	38 minutes
1 unit = 30 minutes	
1 unit	16 minutes
2 units	46 minutes
3 units	76 minutes
1 unit = 50 minutes	
1 unit	26 minutes
2 units	76 minutes
3 units	102 minutes
1 unit = 60 minutes	

[45] http://www.vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf

1 unit	31 minutes
2 units	91 minutes
3 units	151 minutes

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.

In accordance with the Medicaid Waiver and its managed care delivery model[46], 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

46 Described in section 1.2 of this manual.

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

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.
- 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 Provider 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 can be found on the DMH website.

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 Prevalence of Emotional, mental or behavioral conditions Level of severity of Emotional, mental or behavioral conditions How often have these conditions affect child's ability to do things, severity of impact	Family Strengths Child involvement in Community Activities 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[47]	a. Rate of suicide deaths per 100,000 Vermonters b. % of Vermont adults with any mental health conditions receiving treatment c. Rate of community services utilization per 1,000 Vermonters

47 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 Provider 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[48]

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.

48 https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

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 Gainwell Technologies Enrollment every year. Gainwell 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, Medicaid Members 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 Target Population: Children under 22 with Mental Illness & CRT 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) Target Population: Children under 22 with Mental Illness & CRT 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 Target Population: Children under 22 with Mental Illness 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;** **E02 - Individual Therapy;** **E03- Family Therapy;** **E04 - Group Therapy;** **E05 - Medication and Medical Support**
SKILLED THERAPY SERVICES Target Population: CRT	**E01 - Clinical Assessment;** **E02 - Individual Therapy;**

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.	**E03- Family Therapy; E04 - Group Therapy; E05 - Medication and Medical Support**
RESIDENTIAL TREATMENT Target Population: IHCBS Out of home treatment services that include: • Transitional Living: Short-term out of home care for adolescents requiring intensive supports in order to transition to independent living. • 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. • 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.	**H04 - LICENSED HOME PROVIDERS/FOSTER FAMILIES** H02 Staffed Living
RESIDENTIAL TREATMENT 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).	**H02 - STAFFED LIVING** **H03 - GROUP LIVING**
FLEXIBLE SUPPORT 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.	**B03 - Family Education & Consultation**
FLEXIBLE SUPPORT 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.	**L01 - Day Services**

COUNSELING 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.	**B01 Community Supports**
RESPITE Target Population: IHCBS Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.	**D01 - Respite**
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 CPT/HCPCS Procedure Codes and MSR Category Cross Walk

MENTAL HEALTH CASE LOAD QUALIFYING CODES

MSR CATEGORY	ASSOCIATED MMIS ENCOUNTER CODES
A01	H2017
A01	T1017 Howard Center ARCH
B01	H2015
B01, B02	H2014
B01	H2000
E01-E05	99212
E01-E05	90791
E01-E05	90792
E01-E05	90832
E01-E05	90834
E01-E05	90837
E01-E05	90846
E01-E05	90847
E01-E05	90853
E01-E05	99202

MSR CATEGORY	ASSOCIATED MMIS ENCOUNTER CODES
E01-E05	99203
E01-E05	99204
E01-E05	99205
E01-E05	99213
E01-E05	99214
E01-E05	99215
E01-E05	99241
E01-E05	99242
E01-E05	99243
E01-E05	99244
E01-E05	99245
E01-E05	H0031
E01-E05	H2010
E01-E05	90833
E01-E05	90836
E01-E05	90838
G01	90839
E01-E05	97151

MSR CATEGORY	ASSOCIATED MMIS ENCOUNTER CODES
E01-E05	97152
G02	H0046
H02-H03	T2038
E05	99366
E05	99367
E01	H0001
E01-E05	H0004
E04	H0005
B01	H0040 Pathways Only
B01	H2019
B01	H2020
B01	H2032
E01	96130
E01	96136
E01-E05	99441
E01-E05	99442
E01-E05	99443

MENTAL HEALTH CASE LOAD SUPPORTING CODES

MSR CATEGORY	ASSOCIATED MMIS ENCOUNTER CODES
B03	H2027
C01	H2024
C02	H2023
C03	T2019
C04	H2025
D01	S5150
D02	S5151
E01-E05	99211
E01-E05	90785
G01	H2011

MSR CATEGORY	ASSOCIATED MMIS ENCOUNTER CODES
H02	T2033
H02	H0019
H03	T2016
H03	H0018
H04	S5145
I01	99082
I01	T2003
L01	S5101
L01	S5102

MSR CATEGORY	ASSOCIATED MMIS ENCOUNTER CODES
L01	S5100
E01	96131
E01	96137
E01	96138
E01	96139
A01	T1013
G01	90840
A01, E05, F01	T1002

ATTACHMENT F

SPECIAL SERVICE FUNDING

Department of Mental Health administers a fund for one-time expenses to both CRT enrolled clients and to children receiving services through Children Youth and Family Services at a DA/SSA.

DEFINITION

Special Service Funding is Global Commitment Investment funding with the goal to increase the access of quality health care to uninsured, underinsured and Medicaid Members. This fund is earmarked for unmet needs and service costs that, if not provided, might negatively affect overall mental health treatment stability and where no other funding source is available.

Both Children and CRT Special Service Funds do not limit the types of funding requests, but distributes available funds in the following priority:

1. Unmet physical or mental health need
2. safety
3. stability
4. personal care
5. access
6. self-development
7. other needs

*CRT Special Service Funds prioritize unmet vision and dental needs for CRT clients

The fund is to be used only for those things for which there is no other funding source available. It is expected that alternative resources will be explored and denied prior to a request for Special Services funding.

ADULT SPECIAL SERVICE FUNDS

Target Group: The individual is enrolled in CRT.

CONDITIONS OF COVERAGE

Requests for funds should be directed the Department of Mental Health using the attached application and invoice entitled CRT Special Services Funding Request and/or CRT Special Service Funding Authorization Invoice. It is important that all information on the form be complete and include the CRT Director's signature.

Guidelines to access CRT Special Service Funds Include:

- These funds are for individuals enrolled in CRT.
- There is a limit of $3,000 per State fiscal year per client, excluding eyewear which has a limit of $250.
- Pre-authorization is required before services are rendered.
- Pre-authorization expires after 90 days. A new application for pre-authorization can be submitted upon expiration.

CRT Special Service Funding Requests can be found on-line in the Forms section of the Department of Mental Health:

https://mentalhealth.vermont.gov/document/special-services-funding-request-formadult

If an adult is requesting dental services, the Adult Dental Request From must also be completed:

https://mentalhealth.vermont.gov/document/adult-special-services-ada-dental-claim-form

Adult Special Services Funding accepts rolling applications throughout the year. If a request is received and all funding has been committed, DMH will notify the DA that the request has been placed on hold until the beginning of the next state fiscal year (July 1st). If a Special Services Funding request has been authorized but requested dental work not completed or an approved expenditure not made within 90 days, a new request for Special Services Funding must be submitted by the DA/SSA and will be considered a new request subject to funding availability on the date the request is received.

CHILDREN'S SPECIAL SERVICE FUNDING

Target Group: Children from 0-22 that are Medicaid enrolled and an active client through Children Youth and Family Services at a DA/SSA

CONDITIONS OF COVERAGE:

Requests for funds should originate from the Children's Mental Health Designated Agency or Special Services Agency and be directed to the Child, Adolescent, & Family Unit at the Department of Mental Health, using the attached application and invoice entitled Special Services Funding Request for Child, Adolescent & Family Services. It is important that all information is completed on the form and includes the Children's Director's signature

Guidelines to access Children's Special Service Funds Include:

- Child must be Medicaid enrolled and an active client of a Children's Mental Health Designated or Special Services Agency
- There is a limit of $2,500 per State fiscal year, per child when using special service funding.
- Whenever appropriate, funding should be blended amongst multiple sources.

Children's Special Services Funding has a deadline of May 15th of every year unless otherwise specified by the Operations Chief of the Child, Adolescent and Family Unit.

Children Youth and Family Special Service Funding Requests can be found on-line in the Forms section of the Department of Mental Health:

https://mentalhealth.vermont.gov/document/special-services-funding-authorization-formcyfs

ATTACHMENT G
HOUSING SUPPORT FUNDS

Target Group: The individual is enrolled in CRT.

DEFINITION

The Department of Mental Health uses the Housing Support Fund to provide housing subsidies to enrolled clients waiting for HUD Section 8 or other subsidized housing.

The goal of the program is to bridge an eligible CRT program beneficiary to other federal or state housing subsidy programs. Any housing support fund recipient is signed up for at least one Federal or State housing subsidy program.
Housing Support Funds may be used for the following purposes:

- Temporary Rental Assistance (TRA)
- Security and apartment set-up costs
- Ongoing Rental Subsidy while on a Section 8 subsidy waiting list[49]
- Small loans[50] and other one-time assistance
- Hospital Prevention
- Hospital Step down

At the start of the fiscal year, the Department of Mental Health administers funding to the Designated Agencies to manage the Housing Support Funds based on the eligibility criteria described below.

PROGRAM ELIGIBILITY.

The individual must be enrolled in CRT (Adults 18 and over with a severe and/or persistent mental disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, employment, or housing).

Priority is given to catchment area residents who are either at risk of being hospitalized at a Level One bed as defined by Act 79 (2012) or are being discharged from Vermont Psychiatric Care Hospital (Berlin, VT), Brattleboro Retreat or Rutland Regional Medical Center. Priority is subsequently applied to involuntary patients being discharged from other designated hospitals, including Central Vermont Medical Center (Berlin, VT), University of Vermont Medical Center (Burlington, VT) and the Windham Center (Bellows Falls, VT).

Final priority is given to persons with severe mental illness who are paying 50% or more of their income on housing, living in substandard housing, or homeless or at risk of becoming homeless.

All recipients **must** apply for a Section 8 subsidy from the Vermont State Housing Authority and/or from other local public housing authorities or from a subsidized housing development (local not for profit housing developer) before participating in the Housing Contingency Fund Program. Should the Housing Authority list be closed, staff must document at least one application for a not-for-profit housing developed property in your catchment area. Clients that would have been deemed ineligible for federally funded housing, may ask for an exception from Department Housing Program Administrator.

[49] The state provides funding related to room and board under this category using state-only general funds.
[50] Permitted use when a client has the need for temporary limited financial assistance to fund a small arrearage that will improve capacity to remain housed independently.

Consideration can be given on a case by case basis for non-CRT client. These requests would need to be approved by the Department Housing Program Administrator.

The recipient must request Priority Status (as it remains available) on the Section 8 waiting list. Recipient income will be no more than 50% of county median income calculated by household size.

ELIGIBLE USE OF THE CRT HOUSING SUPPORT FUND

Program eligible uses of the CRT Housing Support Fund include apartment set-up cost, temporary rental assistance (TRA), ongoing rental assistance (ORA), partial rental assistance (PRA), one time only supports (OTO), hospitalization/crisis prevention (HCP), and hospital step down (HSD).

The goal of the program is to bridge an eligible CRT program beneficiary to other federal or state housing subsidy programs. In order to accomplish this, the enrolled CRT client will *need to be signed up for at least one Federal or State housing subsidy program.* Vermont State Housing Authority, local housing authorities, not for profit housing development program in your catchment area, senior housing if applicable and rural housing development projects are preferred programs used to link to other subsidies. 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.

HOUSING SUPPORT FUNDS REPORTING

Each year the Agency of Human Services requires those state departments that maintain housing resources to inventory and report outcomes for these programs. The CRT Housing Support Fund is part of the AHS Housing inventory. DAs/SSAs are required to report on the success of clients who are in this program. Success is determined by the length of client stay in housing. This outcome is reviewed for all clients who have the long term housing subsidy from this program and currently the measure used is recording the number of persons in long term housing who receive a subsidy and the percentage of all of those who remain in housing for greater than 90 days.

Section 2: Integrating Family Services

INTEGRATING FAMILY SERVICES

Part 2 of this Provider Manual describes the additional scope and requirements of the Integrating Family Services (IFS) payment and delivery system reform model. Part 1 of this manual sets forth baseline definitions and expectations of Mental Health service delivery that also apply to the IFS payment model unless explicitly described as otherwise in Part 2 of this manual.

1.1 OVERVIEW

Integrating Family Services is an innovative approach, spearheaded by the Vermont Agency of Human Services, to reform how Vermont provides resources that support children, youth (through age 22), their families and their communities. This includes:

- Maternal and child health, which focuses on health promotion, prevention and wellness
- Early childhood through young adult development
- Mental health and social emotional health
- Child and youth safety
- Youth justice
- Child and youth well-being
- Developmental needs and disabilities
- Substance use and abuse
- Special health care needs
- Integration and working partnerships with health care providers

1.2 VISION

Vermonters work together to ensure all children, youth and families have what they need to reach their full potential.

1.3 MISSION

Integrating Family Services brings state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families.

1.4 AHS ACT 186 OUTCOMES

1. Help ensure that families are safe, stable, nurturing, and supported.
2. Pregnant women and young children thrive.
3. Youth choose healthy behaviors.

4. Youth successfully transition to adulthood.

1.5 GUIDING PRINCIPLES

1. Promote the well-being of Vermont's children, youth and families. Policies, services and service providers are sensitive and responsive to the unique aspects of each family.
2. Build communities' capacity to provide a full range of resources in a flexible and timely way that is responsive to the needs of children and youth (prenatal through age 22) and families.
3. Focus on the individual and the family. Understand the child's needs in the context of his/her family.
4. Ensure that youth and families' voices inform processes, plans and policies.
5. Adopt the Strengthening Families approach. Strengthening Families' five protective factors guide our work.
6. Invest in a skilled, competent and valued workforce. People working with children, youth and families need training, support and adequate compensation.
7. Balance innovation with families' experiences, research and data to inform decisions about how to best use available resources and achieve positive outcomes.
8. Assure continuous quality improvement. Data informs decisions and drives change at the state and local level.
9. Promote a common language, shared decision-making and cross-disciplinary team work.

For more information about IFS, go to http://ifs.vermont.gov

1.6 LOCAL COLLABORATIVE LEADERSHIP AND DECISION-MAKING

A comprehensive, written, local agreement for an integrated system of care should be in place at all times. The written agreement will be signed, at a minimum, by the DA, DCF-FSD District Director, AHS Field Director, and LIT Coordinator. The local agreement will, at a minimum, clarify local agreement and operating processes and practices.

General Collaborative Leadership for IFS

1. Modifications to and yearly review of local operating agreements.
2. Clearly defined of roles and responsibilities of each party signing agreement.
3. Clear description of decision making processes including resolution process of disagreements.
4. Clear descriptions of the advisory nature of this group and, when appropriate, of who has decision making authority.
5. Implementation of an agreed upon process for strategic planning and achievement of outcomes.
6. Mutual accountability in order to ensure the purpose and performance measures of the grant are being met.
7. Coordination with other state initiatives as they pertain to IFS and other related AHS funded services and providers (e.g., primary prevention activity, The Vermont Blueprint for Health, School Based services, Building Bright Futures, etc.).
8. Accountability to ensure active engagement and participation of families, other service providers and community stakeholders in local collaborative leadership.

The underlying infrastructure of the IFS is based on the premise that all providers come together locally to create formal working agreements, define roles and responsibilities and create a local system of care that will promote population health, prevention, early intervention and intensive home and community-based treatment in a unified and outcome driven manner for children and families. Providers will work

together and adhere to individual overall aggregate budget caps.

In exchange for flexibility to serve clients in the most cost effective, clinically appropriate manner feasible, using a global budget process that provides an aggregate annual Medicaid cap, local providers agree they will not deny, wait list or otherwise terminate services to Medicaid clients based solely on reaching their aggregate financial cap and that they will adhere to clinical standards and best practice guidelines promoted by the State.

Providers are expected to collaborate to ensure the delivery of a continuum of preventive, prenatal care for pregnant women and other services for children and families with developmental, mental health and/or substance abuse needs. Providers are asked to create administrative mechanisms and agreements that support unduplicated billing, meaningful use of electronic health records and federal reporting. IFS Population Indicators outlined in the State of Vermont grant award are considered collective responsibility of all signatories involved in the local collaborative leadership agreement.

1.7 SCREENING AND ASSESSMENT

The use of standardized screening and/or evaluation tools is expected. 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, all assessments should address family needs as well as the identified child or youth.

1.8 PROGRESS MONITORING USING THE CANS (CHILD AND ADOLESCENT NEEDS AND STRENGTHS)

The CANS (5-22) must be utilized for each child who is:

- 5-22 years old, and
- who are receiving more than one service

On January 1, 2020 the use of CANS was expanded to all children and youth age 5-22 receiving mental health supports and services at the DA/SSA.

EARLY CHILDHOOD SERVICES

PRE-NATAL CARE AND SUPPORT TO PREGNANT WOMEN

It is important to link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing, and prenatal care. Additionally, all pregnant women should be encouraged to obtain early prenatal care and ensure that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk. Late care or no care is related to increased prematurity rates. Low birth weight is the most important predictor of illness or death in early infancy. Higher costs of care are associated with the need for neonatal intensive care, extended and repeated hospitalizations, and follow up services for infants born at risk. Prenatal care may include, but not limited to nurse midwife services in pregnancy, labor, birth, and the immediate postpartum period.

2.2 SCREENING, SURVEILLANCE AND EVALUATION

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.

Surveillance/Early Identification: This 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.

Screening: This 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.

Evaluation: This 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.

2.3 FAMILY SUPPORT

Strong Families Vermont Family Support Home Visiting services focus on increasing parenting knowledge and skills, social supports, and child and family access to high quality child development services, medical and dental care, and safe environments. Using culturally competent, family centered supports, staff provide role modeling, parent education and mentoring aimed at successful development functional skills of parents and their child(ren). Families are encouraged to plan for and achieve their health, education, economic, inter-personal, social, and parenting goals as well as receive assistance to learn about and connect with community resources as needed.

2.4 PARENT CHILD CENTER SERVICES

Parent Child Center base services serve as a community resource and place of expertise on early childhood development and parenting for parents of young children. PCC's will ensure that all pregnant women and parents of young children in the community can access their services. The primary goals of this prenatal and early childhood work are aligned with EPSDT and include, but are not limited to ensuring that:

a. parents of young children are actively engaged in their children's learning;
b. parents are socially connected and have support systems in place; and
c. parents have the resources to meet their family's basic needs.

2.5 EARLY CHILDHOOD INTERVENTION AND FAMILY MENTAL HEALTH

Early childhood and family support services are intended to assist children, families, child care providers, and individuals, programs, and/or organizations serving the needs of young children and their families. Services are intended to address parent/child relational concerns, support access to and effective utilization of community services and activities, and develop parents', caregiver's and professional's skills in order to promote and support children's healthy social, emotional, and behavioral development.

a) **Early childhood and family support services** for all age groups are intended to address an event, systems or programmatic challenges, and/or promote the healthy social, emotional, and behavioral development of young children using evidence-based practices or curriculum.

b) **Consultation and education** services delivered must be outcomes-based using a pre- and post-assessment tool, and utilizing the integrated treatment plan. Consultation and education services are considered collateral contacts when they are intended to build the skills or capacity of individuals to improve their ability to meet the social, emotional, and behavioral development of young children identified for services in their care.

c) **Therapeutic Child Care** services are intended to provide outcome-based, planned combinations of intervention, consultation, and education services within high quality child care settings to improve child care staff's and parent's skills and abilities to support optimal social, emotional, and behavioral development of the young children in their care. Therapeutic Child Care services must be delivered in accordance with guidance provided by the Child Development Division which can be found at (http://dcf.vermont.gov/cdd/cis

MEDICAID STATE PLAN SERVICES

All services that are medically necessary need to be provided whether or not it appears in the Vermont Medicaid State Plan.

3.1 MEDICAID STATE PLAN SERVICES FOR CHILDREN AND FAMILIES INCLUDED IN THE IFS CASE RATE

Service definitions below are taken from the approved VT Medicaid State Plan which should be referred to for most up to date definitions.

Coding Guidelines: ***Please ensure all services are communicated to DXC through the list of available procedure codes in the MH Provider Manual Attachment E in order to be counted toward the case load count.***

Medicaid State Plan Service	Medicaid State Plan Definition	Target Group Restrictions	Provider Restrictions & Procedure code guidelines

Clinic Services Diagnosis and Evaluation Services	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,	None	DMH Designated
	personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to 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.		
Developmental Therapy (CIS portion in sub-capitation payment)	Evaluation and treatment services provided to a child in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor development. Services must be specified in a child's Individualized Family Service Plan (IFSP) under Part H of the Individuals with Disabilities Education Act (IDEA) and must be furnished by providers who meet applicable State licensure or certification requirements.	Young children who have an Individualized Family Service Plan recognized under IDEA Part C and H	LEA and/or Part C & H designated providers
Specialized Rehabilitative Services	Basic living skills, collateral contact, service coordination, specialized counseling		DMH Designated
Intensive Family Based Services (IFBS)	IFBS are family-focused, in-home treatment services for children that include crisis intervention, individual and family counseling, basic living skills and care coordination.	None	DMH and DCF designated
Clinic Services - Psychotherapy, individual & family	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 family therapy when only one family is being treated.	None	DMH Designated

Clinic Services 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 adaptive skills involving social interaction and emotional reactions to reality situations	None	DMH Designated
Clinic Services 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.	None	DMH Designated
Extended Services for pregnant women	Pregnancy-related and post-partum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. (Home visiting)	Authorized by the Title V agency as part of CIS package	VDH & DCF-CDD designated

Targeted Case Management for children 0-12 months and pregnant and postpartum Women	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities	Must be enrolled in the DCF Healthy Babies, Kids, and Families Program (now known as Children's Integrated Services (CIS).	DCF- CDD designated
Targeted Case Management for 1-5 years olds	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management	Must be enrolled in the DCF CIS programs and	DCF-CDD designated

	includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities	identified by a health professional or community program as at risk of inappropriate health care service utilization, medical complications, neglect, and or abuse.	
Target Group 0-22 years old w/Developmental Disabilities	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities.	Persons who do not have access to case management through any other program	DAIL Designated
Clinic Services 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.	None	DMH designated

Service	**Special Program (STC) or Federal Definitions**	**Target Group Restrictions**	**Provider Restrictions**
Home Provider	See MH Provider Manual Section 3.18	See Manual Section	DMH, DAIL and DCF designated
Respite	See MH Provider Manual Section 3.15	See Manual Section	DMH, DAIL and DCF designated
Transportation	Mileage reimbursements or other arrangements necessary due to challenging behaviors for transportation to services pursuant to the integrated family plan when such activities do not meet the definition on	None	DMH, DAIL, and DCF designated

	non-emergency transportation reimbursement by DVHA.		
EPSDT Outreach and Education	See MH Provider Manual Attachment A	None	DMH and DCF designated

CORE Service	**Managed Care Investment or other Federal Funds**	**Target Group Restrictions**	**Provider Restrictions**
Parent Child Center	Parent Child Center base services serve as a community resource and place of expertise on early childhood development and parenting for parents of young children. PCC's will ensure that all pregnant women and parents of young children in the community can access their services. The primary goals of this prenatal and early childhood work are aligned with EPSDT and include, but are not limited to ensuring that: a. parents of young children are actively engaged in their children's learning; b. parents are socially connected and have support systems in place; and **c.** parents have the resources to meet their family's basic needs.	None	DCF- CDD designated

3.2 VERMONT MEDICAID STATE PLAN SERVICES FOR CHILDREN AND FAMILIES NOT INCLUDED IN CASE RATE

Services NOT currently included as core services in Case Rate payment
Outpatient Hospital Services
Inpatient Hospital Services
Lab and X-ray
Nursing Facility
Physician Services
Medical/Surgical Services provided by a dentist
Medical Care and any other remedial care (chiropractic, podiatry, optometry, opticians, naturopath, midwife, high tech nursing)
Behavioral Health provided by non-DA/SSA providers reimbursed by DVHA fund sources
EPSDT Medical, dental and vision services
Family Planning Services
Face to Face tobacco cessation counseling services
Home Health Services
Private Duty Nursing
OT/PT/SLP

Clinic services designated by VDH
Prescription drugs, prosthetics, dentures, eyeglasses
Substance Abuse Services
Private Non-Medical Institutions
School Health Services (IEP related)
Child Sex Abuse and Juvenile Offender Services
ICF/MR
Hospice TB-related Case management
Respiratory Care Services
Pediatric or Family Nurse practitioner
Personal Care Services
Ambulance
Non-Emergency Transportation
Family Services Division - Targeted Case Management (DCF)

3.3 REIMBURSEMENT AND FINANCIAL MONITORING

The State of Vermont has created an alternative reimbursement approach in order to achieve the following objectives:

- Promote flexibility in service delivery to meet the needs of program participants and promotion of early intervention/prevention and a full continuum of EPSDT services in each region of the State
- Reduce paperwork demands created by and serving only Medicaid fee-for-service billing
- Facilitate documentation requirements based on best clinical practice, quality and outcome driven oversight
- Shift focus of program reviews from volume and adequacy of billing documentation to clinical appropriateness, quality and efficacy
- Establish a predictable funding mechanism for providers
- Promote a seamless and integrated health and human service delivery system at the local level
- Enable schools, providers and State staff to collaborate and identify the best use of clinical resources for their service region

To achieve the objectives outlined above, three types of payments have been created:

3.4 IFS PROSPECTIVE PAYMENT MODEL

DMH pays for IFS Services listed in Section 5 of this addendum through a monthly case rate. The 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 the DA. 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.

See *Section 5: Reimbursement and Financial Reporting*, of the MH Provider manual for additional information.

QUALITY AND MONITORING

6.1 AUDITS AND MONITORING

A cross departmental IFS team will be assigned to each region and designated to monitor outcomes, and program integrity to oversee quality improvement monitoring. The monitoring team will conduct at least one site visit and chart review on a biannual basis and as needed participate in check in calls or meeting with providers to assess progress and provide technical assistance. The team will employ consistency in methodologies for tracking the utilization of intensive services used to determine shared savings incentives across all regions of the State.

6.2 OUTCOME MEASUREMENT

Vermont statute Act 186 (2014) establishes outcomes and indicators that are intended to align programs and strategies across the state toward the same ends. Population Indicators will be used by IFS Regional Core Teams to inform how they target supports and services. IFS regions are not solely responsible for bending the curve on population indicators; rather there are performance measures IFS regions have accountability to with the thought being, those measures will positively impact trend data in whole population health. An entire community is responsible for population level indicators.

Value Based Payment measures are performance and monitoring measures required to earn a separate quality payment. The measures, reporting criteria, targets, benchmarks and value-based payment opportunities are set forth in Provider Agreements.

ATTACHMENT 1

INTEGRATED CHART REVIEW FORM

File Review Date: Click here to enter text.

File Reviewer Name: Click here to enter text.

Agency/Service Provider: Click here to enter text.

Client Identifier *(choose one from below):*

Record #: Click here to enter text.

Client DOB: Open Date: Closed Date: Click here to enter text.

Type of File *(select one):* ☐ Full OR ☐ Brief contact/consultation: Click here to enter text. Visits/contacts (indicate #) ☐

KEY

Shaded areas = where the element is truly a present/not present and doesn't have a quality component. In other words, it could not be rated as better or worse; it just is or is not there.

NOTES TO REVIEWERS

- When you indicate that something needs attention, please explain your response in the "comments" section.
- Please direct any questions or suggestions regarding this form to Cheryl Bilodeau, Director, Interagency Planning Director: cheryle.bilodeau@vermont.gov or 802-760-9171

R. 8-17-17

Standard/Guideline	Present (1)	Not Present (0)	N/A	Comments
Compliance Section-Minimum Standards				
I. GENERAL INFORMATION				
1. Signed authorization by parent/guardian to release information form	☐	☐	☐	Click here to enter text.
2. Signed client rights form	☐	☐	☒	
Referral documents (CIS only-federal requirement) *These can be from the EMR, but need to include, at a minimum: Client name, DOB, Address, phone number, Parent name (if other than the client) Estimated due date if a pregnant woman, Referring concerns (CIS has a list) Referral source: name, role, contact info., Date referral received by CIS Who received the referral (from CIS)*	☐	☐	☐	
4. Permission to bill insurance	☐	☐	☐	Click here to enter text.
5. Patient payment responsibility/fees form is present	☐	☐	☐	Click here to enter text.
6. Consent for evaluation & treatment/services signed by client	☐	☐	☐	Click here to enter text.
7. Evidence that client received information regarding grievances & appeals	☐	☐	☐	Click here to enter text.
8. Medical home/PCP identified	☐	☐	☐	Click here to enter text.
9. Dental home identified	☐	☐	☐	Click here to enter text.
10. Medical History is explored with a summary of health issues/events and allergies	☐	☐	☐	Click here to enter text.
11. Emergency medical information is easily accessible. *For a child/youth in out of home placement emergency fact sheet for children/youth who are receiving care in an agency contracted foster or developmental home chart should include: Immunization record, Medication administration records, Medication Prescription, Annual physical, Semi-annual dental hygiene visit, Seizure record, Quarterly psychiatric medication checks, Tardive dyskinesia (TD) check.*	☐	☐	☐	Click here to enter text.
12. Special medical care procedures plan is included in file if the child has specialized procedures that must be followed by direct care staff.	☐	☐	☐	Click here to enter text.
13. Use of seclusion or restraint is recorded and reported as a critical incident.	☐	☐	☐	Click here to enter text.
14. Evidence of current services: Is child/youth/family receiving other supports/services? Who else is or should be part of this child/youth/family's team?	☐	☐	☐	Click here to enter text.
15. Qualified signature and date appears on plan of care, interpretive summary/Co-signature of Licensed Alcohol and Drug Counselor (LADC) or eligible MD when required.	☐	☐	☐	
SECTION I SCORE				

Standard/Guideline				
II. EVALUATION, ASSESSMENT, SCREENING AND INTEGRATED PLAN OF CARE				
1. Assessment is completed within required days: · intake/referral, or · re-evaluation must be completed annually (0-6 y.o) or within 2 years (6+ y.o.)	☐	☐	☐	Click here to enter text.
2. If the initial plan fell under the period under review it was completed within 45 days of client *initiating services*. For prenatal to age 6, the plan must be completed within 45 days of referral	☐	☐	☐	Click here to enter text.
3. If the plan is an update, it was completed within the last year. For prenatal to age 6, a plan update must happen every 6 months.	☐	☐	☐	Click here to enter text.
4. Signature of psychiatrist/ psychiatric nurse practitioner is required only if any of the following conditions are present:	☐	☐	☐	Click here to enter text.
5. Physician's signature on completed integrated Plan of Care for children receiving CIS early intervention services	☐			
6. Client and/or guardian dated signature if required.				
SECTION II SCORE				
III. ACCESS TO SERVICES				
1. Any pregnant woman seeking substance abuse services is seen and begins treatment within 48 hours of request for services.				
2. If there is a waitlist for substance abuse services, intravenous (IV) drug users must be placed at the top of the waitlist.				
SECTION III SCORE				
IV. TRANSITION & DISCHARGE PLANNING				
1. A transition or discharge plan should be developed when a child/youth transitions outside of the IFS system.	☐			
2. Required timeline(s) met. A transition or Discharge Plan was developed at least 30 days prior to the change in or termination of services.	☐			
SECTION V SCORE				

Quality Section-Minimum Standards							
Standard/Guideline	**N/A**	**Present (1)**	**Not Present (0)**	**Needs Attn. (1)**	**Meets Std. (2)**	**Exceeds Std. (3)**	**Comments**
I. EVALUATION, ASSESSMENT AND/OR SCREENING							
A) Presenting Issues, Symptoms and History							
1. Clear indication of client's hopes and dreams	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. History of presenting issues/target symptoms from multiple informants, where appropriate, and described in multiple settings (home, community, school)	☐	☐	☐	☐	☐	☐	Click here to enter text.
3. Clear indication of client's strengths, abilities, interests, assets, resources, skills and capabilities.	☐	☐	☐	☐	☐	☐	Click here to enter text.
4. Developmental history and needs	☐	☐	☐	☐	☐	☐	Click here to enter text.
5. Medical history	☐	☐	☐	☐	☐	☐	Click here to enter text.
6. Psychosocial history	☐	☐	☐	☐	☐	☐	Click here to enter text.
7. Complete mental status exam	☐	☐	☐	☐	☐	☐	Click here to enter text.
8. At least one standardized screening/assessment tool is used to assess clients' functioning and/or care/treatment needs **(do hover box)**	☐	☐	☐	☐	☐	☐	Click here to enter text.
9. Clients with criminal justice involvement, assessment documents required elements. **(do hover box)**	☐	☐	☐	☐	☐	☐	Click here to enter text.
QUALITY SECTION IA. SCORE							
B) Formulation Interpretive Summary							
1. DSM 5 or ICD Diagnosis is consistent with evaluation findings	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. Clinical formulation or interpretive summary that uses the information gathered, is developmentally sensitive, and identifies strengths and needs.	☐	☐	☐	☐	☐	☐	Click here to enter text.
3. Clear and specific treatment/supports/services recommendations that address presenting issues and target symptoms, and reflect best practices.	☐	☐	☐	☐	☐	☐	Click here to enter text.
4. Qualified provider used American Society of Addiction Medicine (ASAM) criteria to document risk rating across all 6 dimensions.	☐	☐	☐	☐	☐	☐	Click here to enter text.

5. Substance use history, current use & amounts documented.	☒	☐	☐	☐	☐	☐	Click here to enter text.
6. If client screens positive for substance use, a substance use assessment is completed within the next 3 days of service or 30 days.	☐						
7. Interpretive summary includes substance use issues when appropriate.							
QUALITY SECTION IB. SCORE							
Standard/Guideline							
II. PLAN OF CARE							
1. Goals are meaningful to and have been developed in partnership with client and families	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. Goals reflect evaluation and/or other assessments, or recent progress notes if the plan is an update.	☐	☐	☐	☐	☐	☐	Click here to enter text.
3. All goals tie back to the child/youth, even when the family is the focus of the intervention.	☐	☐	☐	☐	☐	☐	Click here to enter text.
4. Goals have realistic, measurable action steps that clearly define the work and expectations between service provider and family.	☐	☐	☐	☐	☐	☐	Click here to enter text.
5. Interagency coordination is evident if appropriate (as demonstrated by e.g.: One Plan (CIS), Coordinated Services Plan, releases to disclose information, documentation in progress notes).	☐	☐	☐	☐	☐	☐	Click here to enter text.
6. If progress isn't being made on their goals, the reasons are clearly articulated and revisions, if appropriate, to the plan are made.	☐	☐	☐	☐	☐	☐	Click here to enter text.
7. Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and integrated into the plan of care (consider how to take into account confidentiality of parents).	☐	☐	☐	☐	☐	☐	Click here to enter text.
8. A Behavior support/safety plan must exist for children/youth who have complex and challenging behaviors, and who might also need physical intervention for safety.	☐	☐	☐	☐	☐	☐	Click here to enter text.
9. Type of intervention or service, frequency, time frame and provider with title/position of services are all identified	☐	☐	☐	☐	☐	☐	Click here to enter text.
10. If the child/youth has significant challenges with communication a communication plan is included in the plan	☐	☐	☐	☐	☐	☐	Click here to enter text.

11. CIS are provided primarily in the home or in programs with typically developing children.	☐	☐	☐	☐	☐	☐	
12. Plan is modified to reflect changes in treatment being prescribed.				☐			
13. Plan includes a goal that specifically addresses why the client is receiving services: substance abuse, mental health, developmental services, etc.							
QUALITY SECTION II SCORE							
III. SERVICE DELIVERY & DOCUMENTATION							
Standard/Guideline	**N/A**	**Present (1)**	**Not Present (0)**	**Needs Attn. (1)**	**Meets Std. (2)**	**Exceeds Std. (3)**	**Comments**
1. Weekly or monthly summary of services provided.	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. Intervention content is consistent with client's plan goals.	☐	☐	☐	☐	☐	☐	Click here to enter text.
3. Evidence of adherence to best practice as defined by content experts.	☐	☐	☐	☐	☐	☐	Click here to enter text.
4. Service is delivered or supervised by a qualified provider.	☐	☐	☐	☐	☐	☐	Click here to enter text.
5. If appropriate, there is documentation of integration or collaboration with primary care.				☐			
6. If client is admitted to hospital or hospital diversion, is there evidence of discharge planning and participation from the agency.							
QUALITY SECTION III SCORE							
IV. PERIODIC REVIEW & ASSESSMENT OF PROGRESS							
1. A standardized screening or assessment tool is used to periodically assess progress on goals.	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. Information from a screening/assessment tool and progress notes are used to inform client-planned goals and demonstrate need for ongoing services.				☐			
3. Evidence of assessment of progress towards client plan goals.							
QUALITY SECTION IV SCORE							
V. CRISIS PLANNING							

1. A Pro-Active Crisis plan clearly identifies triggers, strategies and resources. There should be a pro-active crisis plan if any of the following is present: • Are there multiple crisis or law enforcement contacts? • Has client had a recent (within last six months) hospital or crisis bed stay? • Has the client stepped down from a higher level of care within the last six months? • Has client recently had a traumatic or significant life event or stressor that might indicate need for pro-active crisis planning?	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. If there are crisis screenings, does the screening form include the following: a. A clear description of the situation b. Safety issues are identified if present and a plan to address them c. If the situation is easily resolved, is there a description of resolution and a follow-up plan identified if appropriate.	☐	☐	☐	☐	☐	☐	Click here to enter text.
3. If there are crisis screenings, are the screening forms easy to identify/ access?	☐	☐	☐	☐	☐	☐	Click here to enter text.
4. If a full screening is appropriate, there is a mental status exam, consultation w/ MD or psychiatrist, the level of care needed is identified, resources are explored, and resolution described with follow- up plan identified.	☐	☐	☐	☐	☐	☐	Click here to enter text.
QUALITY SECTION V SCORE							
VI. TRANSITION & DISCHARGE PLANNING							
Standard/Guideline	**N/A**	**Present (1)**	**Not Present (0)**	**Needs Attn. (1)**	**Meets Std. (2)**	**Exceeds Std. (3)**	**Comments**
1. Evidence of proper transition/discharge planning.	☐	☐	☐	☐	☐	☐	Click here to enter text.
2. Transition planning and conference completed at least 90 days prior to a child turning three.	☐	☐	☐	☐	☐	☐	Click here to enter text.
3. If the youth has been receiving substance abuse services, there is a discharge summary is completed within 7 days following discharge date that is signed and dated by the counselor and includes required elements.	☐	☐	☐	☐	☐	☐	Click here to enter text.

4. If the youth has been receiving substance abuse services, a written aftercare plan for **planned** discharges is developed with the youth that is signed by the client or appropriate guardian and includes required elements.	☐	☐	☐	☐	☐	☐	Click here to enter text.
5. All children who are potentially eligible for Part B special education and exiting early intervention receive a timely transition conference not more than 9 months prior to a child's 3rd birthday.				☐			
6. If client is receiving services through residential care, there must be ongoing DA participation in treatment and discharge planning.							
QUALITY SECTION VI SCORE							

VIII. Qualitative Information (optional)

This file was exemplary in the following areas:

Click here to enter text.

Careful consideration needs to be paid to the following areas of this file:

Click here to enter text.

The following needs immediate attention:

Click here to enter text.

Additional Notes

Click here to enter text.

Section 3: School Mental Health - Success Beyond Six

1. BACKGROUND

Success Beyond Six (SB6) is a funding mechanism that allows schools to provide Medicaid billable, school-based mental health and behavioral services through direct contracts with their local mental health Designated Agencies.

Success Beyond Six (SB6) was developed with the intent to ensure partnership between the local school system and community mental health, recognizing that such a partnership strengthens the ability of both entities to meet the needs of students and families. It is also a means to reduce the cost burden on education by using local education funds as the state match to draw down federal Medicaid for eligible services to eligible children.

Local decision-making has been the primary determinant of how the DA and school systems collaborate and the AHS role has been to apply general Medicaid program oversight standards and, specific to this program, standards for covered services and claims payment. State matching funds for this program are provided by the local communities and certified by the local education agencies. Those matching funds are used by AHS as the source of state share to draw down the federal Medicaid/CHIP match and to reimburse the DA based on the contract for costs and services between the supervisory union/school and the DA. DMH holds funding agreements with each DA to address the programmatic, quality and fiscal requirements of using Success Beyond Six Medicaid for school mental health.

SB6 has three main components: School-Based Clinical Services, School-Based Behavioral services, and CERT (Concurrent Education, Rehabilitation, and Treatment) with different funding structures within SB6 Medicaid.

SAMHSA and CMS issued a Joint Bulletin in July 2019 to provide guidance to states and school systems on addressing mental health and substance use issues in schools (CMS/SAMHSA, 2019). This bulletin recognized the “urgent need” to identify and intervene early to address the mental health needs of students, and that “Schools can fill a critical role in both identifying such children and adolescents and connecting them with treatment and other services they need”. SAMHSA/CMS noted that schools use multi-disciplinary approaches, often collaborating with community providers “as a strategy to expand needed services”.

1.3 FEDERAL AND STATE AUTHORITIES

Medicaid authorities for funding school-based mental health include the Early and Periodic Screening,

Diagnostic and Treatment (EPSDT) benefit, and Section 1115 demonstration project. Success Beyond Six is not a statutorily defined program; however, requirements at Title 33, Chapter 43 regarding Children and Adolescents with Severe Emotional Disturbance apply. Medicaid eligible children and youth with assessed need are entitled to medically necessary community mental health services. The Vermont Medicaid State Plan allows these services to be provided by DAs in any setting, including schools. Success Beyond Six (SB6) is the name of the program to provide these services in schools as contracted between the school and the DA.

While not all school mental health services are provided by DAs, DAs are the only qualified entity to provide expanded mental health supports beyond traditional clinical therapies under Medicaid. Federal and State authorities supporting these Medicaid payment models are covered at Part 1, Section 1.2 of this Mental Health Provider Manual.

1.4 MANUAL SCOPE

Success Beyond Six has three main areas of focus:

- School-Based Clinical Services
- School-Based Behavioral Services
- Concurrent Education, Rehabilitation, and Treatment (CERT)

2. POPULATION SERVED

Success Beyond Six serves school-aged children and youth up to age 22 with severe emotional disturbance in schools.

3. COVERED SERVICES

1.5 SCHOOL BASED CLINICAL SERVICES

DEFINITION

School-based clinicians provide mental health services and supports with identified students, including clinical assessments, therapy, supportive counseling, consultation, and coordination between the home, school and other providers. Through the school-based clinical case rate, there is flexibility for schools and Designated Agencies to collaborate on innovative service delivery options which promote access and public health/early intervention strategies to improve care delivery across the school setting.

Where schools are implementing multi-tiered systems of support (MTSS), including Positive Behavior Intervention and Support (PBIS), school-based clinicians can be an active team member of the school MTSS/PBIS implementation team to offer a mental health lens, consultation on mental health topics, and identify roles across the levels of support: Universal for all students, Targeted for those at risk, and Intensive for those with an identified need.

School clinical services may be provided in public elementary, middle and high schools as well as

through partnership with Independent Schools.

1.9 CONDITIONS OF COVERAGE

School Based Clinical Services include the following:

- Clinical Assessment
- Service planning and Coordination
- Community Supports
- Psychotherapies
- In-school mental health crisis response and stabilization

The following services are only provided using the flexibility offered under school-based clinical case rate programming. These are not case rate qualifying services.

- **Consultation** – mental health and behavioral consultation at the classroom or school level, not specific to a Medicaid-enrolled student. This may include training for school personnel on mental health and behavioral topics generally or about population concerns; consultation for the school's crisis planning and implementation of school climate and trauma-responsive approaches.
- **Health and Wellness** – promotion and prevention activities with the general student population and students at risk of social, emotional and/or behavioral difficulties

For additional information about the Department's goals for the use of flexibility available under the case rate payment model, see Section 1 of this Manual.

EXCLUSIONS

School based clinician services do not include vocational activities or education services.

1.10 SERVICE DEFINITIONS, PROVIDER QUALIFICATIONS AND DOCUMENTATION REQUIREMENTS

Service definition, provider qualifications and documentation requirements follow the requirements set forth in Part 1 of the Provider Manual for each specific service including Clinical Assessment (3.1), Individual Therapy (3.4), Family Therapy (3.5), Group Therapy (3.6), Service Planning and Coordination (3.8), and Community Supports (3.9).

1.11 REIMBURSEMENT

CASE RATE MODEL

Monthly Case Rate Per Member, Per Month (PMPM): DMH uses a case rate reimbursement methodology for school-based clinical services within the SB6 program. The Per Member Per Month (PMPM) case rates are established annually for each DA. A case rate is set for PBIS and non-PBIS schools

where there are contracts with both.

The PMPM is based on the total school-based clinician FTEs and the estimated Medicaid revenue for each school contract held by the DA. The contract revenue is divided by the number of clinicians assigned to the program, divided by the minimum number of children to be served in a month. Recognizing the value of SB6 school-based clinician participation in MTSS/PBIS, a higher case rate limit has been established (in other words, the minimum number of students to be served is lower) for clinicians working in Vermont's PBIS-participating schools. The Department set a minimum case threshold per clinician for non-PBIS schools (10) and PBIS schools (8).

BILLING THRESHOLD

The case rate may be paid after the minimum service threshold of 2 hours (8 units) of a qualifying service per month is billed.

QUALIFYING CLAIMS

The State established two procedure codes for billing the monthly case rate: PBIS and Non-PBIS. Designated Agencies may elect to submit claims with a "Billed Amount" below the payment rate on file and payment will be processed at the lesser of the billed amount or rate on file. In the alternative, Designated Agencies may bill at the rate on file, subject to their ability to make local match dollar payments in accordance with State policies. Case rate claims may be submitted at any point in time, subject to timely filing requirements.

Non-PBIS schools: H0023, no modifier, and

PBIS schools: H0023 with a "CG" Modifier

CERT schools: H2020 with a "HK" Modifier

LIMITATIONS

School based clinicians cannot bill a case rate and Fee for Service.

When multiple clinicians provide school-based services, only one claim per child may be submitted.

ANNUAL ALLOCATION

The PMPM may be billed within a total SB6 annual allocation. Designated Agencies will continue to submit claims for individuals receiving at least two hours of service within each month, even if the maximum billing amount has been reached.

CONCURRENT BILLING

Children's mental health case rate: Children who receive services through the children's mental health case rates, including Integrating Family Services, are eligible for case rate or fee-for-service school-based clinician services provided that the services delivered in the educational setting are separate and delivered distinct from the treatment services provided through the individualized plan of care.

Other SB6 services: Children may receive services provided by a school-based clinician under the bundled case rate as well as services provided fee-for-service by a different provider in a Behavioral Interventionist program on the same day provided that the services are separate and delivered distinct as identified through the individualized plan of care.

1.12 ESTABLISHING AND MONITORING SCHOOL-BASED CLINICIAN CASE RATES:

The Per Member Per Month (PMPM) case rates are established annually for each DA. The monthly case rate limits were developed based on historical Fee-For-Service utilization and payment rates, following review of the reasonableness of historic payment rates related to costs.

In advance of the new Fiscal Year, each Designated Agencies reports to DMH how many PBIS and Non-PBIS school contracts they will have with the Local Education Agency (LEA) in the upcoming school year. A case rate is set for PBIS and non-PBIS schools with distinct procedure codes. The PMPM is based on the total school-based clinician FTEs and the estimated Medicaid revenue for each school contract held by the DA. The contract revenue is divided by the number of clinicians assigned to the program, divided by the minimum number of children to be served in a month. The Department set a minimum case threshold per clinician for non-PBIS schools (10) and PBIS schools (8).

Properly submitted case rate claims are paid until the maximum billing amount is reached. DAs continue to submit claims for students who meet the minimum service threshold, even if the maximum billing amount has been reached and no additional payments are made.

1.6 SCHOOL-BASED BEHAVIORAL SERVICES

DEFINITION

School-based behavioral services are provided through Behavioral Intervention Programs. Behavioral Services are a collaboration between the local Designated Agency (DA) and local educational program to provide consultation and behavioral intervention with targeted students in a school setting. The Behavioral services use evidence-based and best practice strategies such as Applied Behavior Analysis (ABA) that are individualized to the student's mental health and behavioral needs to help the student access their academics. The Behavioral Services include clinical training and supervision of the Behavioral interventionist (BI), initial and ongoing assessment by clinical professionals, and behavior interventions that are grounded in the assessment and behavior support plan as described in the BI Minimum Standards.

Behavioral Services may be provided within a mainstream education program in public elementary, middle and high schools, alternative community settings through the public school, or in an alternative education program through partnership with Independent Schools.

CONDITIONS OF COVERAGE

The BI Program, in collaboration with education, will determine if a student is eligible for the BI Program services based on the criteria outlined in the BI Program Minimum Standards.

The behavioral services include:

- Functional Behavioral Assessment (FBA)
- Behavioral support planning (BSP)
- Community Supports, aka Intensive Behavioral intervention
- Service Planning & Coordination
- Behavioral consultation
- Autism-specific programming

EXCLUSIONS

Behavioral services do not include vocational activities or education services.

1.13 SERVICE DEFINITIONS, PROVIDER QUALIFICATIONS AND DOCUMENTATION REQUIREMENTS

Services provided through the BI program include Service Planning & Coordination, Community Supports, and Clinical Assessment. These follow the requirements set forth in Part 1 of the Provider Manual for each specific service including Clinical Assessment (3.1), Service Planning and Coordination (3.8), and Community Supports (3.9).

1.14 REIMBURSEMENT

PAYMENT MODEL

Behavioral Services are billed fee-for-service (FFS) as provided in accordance with the Mental Health provider manual. FFS rates are established statewide through performance of an environmental scan of rates of payment by other payers for similar services and to providers of similar qualifications. DMH has established FFS rates that are updated with increases or decreases provided by the Legislature during the annual budget process. FFS rates are the same across DAs.

DAs may enter into contracts with a school for behavioral services for a specific student or for a package of behavioral services at the school or district level. The structure of the BI Program services is outlined in the DMH SB6 contract with the DA.

ANNUAL ALLOCATION

The Behavioral Services may be billed within a total SB6 annual allocation.

CONCURRENT BILLING

Children's mental health case rate: Children who receive services through the children's mental health case rates, including Integrating Family Services, are eligible for school-based behavioral services

provided that the services delivered in the educational setting are separate and delivered distinct from the treatment services provided through the individualized plan of care.

Other SB6 services: Children may receive services provided by the Behavioral Interventionist program as well as services provided by a school-based clinician under the bundled case rate, provided that the services are separate and delivered distinct as identified through the individualized plan of care.

1.7 CONCURRENT EDUCATION, REHABILITATION, AND TREATMENT (CERT)

DEFINITION

Therapeutic clinical and behavioral services concurrent to education (community support in a school setting) assists individuals, their families, and educators in planning, developing, choosing, coordinating and monitoring the provision of needed mental health services and supports for a specific individual in conjunction with a structured educational setting, often an AOE approved Independent School. Services and supports include planning, advocacy and monitoring the well-being of individuals in the educational environment, and supporting individuals and their families to make, sustain, and follow-through with decisions relevant to their mental health needs in an educational setting.

Concurrent to the educational services provided by educational staff, CERT services are specific, individualized, and goal-oriented services provided by mental health staff either one-to-one or in a group setting and assist students in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily routine, peer engagement and communication skills, supportive counseling, support to participate in curricular activities, behavioral self-control, collateral contacts, and building and sustaining healthy personal, family and community relationships. Daily routine skills can include scheduling, planning, and organizing activities in a manner that promotes success in the educational environment. Active skill building opportunities during the course of the school day may relate to communication, social interactions, adaptive behavior, healthy choices, and coping skills.

CONDITIONS OF COVERAGE

CERT programs must be approved by DMH prior to billing CERT services.

Children must meet the definition of severe emotional disturbance in order to qualify for CERT services.

CERT services include:

- Clinical Assessment
- Service planning and Coordination

- Community Supports
- Psychotherapies
- In-school mental health crisis response and stabilization

If service is provided in a group, no more than 10 students can be present.

Transportation costs are included in the cost of CERT services. For example, if a school-based clinician or other mental health agency worker or contractor provides transportation to or from school, community support or transportation cannot be billed in addition to the daily rate.

EXCLUSIONS

CERT Medicaid services do not include vocational activities or education services. Educational services are covered by the LEA/AOE.

SERVICE DEFINITIONS, PROVIDER QUALIFICATIONS AND DOCUMENTATION REQUIREMENTS

Services provided through CERT include Clinical Assessment, Service Planning & Coordination, Community Supports, and Clinical Therapies. These follow the requirements set forth in Part 1 of the Provider Manual for each specific service including Clinical Assessment (3.1), Individual Therapy (3.4), Family Therapy (3.5), Group Therapy (3.6), Service Planning and Coordination (3.8), and Community Supports (3.9).

REIMBURSEMENT

PAYMENT MODEL

DMH sets a **per diem rate** for therapeutic mental health and behavior services concurrent to education. The Medicaid per diem rate is established based on the treatment-related costs. The DA provides a detail list of staff FTEs, benefits, travel expenses, supplies and notable program changes, with the breakout of costs that are attributed to treatment versus education. The budgets are analyzed for significant changes and compared to actual prior year expenses in order to set the rate.

The total of the estimated treatment costs is divided by the total number of Medicaid student treatment days. The program provides an explanation for the programmatic or other reasons contributing to cost changes and must demonstrate that changes are significant enough to necessitate a rate increase. In those instances, a more thorough analysis is performed DMH.

BILLING THRESHOLD

Reimbursement is limited to the daily service rate, and not to exceed five services per week. Per diem rate may be paid after the minimum service threshold of at least two hours (8 units) of a qualifying service to bill the daily rate.

QUALIFYING CLAIMS

Reimbursement is limited to school-based mental health programs approved by DMH with a rate on file.

LIMITATIONS

There is currently a daily limit for all services per client that can be found on the DMH fee schedule.

When multiple clinicians provide CERT services, only one clinician can bill the daily service rate.

CERT cannot be billed concurrent to other Success Beyond Six Medicaid covered services.

ANNUAL ALLOCATION

CERT may be billed within a total SB6 annual allocation.

CONCURRENT BILLING

Children who receive services through the children's mental health case rates, including Integrating Family Services, are eligible for CERT services provided that the services delivered in the educational setting are separate and delivered distinct from the treatment services provided through the community-based individualized plan of care.

MENTAL HEALTH PROVIDER MANUAL CHANGE TIMELINE LOG

PROGRAM MANUAL CHANGE- February 2019

- Electronic communication clarification
- Guardianship evaluation language added
- What's in/out table in provider manual appendix updated
- Assessment time frames
- Discharge planning language clarified for IHCBS population
- Measures in manual updated and clarified
- Crisis/residential bed- Clarified language about how to account for a bed day
- Interpreter services coding added (T1013)
- Clarified Language on Supervised billing- MD/APRN

PROGRAM MANUAL CHANGE- March 2019

- Minor language changes- ex. Community Based Wraparound to Intensive Home and Community Based.
- Added Children's IHCBS eligibility considerations from the EFT manual
- IHCBS tracking to 99 Cost center
- Updated links to forms and websites
- Added language to CRT disenrollment that was accidentally omitted in move from CRT manual (incarceration)
- Family therapy minimum duration for the encounter to be allowable to case rate billing is 26 minutes (as per CPT definition)
- Added language about Guardianship Evaluations
- Clarifying language about staffed living documentation
- Added language about services prior to the completion of an assessment and Dx coding guidelines prior to completing the assessment
- Added language about Balance billing that is still relevant to payment reform

PROGRAM MANUAL CHANGE- June 2019

- Children's and Adult Special Service Funding will be added and an appendix as well as Housing Support Funds
- Part 2: Integrating Family Services added into the Manual

PROGRAM MANUAL CHANGE-October 2019

- Minor changes have been made to the IFS section to clarify language
- Enhanced Funding Plan process and language changes added

PROGRAM MANUAL CHANGE - November 2019

- Clarified language about IFS, Housing Support Funds etc.

PROGRAM MANUAL CHANGE -December 2019

- Changed language in Urgent CRT assessment- changes "or" to "and"

PROGRAM MANUAL CHANGE - August 2020

- Added in Part 3: Success Beyond Six
- Added in New MMIS codes with definitions
- Added language to 45 days to assessment
- Added language to Dx deferred
- Added Minimum Threshold language and chart
- Changed language from "outlier" to "Enhanced Service/Finance Plan"
- Clarified timeline for intake and assessment
- Indicated unit time for services

- Updated SB6 population served to align with SB6 contract language
- Added “contractor” to CERT transportation billing
- Added alternative service delivery settings to school based services
- Indicated Covid flexibilities around performance based measures
- Updated billing thresholds to state 1 unit using CPT coding guidelines (which indicate a unit of time is achieved when the half point is passed).
- Updated Standardized Assessment tool language for children and adults
- Changed “Billable” service to “Qualifying” service. All services can be submitted to the MMIS now, “Qualifying” is more accurate
- Addition of LADC to list of qualified providers under specific clinical services

PROGRAM MANUAL CHANGE - January 2021

- Clinical Assessments, Section 3.0: At the request of the Vermont Care Partners and after review and discussion at the Department of Mental Health, Licensed Alcohol and Drug Counselor has been added as a qualified staff to complete a clinical assessment. As is true for any service provided, qualified staff must work within the scope of their practice, education and training.
- Conditions of Coverage, minimum duration, section 3.9: refers to individual therapy where it should read group community supports. That error has been corrected.
- Diagnosis code: DMH had previously written into the provider manual that R69 could be used as a preliminary diagnosis code before the assessment was complete. This update removes that guidance so that R69 is not used as the primary diagnosis code as the associated claims will be denied per Medicaid coding policy. See Section 4.3 Access to care, pg. 60 for reference.

PROGRAM MANUAL CHANGE - March 2021

- Integrated content previously referenced in Emergency Services Standards directly into this manual

PROGRAM MANUAL CHANGE – July 2023

- Moved Change Timeline Log to the end of this document
- Updated broken hyperlinks to outdated PDF documents
- Removed and replaced biased-language: “Master Agreements” changed to “Provider Agreements”
- Background and Reform Goals, Section 1.1, removed date-based language and removed introductory list
- Multi-Year Reform Plan Section, 1.3, included a link to the provider manual revision protocol
- Covered Services, 3., Replaced the American Board of Medical Specialties with American Board of Psychiatry and Neurology throughout
- Respite, Section 3.16, clarified language for hourly and overnight respite units of service
- Interpreter Services, Section 3.22, fixed spelling error
- Facility-Based Crisis Stabilization and Support Services, Section 3.3, clarified bed utilization language
- Medical Evaluation and Consultation Services, Section 3.7, changed error from “individual therapy” to the correct encounter type
- Medical Evaluation and Consultation Services Section 3.7, Staff qualifications updated to include board-eligible physicians; changed APRN to “Advanced Practice Provider”; and included new language for conducting annual performance reviews
- Service Planning and Coordination, Section 3.8, changed error from “individual therapy” to the correct encounter type
- Employer Relationships and Job Development, Section 3.10, Added “Integrated Competitive Employment” definition
- Member Grievance and Appeals, Section 4.2, corrected spelling error.
- Screening and Assessment, Section 4.4, deleted date-based language for ANSA requirement implementation
- Additional information added for CANS, ANSA and RN Services in 4.7 Documentation Requirements
- Establishing and Monitoring Case Rates, Case Rate Monitoring and Adjustments, Section 5.1, removed

date-specific guidance on when to begin billing payment reform MMIS claims

- Establishing and Monitoring Case Rates, Case Rate Model, Section 5.1, added definition and examples about Case Rate Qualifying Services and Case Rate Support Services
- General Payment Provisions, Section 5.2, clarified provider Medicaid ID guidance and clarified what $0-paid claims, and removed “case rates” language
- Minimum Requirements, Section 5.2, removed date-specific guidance on when to begin billing
- Medicare Coverage, Section 5.2, removed date-specific guidance on when to begin billing
- Value-Based Payments, Section 5.3, Generalized language from “The Designated Agency” to say “Each Agency” to include SSAs.
- Value-Based Payments, Section 5.3, removed reference to Attachment G for Value-Based Performance Measure Specifications
- Reporting Requirements, Section 6.1, clarified encounters with the word “eligible” and included Modifiers description subsection
- Part 3: School Mental Health: Success Beyond Six, Qualifying Claims, Section 3, Added MMIS billing codes and modifier information
- Attachment E; Renamed and Replaced MMIS/MSR Coding Table
- Attachment F & G; removed, Value-Based Performance Measure Specifications and updated title of subsequent attachments & Case Rate DA/SSA Program Matrix; Subsequent Attachments Renamed Outcome Measurement, Section 7.2,
- Removed reference to Attachment G for value-based reporting information.

PROGRAM MANUAL CHANGE – December 2023

- Reporting Requirements Section 6.1, added Modifier 93 MMIS billing information
- Attachment E; Added new procedure codes
- Population Served, Section 2.2, updated CRT Treatment History requirements
- Establishing and Monitoring Case Rates, Section 5.1, Corrected example code
- Documentation Requirements, Section 4.7, Clinical Documentation Table: Provider Qualifications for B01 – CANS/ANSA – Removed Supervised Billing language
- Linked the Community-Based Mobile Crisis program manual