



**VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF MENTAL HEALTH**

**Community Rehabilitation and
Treatment (CRT) Program**

**Designated Agency
Provider Manual**

Fourth Edition

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Department of Mental Health
Community Rehabilitation and Treatment (CRT) Program
Provider Manual

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Revision History

April 2016	New fourth edition manual issued
December 2016	Added language clarifying CRT eligibility
March 2017	Added language clarifying requirements for urgent reviews

Introduction

On April 1, 1999, the Community Rehabilitation and Treatment (CRT) Program was added to the Medicaid Waiver operated by the Department of Vermont Health Access (DVHA). Through an intergovernmental agreement with DVHA, the Department of Mental Health (DMH) and its network of designated and specialized service agencies (DAs and SSA) continues to fund and operate the CRT program.

On September 30, 2005, The Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Program. The Global Commitment to Health is a Demonstration Initiative operated under the Section 1115(a) waiver and encompasses all of Vermont's Medicaid programs with the exception of the Long Term Care Waiver, the State Children's Health Insurance Program and the Disproportionate Hospital Payments. The Legislature gave full approval for participation in the waiver on December 13, 2005.

The Global Commitment Waiver provides the State with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g. case rates, capitation, combined funding streams, incentive reimbursements) rather than individual fee-for-service payments, flexibility to pay for healthcare related services not traditionally reimbursable through Medicaid (e.g. pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). It is based on a managed care model that also encourages inter-departmental collaboration and consistency across programs.

The Center for Medicare and Medicaid Services (CMS) requires that all programs operating within Medicaid Waivers meet the requirements of 42 CFR 434.6, all applicable Federal and State laws, and regulations including Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act (ADA) of 1990 incorporating changes made by ADA Amendments Act of 2008. As a managed care plan, the program also operates subject to the Balanced Budget Act regulations currently in force. Specific policies and procedures for communicating with plan members (clients), grievance and appeals process and their resolution, management of subcontracted providers, quality improvement, and data reporting are required. In addition, the CRT program requires policies and procedures for eligibility, enrollment, re-enrollment, transfer and so forth.

The Vermont state mental health authority, the Department of Mental Health (DMH), operates as a prepaid, inpatient behavioral health plan (PIHP). In this role, the Department contracts for community and inpatient services on behalf of eligible and enrolled beneficiaries. Federal participation in the program is achieved through a "Per Member, Per Month" (PMPM) capitation arrangement between Department of Vermont Health Access (DVHA) and the Department of Mental Health. The Department of Mental Health, in turn, makes monthly payments to designated agencies, allocates funds for the Inpatient Psychiatric functions at Designated Hospitals, and sets aside funds for fee-for-service billing by Designated Hospitals (DH) psychiatric units on behalf of CRT program enrollees. The Department of Mental Health puts additional State General Funds into the monthly DA payments to cover CRT program participants who are not enrolled in Medicaid as well as services that are traditionally not billable to Medicaid.

The monthly payments to community providers are based on enrollment and services trends. These trends are reported monthly and use client-level service-encounter data to compute the variance between the actual payment and services rendered to program enrollees. A three percent (3%) variance corridor is used and a six-month trend of exceeding the variance corridor (either over or under) may trigger changes to the monthly payment going forward. The monthly payments to providers are designed to be used flexibly to render clinically indicated treatment, rehabilitation, and support services to program beneficiaries.

This Provider Manual describes the necessary policies and procedures in detail. To ease access to up-to-date information and reduce the paper burden, you will find hyperlinks throughout this document directing the reader to the DMH website <http://mentalhealth.vermont.gov> for prototype policies and other necessary information to be adapted by each CRT program.

Section One: CRT Eligibility Determination and Program Enrollment

1.1 Referral to CRT

Referrals to the CRT Program are not restricted and can be made by the individual, family members, and service providers.

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 through the CRT program and the geographical region/community it serves. The DA/SSA shall also provide information about the eligibility criteria and enrollment process and the right to appeal if the prospective service recipient is found ineligible for the program.

The DA/SSA must assure access to the CRT program by offering an easy screening and intake process.

A DA/SSA cannot deny an eligibility determination for any individual requesting CRT services.

1.2 CRT Eligibility Determination Process

The DA/SSA is responsible for evaluating all referrals for CRT enrollment. **Urgent care requests for eligibility shall be assessed within 48 hours, and include individuals who are currently served in inpatient hospital settings and in crisis beds, and may include individuals held in Emergency Departments.** Non-urgent requests for assessment to determine CRT eligibility shall be completed with 30 days of referral, contingent on the individual's participation.

Referrals are evaluated 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 next section for more information on eligibility criteria.

The CRT program prioritizes enrollment for persons with schizophrenia, other psychotic disorders and seriously debilitating mood disorders. Persons with other significant mental health disorders may be enrolled and served contingent upon program resources and capacity of the DA/SSA, and contingent on approval by DMH.

The initial intake and screening process by the DA/SSA should include the following:

- 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 likely eligibility status.

Once the intake materials are reviewed and it appears the person is likely to meet eligibility for CRT, an appointment is scheduled for a full, in-person, clinical assessment.

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

The eligibility 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 eligibility determination.

The DA/SSA CRT program will maintain a log of all requests for CRT eligibility evaluation and the resulting determinations, including referrals found ineligible. 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 eligible and ineligible determinations, and date of notice of right to appeal ineligible determination. This log will be made available to DMH upon request. These logs need to be maintained for a period of at least four years.

1.3 CRT Eligibility Criteria

CRT eligibility requires demonstration of a severe, persistent mental illness that has not responded to less intensive treatment (i.e. history of substantial treatment needs) and has resulted in significant functional disability. All three of the following criteria must be met for CRT enrollment.

Mental Health Diagnosis

To meet eligibility criteria for enrollment into the CRT program a person must have one of the following qualifying diagnoses meeting DSM-V criteria.

- 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.

The eligibility process requires that all other contributing diagnoses be referenced including substance use disorders. It is expected that the CRT program will competently treat co-occurring substance-related disorders.

Treatment History

Eligibility for CRT enrollment requires demonstration of need for substantial treatment supports as demonstrated by **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 hospital diversionary program (e.g. 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 a six-month period during the last twelve months with no evidence of improvement
- The individual is on a court Order of Non-Hospitalization.

Functional Status

Qualification for enrollment in CRT requires documentation of severe functional impairment in social, occupational or self-care skills **as a result of the eligible mental health disorder.**

This is demonstrated by a **GAF score of 50 or below** and **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.

1.4 CRT Enrollment

The DAs may not deny access to CRT program services to qualifying individuals in their catchment area or to individuals who relocate to their catchment area.

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

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

Persons enrolled in the CRT program at any time between the last business day of the previous month and the second-to-last business day of the current month will be added to the CRT list as of the first of the next month.

Medicaid Eligibility and Spend-down

The current Medicaid eligibility status of the referred person must be verified prior to completion of the clinical assessment for the CRT Program. If the person is not currently enrolled in Medicaid but appears to 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.

The DA will have an identified mechanism in place to track and monitor Medicaid entitlement status for any person enrolled in CRT. The case manager (or designee) should 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. Additionally, DMH must be notified if an individual is found to be retroactively eligible for Medicaid benefits as matching Federal capitated payments may be received for that period.

Adults who are also eligible for medical assistance in accordance with the State Medicaid plan (Title XIX eligible) or the State Medicaid 1115 Global Commitment waiver are entitled to certain rights and protections under Federal regulations that may not apply to adults who do not meet Medicaid/VHAP eligibility. These additional rights and protections are indicated as applicable throughout the Provider Manual.

Medicaid Spend-down

Medicaid spend-down is the amount by which the individual's countable income and resources for the period in question exceeds the allowable income level for Medicaid eligibility. Individuals who must meet Medicaid spend-down requirements must incur medical expenses for which no third party is liable. Allowable expenses must be incurred during the accounting period. These expenses may be deducted from the total excess income or resources during the accounting period (usually for a six-month period), allowing Medicaid eligibility prior to the end of the six-month period.

Expenses may include health insurance premiums; mental health treatment, rehabilitation, and support services; over-the-counter medicines and supplies; some transportation costs; dental services; ongoing non-covered personal care services; and, in some instances, assistive community care services provided to residents in a licensed community care home. The DA/SSA is encouraged to count only what the DA/SSA

would actually charge a person for the service (e.g. based on a sliding-fee scale if the individual would qualify for a reduced fee).

1.5 Provisional CRT Eligibility

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

- Ensure completion of a comprehensive clinical assessment summarizing why the individual has been provisionally enrolled in CRT services.
- Ensure attainment of contributing evaluations or assessments from external sources.
- 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 his/her right to appeal the decision¹; *or*
- Notify DMH of full enrollment changing provisional to active CRT status by completing and submitting the Enrollment Form/Eligibility Checklist.

1.6 CRT Dis-enrollment

Disenrollment will occur whenever the individual chooses to be dis-enrolled, moves out of State, transfers to another program (e.g. Adult Outpatient), or dies.

If an enrolled individual has not received services for a six-month period, the DA/SSA should dis-enroll 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.

¹ Individuals, guardians, and other interested parties may appeal all eligibility decisions using the CRT Program Grievance and Appeal Process.

The person must be placed on inactive status if the person is expected to be incarcerated for 90 days or less, and dis-enrolled 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 must notify DMH within 48 hours of its knowledge of the event, by sending the CRT Dis-Enrollment form to the designated DMH staff member. The form is available on the DMH website at <http://mentalhealth.vermont.gov/forms>.

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

As with enrollments, dis-enrollments are effective as of the last day of the month DMH is notified, with the exception of a dis-enrollment due to the death, in which case the dis-enrollment 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 a dis-enrollment 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 the all those ineligible.

1.7 Transfer Enrollment

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

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

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

1.8 CRT Re-enrollments

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.

1.9 Inactive Status

Persons who have not received CRT services within a period of 105 days will be deemed “inactive” and will not be included in that month’s billing. DMH will not receive a capitation payment from the Department of Vermont Health Access (DVHA) for these individuals.

Persons deemed “inactive” are still enrolled and eligible for services through the CRT Program. The CRT “enrolled” status continues to preclude any other billing for mental health services.

DMH and DDA/SSA remain responsible for coverage of psychiatric hospitalization expenses for all those who are deemed inactive.

DAs/SSAs are responsible for tracking service utilization of enrolled individual 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 dis-enrollment of those deemed “inactive” when there are clear indications that an individual no longer has a need, or interest in CRT services.

DMH will use the Monthly Service Reports (MSRs) to determine individual “inactive” or “active” status. If a person receives a CRT, Adult Outpatient, or Emergency service from a DA/SSA during the 105-day period, the person will remain on active status. If a person does not receive a service in these programs during the time period, he will be placed on inactive status. After two consecutive years of inactive status, the person will be administratively dis-enrolled from the CRT Program by DMH.

The same process will be followed for clients resuming active status. Given that the MSRs will be the source for determination of status, there will be a lag between the times in which the client actually stops (or resumes) accessing services and when the client’s status is changed. DAs/SSAs may not file claims on a fee-for-service basis for mental health services on behalf of CRT clients who are on inactive status. Any claims filed will be rejected. Inpatient providers can bill on a fee-for-service basis for authorized inpatient services.

Inactive status does not affect the client’s eligibility for Medicaid services, nor does it affect eligibility for access to CRT services.

Section Two: Description of Member Services

2.1 Comprehensive Services

The Community Rehabilitation and Treatment (CRT) Medicaid waiver supports provision of evidence-based practices to promote rehabilitative/recovery outcomes for the individuals served.

The CRT core service capacities include an array of rehabilitation, diagnosis-specific treatments, and emergency services including crisis stabilization services. These services must be available locally or regionally to the enrolled CRT population. They are either directly provided or contracted for by the DA/SSA providers.

Minimum required covered services include:

- Clinical interventions
- Emergency care and crisis stabilization
- Individual, group, and family Therapy
- Medication evaluation, management and consultation with Primary Care
- Community supports
- Service planning and coordination
- Diagnosis-specific practices as appropriate. For example:
 - Integrated Dual Disorders Treatment (IDDT)
 - Dialectical Behavioral Therapy (DBT)
 - Cognitive Behavioral Therapy (CBT)
- Inpatient psychiatric services
- Private practitioner behavioral health services as appropriate.

Additional services include:

- Peer support
- Employment services: Individual Placement and Support (IPS) Supported Employment
- Individual psycho-education, including recovery education
- Housing and home supports
- Support for families and significant others
- Referrals to specialty services.

2.2 Individualized Plans of Care (IPC)

Service provision is directed by an Individualized Plan of Care (IPC) which is based on

- clinical and functional assessments
- the effectiveness and appropriateness of the services/interventions to address the identified treatment goals, and
- the individual's goals and choices.

IPCs reflect a 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 CRT 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.

An IPC shall be created and completed with the individual within thirty (30) days of enrollment into the CRT program. At a minimum, the treatment plan must be signed by the individual served and a licensed master's-level clinician, a physician or authorized advanced practice psychiatric nurse practitioner (APRN).

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

The lead clinician signing the treatment plan will work with the entire treatment team to coordinate care. Each enrollee is assigned a case manager to assure implementation of the IPC. Case managers also provide some of the services and help coordinate the care.

Components of the IPC

The IPC must contain the following components:

Goals: *What are the desired outcomes of CRT services?* A statement of the overall, long term desired results of service interventions, expressed in the individual's words as much as possible.

Objectives: *What are the steps to getting to the desired outcome(s)?* Objectives are short-term intermediate goals that help people move toward realizing their larger long-term goals. Objectives describe the specific changes in behavior, function and/or status that the individual will achieve as a result of receiving services and working on their recovery. Objectives are stated in observable and measurable terms, using language that is understandable for the person served. Objectives include specific time frames for achieving/assessing progress.

Interventions: A description of the actions used to achieve each objective including:

- Who? The roles and responsibilities of the person, staff, family and/or natural support network.
- What? The specific service to be provided.
- When? How often, how much time, 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. See table below.
- Where? The location of service delivery.
- Why? The purpose of doing this intervention or action. Link the intervention back to desired outcome.

Outcomes: The anticipated outcomes resulting from the treatment and/or services provided for the identified goal. Outcomes tend to reflect short-term or incremental goals.

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

Frequency of Service:
The following ranges may be used as Minimum Guidelines in the IPC

Type of Service	Recommended Ranges
Service Planning and Coordination	Daily to Weekly
Community Supports	Weekly to Monthly
Clinical Interventions	Monthly to Quarterly
Transportation	Quarterly to Annually
Day Peer Recovery Consultation, Education, Advocacy	Range not required
Employment Services	Active – Daily to Weekly Transition – Weekly to Monthly Maintenance – Quarterly to Annual
Housing and Home Supports	<u>Supported Residential Care Ranges:</u> Daily to Weekly Weekly to Monthly Monthly to Quarterly Quarterly to Annually *No planned service <u>Group Residential Range:</u> Daily No planned service*
Crisis Service	Range not required

* A DA may choose to include specific reference to ‘no planned service’ on an individual basis, but is not required to identify ‘no plan of service’ for every service type.

Plan Necessity

Plan necessity is determined by a qualifying clinician, operating within the scope of their clinical practice, to deliver necessary and specific treatment services to address the individual’s assessed needs and is authorized by their signature. on an IPC.

Treatment and service modalities must be authorized in the IPC or subsequent addendums for the period in which the treatment and service modalities are provided to be eligible for reimbursement.

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 services that you intend to deliver (not every possible option).

Involvement of Persons Receiving Services

It is expected that the individual takes a central role in the development of the goals, objectives, and expected outcomes in the IPC, and that the IPC is completed with the collaboration of the individual and his/her identified family and/or support persons as requested. It is expected that the individual is present whenever the IPC is updated. The individual’s signature on the IPC should indicate their understanding and acceptance of the plan.

Updates and Revisions to the IPC

A reviewed and updated treatment plan is required whenever there is a significant change in the CRT enrollee's life circumstances. (See memorandum dated October 29, 2010 entitled "Negotiated Changes in Paperwork and Administrative Burden".) It is expected that the treatment team will work in partnership with the individual and their identified support network to review and revise the IPC on an ongoing basis as needed. However, there are some circumstances that trigger a required review. These include but are not limited to:

- lack of treatment progression over a period of six months
- attainment of rehabilitation/ recovery goals and development of new goals
- hospitalization
- new, complicating or worsening symptoms (mental health or physical health changes)
- major changes in job, residence, personal and professional relationships
- significant milestones, e.g. marriage, birth, death
- change/relapse of substance use disorder
- change in need of support services or revisions to current service/support agreements
- financial support changes
- concerns of abuse or neglect as victim or perpetrator
- criminal justice involvement or change in legal status
- referral to Supported Employment.

Significant changes in life circumstances require a review of the current IPC by the clinician and the CRT enrollee to determine whether a revision is appropriate.

IPC reviews and updates must be signed by a licensed master's level clinician operating within their scope of licensure or an advanced practice psychiatric registered nurse operating within their scope of practice. It is also recommended that all ongoing treatment providers also review and sign the updated IPC.

2.3 Progress Reports

Monthly progress summary reports by case managers or designees must refer to the IPC, describing the effectiveness of the prescribed interventions, and documenting progress towards desired outcomes. The monthly progress note should substantiate any changes in clinical status and the rationale for any planned service modifications. Participation of the individual at lesser service levels, including non-participation, should be documented in the monthly note.

2.4 Reassessment (Clinical and CRT eligibility)

The DA/SSA is required to periodically reassess the status of persons enrolled in the CRT Program. Comprehensive diagnostic and treatment reassessment is required every two years for individuals enrolled in the CRT Program to closely re-examine their ongoing service needs. Reassessment 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 transition or milestone indicators (for example, clarification of diagnosis, rule-out of eligible severe and persistent mental illness)
- 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 in diagnosis.

Reassessment should also consider ongoing clinical eligibility for CRT Program services and the need to update the IPC.

2.5 Notification of Change or Decrease in Services

If the provider plans to significantly change services detailed in the treatment plan (e.g., a decrease in service that exceeds the agreed-upon range for the service or a discontinuance of the service prior to the expiration of the service plan), the DA/SSA must provide individuals with written notification of a decrease in services in advance of the service change and inform them of their right to appeal the action to discontinue or reduce services. Notice may be given verbally on the date of action under the following circumstances:

- The individual requests in writing that the service be changed
- The treatment team and physician immediately change the treatment plan (i.e., a new IPC is created)
- The individual requests and is denied a new service or range increase.

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.

In addition, the DA/SSA may not reduce any range through combination with another range without notice to the individual. DAs/SSAs are encouraged to select a recording mechanism that demonstrates adherence to the practice (e.g. notice with the individual's signature, progress note documentation, staff notation of review of patient rights, tracking log in the individual's chart).

An increase in services does not require such notification.

At any given time, an individual may choose not to participate in authorized services. If an individual chooses not to participate in a service or to participate at a lesser level of service than authorized in the service plan, there is no obligation to notify the person. This pattern of service use should be documented in monthly progress notes or in individual service contact notes.

2.6 CRT Handbooks

All individuals enrolled in the CRT Program must receive a CRT Handbook within 45 days of effective enrollment in order to understand the requirements, rights, and benefits of the CRT Program. CRT

handbooks will be distributed by DMH to each person newly enrolled in the CRT Program within ten working days of notification. This will be a hard copy edition unless an alternative format is requested.

A copy of the handbook is available online at <http://mentalhealth.vermont.gov/publications> under Adult Mental Health Publications.

The DA/SSA should verify that the new CRT enrollee received the handbook. It is expected that the information in the handbook will be reviewed with the enrollee when he/she begins CRT services.

The handbook contains the following information:

- General description of the CRT Program and services
- Description of covered services and benefits
- Information on how to access services in urgent and emergent situations
- Information on how to access services in other situations
- Grievance and Appeal procedures
- Dis-enrollment rights
- Advocacy and Ombudsman Services
- Information about Advance Directives and the Vermont Durable Power of Attorney for Health Care Decisions

DMH will periodically revise the handbook. The DA/SSA is responsible for distribution of the updated version or providing notification that a change has occurred and is available via the DMH website at the next scheduled follow-up appointment or via mail.

Distribution of CRT Handbooks must be documented, either in a person's record or in a separate log.

2.7 Service Hours of Accessibility

DA/SSA staff members must be accessible by phone during normal business hours in order to answer callers' questions about the CRT program, to take grievance and appeals information, and to schedule appointments for CRT services.

Individuals may also contact DMH Administrative staff, Monday through Friday, from 7:45 a.m. to 4:30 p.m., except holidays using the toll free number (1-888-212-4677) as noted in the CRT Handbook. Incoming calls are reviewed and directed to the appropriate DMH staff.

2.8 Grievances and Appeals

The DA/SSA must have a grievance and appeal process for resolving service disagreements/complaints between service recipients and/or their representatives and the DA/SSA for CRT clients with Medicaid or dual eligibility with Medicaid and Medicare. The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance individual and public confidence in the equity and integrity of the service system, to ensure the rights of those enrolled in CRT to clinically indicated, covered benefits, and to ensure providers' clinical decision-making roles.

The DA/SSA is required to follow the procedures and processes described in the DMH Grievance and Appeals Manual that is available at <http://mentalhealth.vermont.gov/about/grievance>.

2.9 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.

Section Three: Description of Network Monitoring and Control

3.1 Provider Requirements

Credentialing and Re-credentialing

All providers participating in the CRT Program 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. (see ATTACHMENT 1: Provider Credentialing and Re-Credentialing.)

Provider Eligibility

Billing is allowed only for services provided by:

- Qualified staff that are employed by a DA/SSA
- Qualified sub-contractors that are hired by the DA/SSA
- Students/interns, provided that the student/intern is supervised by a qualified staff of the DA/SSA, is subject to all DA/SSA policies and procedures, and that the DA/SSA assumes responsibility for the work performed.

Only those services specifically allowed under a given provider number will be reimbursed. In cases where multiple provider numbers are issued to a DA/SSA, DMH staff will have access to settlement sheets documenting payments under each number. Ongoing Medicaid review activities by DMH will include verification that double payments are not made under multiple provider numbers for the same service.

Staff Qualifications

Services will be provided by a Vermont Medicaid enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on his/her 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.

The DA/SSA is required to provide all covered CRT Program services either through qualified employed staff or contracted providers. Staff qualifications apply to contracted employees.

Supervised billing for Behavioral Health Services

'Supervised billing' is a way for a supervising provider who is enrolled in Vermont Medicaid to bill for clinical behavioral health services provided by non-licensed personnel under their direct supervision. (Please reference the Green Mountain Care Provider Manual for more details.) These 'supervised billing' requirements apply only to clinical services: diagnosis and evaluation; individual, group, and family therapy, medical evaluation/management, medication/psychotherapy. This is not applicable to case management, specialized rehabilitation or emergency care and assessment services.

Billable services provided by supervised non-licensed providers must fall within the provider's scope of practice.

Providers who are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number; they cannot bill under another provider's name.

The following Medicaid contracted providers may bill for supervised services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties
- Licensed psychiatric nurse practitioner
- Licensed psychologist
- Licensed psychologist
- Licensed marriage and family therapist
- Licensed clinical mental health counselor
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselor (LADAC).

The following conditions apply to the Medicaid-contracted provider in order to bill for unlicensed clinical services:

- Supervisors must be licensed and actively enrolled in Vermont Medicaid.
- All supervising providers must only supervise for services within their scope of practice.
- Supervisors must adhere to the supervision requirements outlined in the Secretary of State's Administrative Rules for their specific provider type. For LADACs, supervisors must meet requirements outlined by Vermont Alcohol and Drug Addiction Certification Board.
- Supervisors do not need to provide direct services in order to bill for supervised services.

- Supervisors must provide regular, face-to-face ongoing supervision to the unlicensed provider, according to the regulations for the specific provider type.
- Supervisors must sustain an active part in the ongoing care of the individual.
- A licensed provider qualified for scope of practice must be immediately available in person or by phone within 15 minutes.

Supervisors may bill Medicaid for clinical services provided by the following non-licensed providers:

- Master-level mental health practitioners including clinical social workers, clinical mental health counselors, and marriage and family therapists, actively fulfilling 3,000 hours of supervised practice.
- Psychiatric nurse practitioners actively fulfilling 24 months and 2,400 hours of supervised practice.
- Psychologists actively fulfilling 2,000 hours of supervised practice after receiving a doctoral or master's degree in psychology.
- Addiction counselors who are actively fulfilling the required hours of supervised work experience, or possessing (within 180 days of hire) a Vermont Addiction Apprentice Professional certificate, or possessing an Alcohol and Drug Counselor Certification.

The following conditions must apply to non-licensed providers in order for the supervisor to bill for their non-licensed services:

- Mental health practitioners will be entered on the roster of non-licensed and non-certified psychotherapists, and must be actively working towards professional licensure.
- Psychologists will be entered on the roster of non-licensed and non-certified psychotherapists, and must be actively working towards professional licensure.
- Psychiatric nurse practitioners will be a Registered Nurse with a Collaborative Provider Agreement, and must be actively working towards professional licensure.
- Non-certified addiction counselors must be actively working towards professional licensure.

Individuals who have been on the roster maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than 5 years after January 1, 2016 will no longer be eligible under Medicaid to provide clinical services. Extensions may be granted on a case-by-case basis for DA/SSA providers only. (See Green Mountain Care Provider manual for details.)

3.2 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 Provider Subcontracts

Any CRT Program enrollee may request to access services from a non-DA/SSA provider if the DA/SSA is unable to provide the clinically necessary covered services to the individual through its CRT Program or other service programs for as long as the services are necessary and the DA/SSA elects to provide services in this manner.

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 contractor to the DA/SSA to assure that all activities under the contract are carried out.

Sub-contracts for CRT 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
- Allow for inspection and auditing of any financial records of such contractor/ subcontractor.

In the event that a CRT Program elects to sub-contract for behavioral health services from an unlicensed non-DA/SSA provider, the DA/SSA must enter into a contract with the provider only if the provider:

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

The DA/SSA is not required to contract with providers who do not meet its credentialing standards.

Funding

Sub-contract arrangements that provide clinically necessary covered services to the individual (and therefore included in their IPC) will be supported with CRT program funds.

The DA/SSA is not required to pay for services that are not required in the individual's IPC or for services that the DA/SSA can provide.

If a DA/SSA is providing services for a person enrolled in another DA/SSA, the services shall be reimbursed by the DA/SSA receiving the case rate.

3.4 Subcontractor Grievances and Appeals

Subcontractors to the DA/SSA may file grievances with the DA/SSA when dissatisfied with the DA/SSA or its staff, or appeals, if duly authorized by 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 provider 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 enrolled in CRT 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.

3.5 Enrollee Access to Non-DA Medicaid-Enrolled Licensed Providers

Any CRT Program enrollee may access services from a Medicaid-enrolled licensed provider if the he/she so chooses. In the event that a person enrolled in the CRT Program 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)
- Accept the DVHA-established Medicaid reimbursement rates.

Medicaid-Enrolled Licensed Providers may bill Medicaid at the DVHA-established Medicaid reimbursement rates. The DA/SSA is not required to pay for services that are not included in the individual's IPC. Nor is the DA/SSA 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.

The DA/SSA shall be prohibited from discriminating against the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

3.6 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 CRT enrollees so that they can make an informed decision about agreeing to provide 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 he/she refuses to disclose relevant information. (See ATTACHMENT 2: Guidelines for Completing the Mandatory Disclosure Form and ATTACHMENT 3: Disclosure to Home Care Providers/ Respite Workers.)

3.7 Fraud and Abuse Investigation and Reporting

Under its agreement with DVHA, DMH is responsible for monitoring the activities of providers and individuals enrolled in CRT for the purpose of detecting potential fraud and abuse of the Title XIX of the Social Security Act. The most common type of provider fraud consists of billing for services not actually provided to CRT enrollees. While DMH has primary responsibility for monitoring potential provider fraud or abuse, each DA/SSA should develop procedures to ensure that all reported services are actually provided and documented. In particular, the DA/SSA should monitor contracted provider billings to identify any unusually high costs or utilization that may indicate the possibility of billing fraud. (See ATTACHMENT 4: Detection and Investigation of Potential Fraud and Abuse.)

All suspected cases of fraud or abuse, along with supporting documentation, must be immediately reported to DMH.

If an instance of possible fraud or abuse is identified, DMH will investigate and will notify the Medicaid Provider Fraud and Abuse Unit if it appears that actual fraud or abuse has occurred.

As part of the biennial Clinical Care Reviews, DMH will compare provider clinical records to encounter data to verify that all reported services are adequately accounted for and documented in the individual's records. DMH will also examine Monthly Service and Variance Reports (See Section 5) to identify providers with unusually high costs and enrollee service utilization.

Section Four: Description of DA/SSA Quality Management and Utilization Management

4.1 Quality Management Program

DMH supports the practice of service improvement and requires that processes are in place whereby the needs and services provided to individuals enrolled in CRT undergo ongoing quality review for improvement opportunities.

The DA/SSA should employ a continuous evaluation process coupled with coordinated plans to improve and build meaningful and effective services. DA/SSA structures that identify individual needs and preferences, collect information through needs assessments, monitor quality, and manage outcomes 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.

4.2 Service Accessibility Standards

Standards for Emergency Services

An "emergency" is defined as a situation in which action must be taken immediately to treat or prevent harm to a person, persons or property.

- Emergency services must be available on a 24-hour, seven-day a week basis, with telephone availability within an average of five minutes, but not to exceed 15 minutes.

- Face-to-face emergency services must be available within an average of thirty minutes of identified need.

Standards for Urgent Services

An “Urgent” or “Emergent” circumstance is a developing situation in which if intervention does not occur within 48 hours an emergency will exist.

- Urgent care must be available within 48 hours.

Standards for Referrals

“Referrals” are defined as referrals to the CRT program by credentialed independent practitioners, by staff from other mental health programs, and by staff from other CRT services (e.g., from a CRT case manager to the CRT vocational program).

- Referral appointments for non-urgent care must be available within 30 days.
- It is expected that the DA/SSA will initiate contact with individuals enrolled in CRT within 24 hours of notification of hospital discharge for any psychiatric admission and assess for impact on well-being for all hospital discharges.
- Routine care must be available in a timely manner consistent with the individualized treatment plan.
- Waiting times for scheduled appointments must not exceed one hour. Exceptions to the one-hour standard must be justified and documented in writing if requested by DMH.

4.3 Monitoring of Standards

The DA/SSA is responsible for monitoring its compliance with the CRT Program Service Accessibility Standards. Compliance should be monitored through a variety of mechanisms, including review of appointment availability, surveys by service users, review of grievances and appeals, CRT ineligibility and non-enrollment logs, incident logs, etc.

DMH will monitor DA 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/Emergent care will be evaluated using medical records to determine if clients with urgent problems were treated within the required 48-hour window.
- Referral appointments will be evaluated using medical records to determine if referral appointments occurred within the required 30-day window.
- Routine care will be evaluated using medical records to determine if individuals received services in a timely manner consistent with their treatment plans through an examination of appointment

books, 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 enrolled in CRT 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.

4.4 Managed Care Organizations (MCOs) and Primary Care Integration

The DA/SSA is responsible for providing case management and coordination for all individuals enrolled in CRT, including coordination/collaboration between physical and mental health service providers.

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 CRT program.

Additionally, DA/SSA case managers 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 Case Manager or other DA/SSA designee must also take steps to assure that CRT enrollees are seen by their PCPs at least once annually or to document the efforts made and ongoing barriers preventing this.
- The Case Manager or DA/SSA 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 CRT program are eligible for physical healthcare or medical hospitalization services apart from the CRT case rate funding. The DA/SSA case managers or designees 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 psychiatrist is ultimately responsible for the overall efforts on the part of the DA/SSA to coordinate care with the primary healthcare provider.

Coordination with Inpatient Psychiatric Providers - Acute Hospital Services

Enrollees in the CRT program are eligible for psychiatric inpatient hospitalization services required to stabilize an acute exacerbation of their mental health illness. The DA/SSA case manager 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 stoppage 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 enrolled in CRT is hospitalized, the DA/SSA Case Managers 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.
- 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.

4.5 Critical Incident/Significant Event Reports

Each DA/SSA is expected to have a process in place for reporting and tracking significant events. The DA/SSA will attend to individual, family, community and DA/SSA staff support needs and will ensure that any necessary action steps or follow-up from a significant event occurs in a timely manner.

The Department of Mental Health (DMH) must be notified verbally of any significant events/critical incidents involving deaths or high-profile incidents attracting public attention within 24 hours.

The significant event requirements are available at <http://mentalhealth.vermont.gov/forms>.

4.6 Utilization Management Program

The Department of Mental Health requires the management of utilization information and its corresponding outcomes to ensure CRT provision of quality services. To ensure compliance with this standard, CRT Programs are required to have a utilization and outcomes management system for measuring and responding to the needs of those enrolled in CRT and evaluating service provider practice outcomes in targeted areas.

Each DA/SSA shall maintain utilization review activities to assess, monitor, and maintain effective, efficient and appropriate utilization of CRT Program resources by means of eligibility review and determination processes for enrollment into the CRT Program and concurrent review via periodic assessment using established CRT eligibility criteria and monthly progress report documentation of service use. 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, effective and efficient manner, that individual service documentation meets DMH standards, and that DA/SSA CRT Program resources are used efficiently.

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 CRT Program will generate and review service use data internally and via DMH monthly reports of patterns and trends related to the quality of care and use of their CRT program 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 in CRT. Review of outcomes management activities and achievements must occur at least quarterly and will be reviewed by DMH during regularly scheduled Program Reviews.

Section Five: Description of Data Management and Reporting

5.1 Reporting Requirements

Service Encounter Data

Service Encounter data are individual-level records of DA/SSA services provided to CRT Program enrollees. Encounter data must be submitted to DMH via the Monthly Service Report (MSR) in accordance with the MSR data submission specifications and include all services provided to CRT enrollees regardless of the actual funding 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. This report is due no later than the last day of the month following the reporting month. 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 eligible for CRT.

If a DA/SSA suspects that an error is occurring in the submission or reporting of data to DMH, they are encouraged to have their IT staff work with the DMH Technology and Process Technician to resolve the problem.

DMH will perform clinical records audits for the purposes of comparing submitted data to the clinical record during the biennial Clinical Care audits. 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.

CRT Service Definitions and Codes, including Guidelines for Evidence-Based Practices

The CRT service definitions and guidelines can be found in Attachment 5 ATTACHMENT 5: CRT Service. These guidelines also demonstrate how DMH-established activity codes can be used to code staff time associated with implementation of Evidence-Based Practices (EBPs). Expanded definitions for key staff and client activities have been identified and referenced for code application. Italics in the service definitions indicate the expanded activities for the CRT program. These guidelines are designed to better reflect staff time spent on clinical activities provided in our CRT programs. All expanded definitions are reflected in the treatment plan.

These coding guidelines are designed to achieve the following objectives for our CRT system:

- Increase flexibility regarding the types of activities that staff can code as direct time to support good clinical practices
- Facilitate better reporting of direct service time to the MSR
- Increase consistency across centers in identifying how an activity should/could be coded.

DMH provides this manual to help clarify and answer questions raised by providers regarding the service codes, definitions and traditional restrictions on service time coded and reported to the MSR.

Financial Data

Financial data is a record of revenues and expenses itemized in accordance with DMH guidelines. Financials must be submitted to the DMH as part of the monthly report. Costs for individuals not eligible for the CRT program cannot be reported to DMH through the CRT financials.

Grievances and Appeals

For all Medicaid beneficiaries, the DA/SSA must 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 not an option.

This action automatically notifies DMH of grievances and appeals. DMH will review the regular reports to identify any trends that may require further investigation and/or corrective action, and to ensure that grievances and appeals are being resolved in a timely manner. EQRO also does a periodic, federal audit of the data base to insure that this Global Commitment requirement is fulfilled by MCO's (DA's/SSA's and DMH).

5.2 CRT Monthly Feedback Reports

DMH prepares a series of monthly reports on the DA/SSA CRT programs to assist in management of those programs. Each DA's/SSA's list of those enrolled in CRT is posted on secure FTP sites in the middle of the month. DAs are expected to review this list to identify any discrepancies in enrollment and to report these to DMH Technology and Program Technician. Other discrepancies are to be reported to DH Finance. In addition, eight payment and service reports are posted to each DA's/SSA's FTP site at the end of the month.

Report #1: Case Rate Payment Analysis: shows the total program CRT allocation, monthly case rate payment, budgeted and 105-day served case load, and percentage of the caseload on Medicaid.

Report #2: Monthly Client Report: organized alphabetically by client, it shows the DA/SSA, the Social Security number of each client, name, and category of Medicaid aid, demographic modifiers, whether or not the client was served in 105 days, and whether or not DMH claimed a capitation payment on behalf of the client.

Report #3: Client-Level Tier Cluster and Service Report: in spreadsheet format, client-level detail of services by cost center and month. This report also includes DA/SSA cash payments made on behalf of clients.

Report #4: CRT Service Utilization by DA/SSA \$ Cost Center: shows all services and costs, organizing services by cost center.

Report #5: Tier Cluster, 105 Day, Unit Cost & Payment Variance: this report analyzes the difference between the actual monthly payments, service-based tier assignments, and unit costs.

It also projects potential monthly changes to the payment amount if the 3% threshold is exceeded. Cash payments are included in the analysis.

Report #6: Crisis Bed Non-DA Clients: this client-level report lists crisis bed services provided by a DA with a crisis bed program to CRT clients of another DA. The Tier Cluster & Payment Variance report (#5) is adjusted for these services.

Report #7: Medicaid Status: this report displays current Medicaid status for all CRT clients.

Report #8: No Service in 2 or More Years: lists the CRT clients by DA/SSA who have not had a service in more than 2 years and are therefore candidates for dis-enrollment.

Section Six: Description of DMH Care Management and Utilization Review

6.1 Introduction

DMH Care Management and Utilization Review processes operate under the 1115B Medicaid Waiver as a managed Medicaid plan and are subject to the regulations outlined by the Center for Medicare and Medicaid Services (CMS) and the Balanced Budget Act. Approval for the Department of Mental Health (DMH) to operate the Community Rehabilitation and Treatment (CRT) program under this Medicaid Waiver depends on meeting the requirements of these regulations. As such, specific policies and procedures are required for the care management of inpatient mental health services.

This manual describes the processes to be followed by the DA/SSA for enrollees in Community Rehabilitation and Treatment programs who are hospitalized for acute psychiatric illness and have Medicaid as their primary insurer.

6.2 Program Description

Vermont's DAs/SSAs and DMH are continuously challenged to manage acute mental health care services (inpatient and crisis stabilization beds) within finite resources. The most viable way to ensure that clients have access to medically necessary care is to have a collaborating network of acute care services with the capacity to triage to the most appropriate level of care using a single set of admission, continued stay, and discharge criteria.

On July 1, 1999 Medicaid funds for Community Rehabilitation and Treatment outpatient and inpatient services were consolidated under DMH management. As a result, DMH created a system to manage the resources that support inpatient care and affect the continuity of care between inpatient and community treatment teams. Care managers negotiate between clinical, financial and administrative considerations with the designated hospitals and the current system of care to best meet the needs of the individual and facilitate movement through the system to the appropriate level of care.

Like traditional managed care systems, the fundamental components are:

- Centralized access to all psychiatric inpatient services
- Review of the basis for continued stays
- Mechanisms to identify and problem-solve discharge issues
- Process for resolving disputes
- Identifying trends and gaps in services, and to problem-solve and use resources most effectively

6.3 Program Implementation

DMH and the Vermont Council of Developmental and Mental Health Services (VCDMHS) now Vermont Care Partners (VCP) worked together to create an acute care management system that is jointly managed by the DAs and DMH. Implementation of the care management system began October 1, 1999.

Following Tropical Storm Irene in late 2011, DMH restructured acute care management into the care management unit and utilization review unit. This was done to meet the increased need for intake and discharge coordination across a decentralized system of care.

6.4 Inpatient Psychiatric Services

Admission

Emergency Services (ES) staff from the Designated Agencies evaluate all proposed CRT psychiatric inpatient admissions. The DA's Qualified Mental Health Professional (QMHP) interviews and evaluates all individuals identified in need of psychiatric hospitalization in order to determine level of care needed and make recommendations regarding immediate intervention strategies. This encounter includes assessment for less restrictive alternatives and review of any existing crisis plan for the individual.

When an individual is determined in need of hospitalization, the DMH Admission Office notifies DMH's Care Management unit. Admissions are tracked by the utilization review care managers.

Continued Stay Reviews

The goal of continued stay reviews is to ensure that CRT enrollees are served in the least restrictive environment and that discharge planning is appropriate and actively progressing.

Based on review of clinical notes and discussion with hospital staff, the DMH utilization review care manager will authorize Medicaid payment for continued stay if clinically appropriate using evidence-based clinical criteria. If the individual's clinical status does not meet hospital level of care, the hospital will be informed.

DMH care managers will review and assess hospital use of best practices and treatment progress. They also review discharge planning, and will assist in identifying appropriate step down opportunities and available community resources.

If the individual is not discharged, the DMH utilization review care manager will set the date for the next continued stay review.

The DMH utilization review care manager enters the review information, including justification for continued stay, into a record that is maintained for clinical tracking and potential Medicaid audits. Continued stay authorizations can be done in increments of 24 hours up to 7 days unless extenuating circumstances exist and all teams agree to an exception.

Discharge

In preparation of discharge, the DMH care manager staff will review the following with the hospital staff:

- The individual's clinical status related to continued stay guidelines
- Use of best practices and treatment progress
- Potential treatment and discharge issues/barriers
- Identification/confirmation of the community treatment team and coordination between hospital and community treatment teams
- Consultation with involved support system (i.e. family, friends) as indicated
- Discharge plan and target discharge date.

The DA/SSA clinical staff is responsible for working with the individual and the inpatient team to develop and implement the community discharge plan. The discharge plan must include a plan to have contact with the individual within 24 hours of notice of discharge to help facilitate the individual's transition back into the community.

The DMH Utilization Review Care Managers enter information about treatment disposition into a data base, and they enter the Medicaid payment authorization into HP (Medicaid claims payment system) at discharge.

6.5 DMH Utilization Review and Management

The goal of the utilization review and care management system is to continually monitor and improve the effective and efficient use of resources to meet the needs of individuals receiving services from CRT programs. (The care management team also oversees the psychiatric admission of all individuals receiving services from a DA/SSA, all individuals under the custody of the Mental Health Commissioner, and all hospitalizations designated as Level 1.)

In order to collect and evaluate the information upon which decisions can be made, a tracking and monitoring process has been developed.

For the CRT program, the DMH utilization review and care management team is responsible for:

- Overseeing all psychiatric admissions of those enrolled in CRT who have Medicaid to all general hospitals, including authorization of Medicaid payment following continued stay reviews.

- Tracking all psychiatric admissions of those enrolled in CRT for whom Medicaid is not the primary pay source.

Utilization data are collected daily and a report is produced each month that reflects admissions, inpatient hospital days for all individuals enrolled in CRT, and cost for CRT enrollees with Medicaid. From these data, key variables are identified and compared to utilization for previous months. Indicators for further evaluation include:

- Utilization rates
- Readmission rates
- Medicaid costs
- Legal status

These variables are used to help explore how we might be able to more effectively impact clinical outcomes, resource management and development, and program participant satisfaction.

6.6 Vermont Psychiatric Care Hospital (VPCH)

All individuals admitted to VPCH are followed by DA/SSA clinical reviewers regardless of the individual's funding source or treatment provider. DMH Care Managers meet weekly with VPCH staff, are available to VPCH and the DA/SSA to assist in the discharge planning process, and maintain clinical and discharge information. However, they do not formally review with the DA/SSA or generate payment authorizations regarding patients at VPCH. Data are maintained by VPCH and reports and analysis are done by the DMH Research and Statistics Unit.

6.7 Payment Source and Program Determination

For inpatient hospitalization, the payer source upon admission remains the same payer throughout the episode of care regardless of any changes that occur during the course of treatment. For example, if a Medicaid client is enrolled in an agency's CRT program after being admitted to a hospital psychiatric unit, the payer that covered the stay at the time of admission remains the payer for the entire episode of care. Conversely, if a Medicaid client is enrolled in CRT at the time of admission and is dis-enrolled prior to discharge from the hospital, DMH is the pay source for the entire episode of care.

CRT verification can be accessed through the VPCH Admissions Office at 802-828-2799. VPCH admission staff are available 24/7 and have access to a current list of those enrolled in CRT, the DA/SSA from which they receive mental health services, and their effective dates of CRT enrollment.

Section Seven: Informational Resources

7.1 Guardianship Information

Court-ordered guardianship evaluations for individuals enrolled in the CRT Program are eligible for reimbursement for the costs associated with the assessment time for this activity. These guardianship evaluation costs may be direct-billed to DMH and will be reimbursed on the Medicaid rate schedule in force at the time of submission.

Court-Ordered Evaluation

After DMH receives a request from probate court for an **ORDER OF EVALUATION**, the DMH verifies that:

- The client is identified as mentally ill (MI) and indigent on the request from the court.
- All clients who are developmentally disabled as (DD) are directed to DAIL.
- DMH then identifies the location of the client to determine which DA/SSA is responsible for the catchment area.
- A letter from DMH then goes to the DA/SSA requesting that the evaluation be completed and filed with the court within 30 days. The DMH correspondence will also identify how to request reimbursement if the evaluation cannot be billed to Medicaid.
- If the DA/SSA requires an extension to the filing date, it is the responsibility of the DA/SSA to contact the probate court in the area and explain the reasons for the delay. This information should also be sent in writing to the court.
- A copy of the court ordered evaluation should be located in the client chart whenever possible.

Completing Evaluation

The evaluation must:

- Describe the nature and degree of the client's disability, if any, and the level of the client's intellectual, developmental, and social functioning;
- Contain recommendations, with supporting data, regarding:
 - those aspects of the client's personal care and financial affairs which he/she can manage without supervision or assistance;
 - those aspects of the client's personal care and financial affairs which he/she could manage with the supervision or assistance of support services and benefits; and
 - those aspects of the client's personal care and financial affairs which he/she is unable to manage without the supervision of a guardian.

The court determines at or after the guardianship hearing which of the powers are given to the guardian and which are retained by the individual, and these are put in the court order. These powers may include:

- the power to exercise general supervision over respondent including choosing or changing his/her residence, care, habilitation, education, and employment;
- the power to approve or withhold approval of any contract, except for necessities, which the respondent wishes to make;
- the power to approve or withhold approval of the respondent's request to sell or in any way encumber his personal or real property;
- the power to exercise general supervision over the income and resources of the respondent including the power to receive, invest and expend all wages, compensation, insurance benefits,

public benefits, and pensions for the benefit of respondent and to liquidate resources for the benefit of respondent;

- the power to consent to surgery or other medical procedures;
- the power to receive, sue for, and recover debts and demands due to the respondent, to maintain and defend actions or suits for the recovery or protection of the property or person of the respondent, settle accounts, demands, claims, and actions at law or in equity by or against the respondent, including actions for injuries to the property or person of the respondent, and to compromise, release, and discharge the same on such terms as he deems just and beneficial to the respondent; and
- the power and duty to aid the respondent in receipt of those benefits and services to which he/she is lawfully entitled including, but not limited to, education if respondent is of school age, residential services, nutrition services, medical and dental services, and finally, therapeutic and rehabilitative services.

7.2 CRT Special Services Fund

The Department of Mental Health's Adult Unit administers a fund for one-time expenses for CRT clients called Adult Special Services Fund. (See ATTACHMENT 6: CRT Special Services Funding Summary) The fund is earmarked for unmet needs and service costs that might negatively affect overall treatment stability and where no other funding source is available. Requests for funds should be directed to the Department of Mental Health using the attached application. It is important that all information on the form be complete and include the CRT Director's signature. (See ATTACHMENT 7: CRT Special Services Funding Request and ATTACHMENT 8: CRT Special Services Funding Authorization Invoice (Non-Dental)).

If Dental Special Services are being requested, the attached dental pre-authorization form (filled out by the dentist) must be attached to the Special Services request form. Only individual dental services for which Medicaid will not pay any portion of the procedure may be submitted to the CRT Special Services Fund.

Below are the guidelines for using the CRT Special Services fund.

- These funds are for individuals enrolled in CRT.
- There is a limit of \$3,000 per State fiscal year, per client.
- 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.
- This fund does not limit the types of funding requests, but distributes available funds in the following priority order:
 1. unmet health need
 2. safety
 3. stability
 4. personal care
 5. access

6. self-development
7. other needs

7.3 CRT Housing Support Fund (CRT HSF)

The Department of Mental Health's Adult Unit administers a fund called the Housing Support Fund for Housing Subsidy while an enrolled client waits for HUD Section 8 or other subsidized housing:

Background

The Department of Mental Health originally created a CRT Housing Contingency Fund in 1988. This housing fund provided financial support from the Department of Mental Health, for increased housing opportunity, temporary rental assistance, chiefly for longer term rental assistance as an individual waited for a HUD Section 8 rental subsidy and financial supports related to improving access to housing, for Vermonters with serious and persistent mental illness enrolled in the Community Rehabilitation and Treatment Program (CRT). The fund was only for persons that signed up for HUD Section 8 housing assistance or other long term affordable housing from projects developed by the Vermont Not for Profit Housing Development Sector (VHCB). Subsequently, additional funding was created for a Housing Recovery Fund (HRF) in 2006. The additional funding mirrored the Housing Contingency Fund but was part of the Vermont Futures project. On July 1, 2014, DMH merged the former HCF & HRF funds. This entailed reporting in the DMH HMIS program and the use of the Self Sufficiency Outcome Matrix to monitor program and client outcomes.

Program Eligibility

The recipient must meet Department of Mental Health definition of a person with severe and persistent mental illness and be a CRT client (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).

First priority is given to catchment area residents who are at risk of being hospitalized at a Level One bed as defined by Act 79 (2012) in contracted, designated hospitals in Vermont, including: Brattleboro Retreat, University of Vermont Medical Center, Rutland Regional Medical Center, Vermont Psychiatric Care Hospital (Berlin, VT) or Windham Center, or are being discharged from a Level One bed (as defined above).

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 housing) before participating in the Housing Contingency Fund Program.

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 uses 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 housing in your catchment area, senior housing if applicable and rural housing development projects are preferred programs used to link to other subsidies.

Housing Program Annual Report

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.

7.4 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 1: Provider Credentialing and Re-Credentialing

PROVIDER CREDENTIALING AND RE-CREDENTIALING

Policy:

The Designated Agency, under its agreement with DMH, is required to conduct credentialing and re-credentialing activities for employed and subcontracted providers, in accordance with the minimum standards established by DMH.

Purpose:

To establish a routine procedure for provider and provider subcontractor credentialing and re-credentialing activities that complies with all applicable State and Federal laws and regulations, and DMH policy.

Procedure:

- I. Providers will establish a process for the completion of credentialing and re-credentialing activities for all employees or subcontractors who participate in the CRT Program.
- II. Prior to becoming credentialed, all providers must complete an application that includes information or attestation to:
 - The reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - Education and/or training;
 - Work experience;
 - Lack of present illegal drug use;
 - History of loss of license and/or felony convictions;
 - Correctness and completeness of the application.

The application will be reviewed by the CRT Program Director and/or DA Human Resources personnel for completeness and accuracy.

- III. **Primary Source Verification:** After receipt of a complete application, the following information will be verified from primary sources:
 - Previous employment;
 - Graduation from an accredited professional school and highest training program applicable to the academic degree, discipline, and licensure of the behavioral healthcare practitioner;
 - Board certification, if designated by the practitioner on his/her application;
 - history of loss or limitation of privileges or professional review board disciplinary activity or action;
 - Current license to practice as an independent behavioral healthcare practitioner;

- Clinical privileges in good standing at the institution designated by the behavioral healthcare practitioner as the primary admitting facility (as applicable);
 - A valid DEA or CDS certificate (as applicable);
 - Current, adequate malpractice insurance according to your organization’s policy;
 - History of professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner;
 - Specialized training for nontraditional behavioral healthcare practitioners;
 - Information from the State Board of Licensure or Certification and/or the National Practitioner Data Bank;
 - Information about Medicaid/Medicare sanction activity; and
 - Information about sanctions or limitations on licensure from the appropriate State agency.
- IV. **Re-credentialing:** Re-credentialing will be completed at least every two years. At the time of re-credentialing, providers must attest to:
- The reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - Lack of present illegal drug use;
 - Status of license and/or felony convictions;
 - Correctness and completeness of the re-credentialing information.
- V. **Re-credentialing Verification:** The following information will be verified from primary sources:
- Board certification, if designated by the practitioner on his/her application;
 - Loss or limitation of privileges or professional review board disciplinary activity or action;
 - Current license to practice as an independent behavioral healthcare practitioner;
 - Clinical privileges in good standing at the institution designated by the behavioral healthcare practitioner as the primary admitting facility (as applicable);
 - A valid DEA or CDS certificate (as applicable);
 - Current, adequate malpractice insurance according to your organization’s policy;
 - Professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner;
 - Information from the State Board of Licensure or Certification and/or the National Practitioner Data Bank;
 - Information about Medicaid/Medicare sanction activity; and
 - Information about sanctions or limitations on licensure from the appropriate State agency.

VI. **Additional Re-credentialing Information:** The re-credentialing process must also incorporate information from the following sources:

- Client grievances or appeals;
- Information from quality improvement activities;
- Information from utilization management activities;
- Member satisfaction data; and
- Clinical record reviews.

VII. DAs are required to provide all covered CRT Program services either through employed staff or **contracted** providers. It is the responsibility of the DA to maintain recruitment, hiring, staff development mechanisms that support employee competencies and who based on his/her education, training, or experience, is authorized by the DA Medical Director and DA Executive Director as competent to provide the services outlined in the employee's job description. Additionally, the DA Executive Director and the Medical Director have the authority to approve and responsibility to enter into a contract only with persons they determine to be qualified non-DA providers.

ATTACHMENT 2: Guidelines for Completing the Mandatory Disclosure Form

GUIDELINES FOR COMPLETING THE MANDATORY DISCLOSURE FORM FOR HOME PROVIDER/ RESPITE WORKERS

WHAT IS THE PURPOSE OF THIS FORM? A Vermont law was passed in May 2002 to assure that home providers and day/overnight respite workers have relevant information about DMH clients so that they can make an informed decision about whether to agree to provide care for a client in their own home. Specifically, the law states that designated and specialized service agencies are required to give home and day/overnight respite providers paid by the agency information about a person's history of violent behaviors, any potential predictors of violent behavior, and any medications they are taking. This must be done with the client's authorization, but the home/respite provider has the option of deciding to still care for the client even if the client refuses to disclose relevant information (see below).

This Mandatory Disclosure Form is meant only to comply with this new law. It does not preclude any information exchange that an agency already has in place to ensure quality care is being provided for clients. In other words, this form is the minimum requirement for information that **MUST** be provided – more information can be provided through this or other mechanisms if deemed appropriate and with the client's authorization.

This mandatory disclosure of information also does not replace a mental health professional's Duty to Warn (*Peck v. CSAC*). In other words, the obligation to exercise reasonable care to protect identifiable potential victims when there is, or should be, knowledge that a client poses a serious risk of danger to him/her remains intact. The Duty to Warn is different from this mandatory information disclosure, and is not affected by it.

WHO SHOULD COMPLETE THIS FORM? The Mandatory Disclosure Form should be completed by the agency staff person who knows the client best, and who has access to the clinical records to assure that all known relevant information is included.

WHO SHOULD GET THIS FORM? The Mandatory Disclosure Form must be given to any home care provider or respite worker your agency is attempting to contract with to provide care in his or her home for a client of your agency. (It is the responsibility of the home care providers to share relevant information with anyone with whom they contract directly to provide respite.) Clients and families who totally self-manage their services or hire their own workers are not included in this mandatory disclosure law.

WHAT IS THE PROCESS FOR OBTAINING AUTHORIZATION? Authorization from the client to disclose this information should be obtained by the designated or specialized service agency in writing, via the agency's routine confidentiality policies and authorization form. The Authorization Form must include notice that information disclosed to home providers will include medications and any relevant information concerning history of violent behavior. If the client does not agree to authorize the disclosure of any or all of the information required on this form, please write "*Client does not authorize the release of this information*" in each of the appropriate section(s) of the Form.

WHAT ARE THE SOURCES OF INFORMATION FOR COMPLETING THE FORM? Please write any information that you believe is relevant in the appropriate section. Obviously, if it comes from the client himself or herself or is

in the client's record, it should be included. You should also include anecdotal or unsubstantiated information to the extent that you have concluded that it is relevant to a home care provider's services to protect the individual and others from harm. This information should be specifically presented on the form as unsubstantiated and should be described as fairly as possible.

WHAT IF THERE IS NO KNOWN INFORMATION? If there is absolutely no information available, please write, "*No information is known*" for each relevant section. Do not leave a section blank.

ATTACHMENT 3: Disclosure to Home Care Providers/ Respite Workers

DISCLOSURE TO HOME CARE PROVIDERS/RESPITE WORKERS

_____ or _____ on behalf of _____
Client's name *Guardian's name* *Client's name*

(has / has not) consented in writing to disclosure of this information to:
circle one

Name: _____ Name: _____

Name: _____ Name: _____

Confidentiality Requirements

All the information in this notice must be kept confidential and not disclosed to anyone other than a respite provider, unless the client consents to the disclosure or a court orders disclosure. If the client has a legal guardian, or is an un-emancipated minor, the guardian or parent must give the authorization. This means that you can only discuss this information with members of the client's treatment team, but not with anyone else. It also means that you have a responsibility to keep this document, and any other written documents containing the client's health care information, in a secure place where other people will not accidentally see it. You have a legal responsibility to keep this information confidential even if you choose not to provide home care for the client. In the event the client leaves your care, this information must be returned to the agency. If you violate the client's right to confidentiality, you may be fined up to \$2,000 or imprisoned for not more than one year [18 VSA, § 7103 (c)].

Disclosure to Respite Providers

If you retain a respite provider to provide care by the day or overnight in the respite provider's home, then you must give the provider the information that is needed to protect the client or others from harm while the client is in the respite home. You may share the information verbally or by giving the respite provider this form for the duration of the client's stay. However, you should not make any copies of this form for a respite provider to keep.

Relevant Information

- 1) Prescription medications and dosage (*Can attach Emergency Fact Sheet or Medication Sheet if all medications are included there*):

- 2) Relevant information/history of violent behavior or conduct that has caused danger of harm to others, that is known by the Agency and/or is in the individual's clinical record. (Must include, *but not be limited to*, any criminal history of violence;¹ history of sexual abuse or relevant physical harm towards others; other violent behavior resulting in involuntary hospitalization or commitment). "Relevant" information includes past actions you think might predict or indicate the likelihood that this person will cause future harm.

- 3) Any known warning signs of dangerous behavior towards others (for example, alcohol or drug use, failure to take medications as prescribed, behavioral signs and symptoms). (*Can attach Behavioral Support Plan, Emergency Fact Sheet or Medication Sheet if relevant information is included.*)

Any relevant information needed to protect the client from harm (for example, people who have victimized or endangered the individual, behaviors that may indicate possible future self-injurious behavior, level of supervision needed). (*Can attach Behavioral Support Plan, Emergency Fact Sheet or Medication Sheet if relevant information is included*)

Signature of Agency Staff Member Date

Signature of Home/Respite Provider Date

I consent to this placement even though the Client/Guardian has not authorized sharing information that the DA/SSA believes is relevant.

Signature of Home / Respite Provider

Date

¹*Criminal history of violence includes being charged with or convicted of: aggravated assault, aggravated stalking, aggravated sexual assault, assault & robbery, simple assault, assault upon law enforcement, cruelty to children, domestic assault, elderly abuse, abuse of a person with a disability, extortion, hate-motivated crime, kidnapping, lascivious conduct, L&L with a child or adult with disability, manslaughter, murder, sexual assault, stalking, and sexual assault on a minor, arson, recklessly endangering another person while driving.*

ATTACHMENT 4: Detection and Investigation of Potential Fraud and Abuse

DETECTION AND INVESTIGATION OF POTENTIAL FRAUD AND ABUSE

Policy: 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 investigate and notify the Medicaid Provider Fraud and Abuse Unit if it believes actual fraud or abuse has been detected.

Purpose: To prevent clients and providers from committing fraud and abuse of the Title XIX of the Social Security Act.

Procedure:

I. Identification of **Medicaid-Eligible Clients:**

- Verify the client's identity
- Confirming the client's current Medicaid status each time he/she uses services

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 the Medicaid eligibility of CRT clients.

- II. 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 behavioral health records 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.

- III. 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.

ATTACHMENT 5: CRT Service Definitions and Codes

COMMUNITY REHABILITATION AND TREATMENT (CRT) SERVICE DEFINITIONS AND CODES & Coding Guidelines for EVIDENCE–BASED PRACTICES

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Introduction

Section I: Service Definitions and Codes for CRT Program

Section II: Specific Evidence-Based Practices

Description, Major Characteristics, Major Staff Activities

- A. Assertive Community Treatment (ACT)
- B. Supported Employment (SE)
- C. Pharmacological Treatment
- D. Family Psychoeducation and Support
- E. Recovery Education and Illness Management
- F. Dialectical Behavioral Therapy (DBT)
- G. Integrated Mental Health and Substance Abuse Treatment (IDDT)

Section III: Procedures for Reporting Staff/Client Time

INTRODUCTION

The attached document will serve as a reference **for CRT programs only**. Expanded definitions for key staff and client activities have been identified and referenced for code application. Italics in the service definitions indicate the expanded activities for the CRT program. These guidelines are designed to better reflect staff time spent on clinical activities provided in our Community Rehabilitation and Treatment (CRT) programs. All expanded definitions are per the treatment plan.

In a fee-for-service Medicaid reimbursement system, a significant amount of clinical effort goes uncoded and unreported because it is not billable to Medicaid and other payers. We feel it is important to capture staff time spent doing activities required in evidence-based practices and activities that are valued and support better outcomes. The CRT Program Medicaid waiver allows this flexibility in our service system.

These coding guidelines are designed to achieve the following objectives for our CRT system:

- Increase flexibility regarding the types of activities that staff can code as direct time to support good clinical practices
- Facilitate better reporting of client service time to the MSR, and
- Increase consistency across centers in identifying how an activity should/could be coded

DMH feels this manual will help clarify many of the questions and issues raised by providers regarding the service codes, definitions and traditional restrictions on service time coded and reported to the MSR.

I. Service Definitions and Codes

Service Planning and Coordination

- A01** **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 for a specific individual. 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, and monitoring the well-being of individuals (and their families), and supporting them to make and assess their own decisions

Examples and/or expanded interpretation for CRT programs:

- *Consultation group (client-related).*
- *Face-to-face, or telephone coordination with other (collateral) providers such as healthcare & entitlements.*
- *Client-specific individual and team treatment planning.*
- *Family coordination and planning for specified client related to treatment plan.*
- *Clinical supervision concerning a specific client.*
- *Collateral contact with a primary care physician for needed healthcare services.*

Community Supports

B01 Community Supports are specific, individualized and goal-oriented services that assist individuals (and families) in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily living, supportive counseling, support to participate in community activities, collateral contacts, and building and sustaining healthy personal, family and community relationships.

Examples and/or expanded interpretation for CRT programs:

Includes telephone coaching for DBT skills (1-14 minutes [1 unit] allowable).

- *Supporting or supervising clients who are paid staff of the DA to provide training and teaching of skills to other clients.*
- *Provision of psychoeducation and support to a family of an identified client.*
- *Relationship-building for engagement in treatment between staff and a client as specified in a treatment plan.*
- *Time spent in failed engagement outreach attempts (up to 2 units). This does not include travel time. Service attributed to failed engagements must be described in the monthly summary.*
- *During transport of a client, the time spent interacting with the client supporting treatment plan services is allowable.*
- *Medication drops by non-medical staff (only time spent interacting with the client).*

B02 Community Supports (as in B01) provided in a group (maximum of four clients) in a natural community environment (i.e., not a clinic facility).

Examples and/or expanded interpretation for CRT programs:

- *In vivo intensive training and skills development, small groups.*
- *Accompanying clients into the community as part of social and skill- building activities in treatment plans.*
- *Supports to encourage relationships and other social connectedness per treatment plans.*

Employment Services assist transition-age youth and adults in establishing and achieving career and work goals.

C01 Employment Assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals.

C02 Employer and Job Development assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

C03 Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

C04 Ongoing Support to Maintain Employment involves activities needed to sustain paid work by the individual. These supports and services may be given both on and off the job site, and may involve long-term and/or intermittent follow-up.

Clinical Interventions are assessment, therapeutic, medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist or nurse.

E01 Clinical Assessment services evaluate individuals' and families' strengths, needs, existence and severity of disability(s), and functioning, across environments. Assessment services may include evaluation of the support system's and community's strengths and availability to the individual and family.

➤ **Staff Qualification for E01 is limited to Master's level clinicians.**

Examples and/or expanded interpretation for CRT programs:

➤ *Reassessments may be completed by Bachelor's level clinicians.*

E02 Individual Therapy is a method of treatment that uses the interaction between a therapist and the individual to facilitate emotional or psychological change and to alleviate distress.

➤ **Please see section relating to staff qualifications for E02, E03, and E04**

E03 Family Therapy is a method of treatment that uses the interaction between a therapist, the individual, and family members to facilitate emotional or psychological change and to alleviate distress.

➤ **Please see section relating to staff qualifications for E02, E03, and E04**

Examples and/or expanded interpretation for CRT programs:

➤ *Family counseling provided to specified client's family member(s) related to coping with the impact of mental illness.*

E04 Group Therapy is a method of treatment that uses the interaction between a therapist, the individuals, and peers to facilitate emotional or psychological change and to alleviate distress (maximum of ten participants per clinician).

E04 and L01 service codes may not be used simultaneously.

➤ **Please see section relating to staff qualifications for E02, E03, and E04**

Examples and/or expanded interpretation for CRT programs are specific to a set protocol and a developed/prepared curriculum:

➤ *CRT group work allowable under this code consists of structured, curriculum-based sessions with clearly delineated learning objectives and therapeutic methods to achieve these. Typically, these groups are time-limited with a curriculum that follows a developmental learning and therapeutic process.*

Eligible treatment/service considerations include:

- *Multi-family group psychoeducation and problem-solving counseling.*
- *Co-occurring mental health and substance abuse engagement/persuasion group.*

- *Co-occurring mental health and substance abuse relapse- prevention group.*
 - *Co-occurring mental health and substance abuse active treatment group.*
 - *DBT skills group.*
 - *Recovery Education group.*
- *Client services identified as an **E04** activity must be clearly identifiable within the monthly summary.*
 - *Developed/prepared curriculum materials for **E04** services under expanded definition examples must be available for Clinical Care and Minimum Standards Review.*

Staff Qualification for services E02, E03, and E04 may either be provided by a Vermont physician enrolled as a Medicaid provider (directly employed by the Designated Agency), or prescribed by such a physician and provided by DA staff who, based on his/her education, training, or experience, is authorized by the prescribing physician as competent to provide the service.

E05 Medication and Medical Support and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical observation, support and consultation for an individual's health care.

- **Staff Qualification for E05 is limited to medical personnel only.**

Examples and/or expanded interpretation for CRT programs services are client-specific:

- *Individual client/group medication education.*
- *Preparing medication for home delivery.*
- *Dosing verification and packaging for dispensing.*
- *Collateral contact with pharmacy and collateral contact with a primary care physician to coordinate provision of needed health and behavioral health care services.*

Crisis Services are time-limited, intensive supports provided for individuals and families who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Services may also be provided to the individual's or family's immediate support system. These indirect services are available 24 hours a day, 7 days a week. The SSA, Pathways Vermont, is not designated by DMH to provide Emergency Services, therefore, the DA will provide Emergency Services and bill fee for service for individuals enrolled in CRT with the SSA.

G01 Emergency/Crisis Assessment, Support and Referral includes initial information gathering, triage, training and early intervention, supportive counseling, consultation, referral and crisis planning. In addition, supports include: outreach and stabilization, clinical diagnosis and evaluation, treatment and direct support, and integration/discharge planning back to the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission.

G02 Emergency/Crisis Beds offer emergency, short-term, 24-hour residential supports in a setting other than the person's home.

Housing and Home Supports provide services, supports and supervision to individuals in and around their residences up to 24 hours a day.

- H01 Supervised/Assisted Living (by the hour)** consists of regularly scheduled or intermittent supports provided to an individual who lives in his or her home or that of a family member. This code may also be used for hourly crisis support (e.g., cadre staffing only).
- H02 Staffed Living** consists of residential living arrangements for one or two people, staffed full-time by providers.
- H03 Group Treatment/Living** consists of group living arrangements for three or more people, staffed full-time by providers.
- H05 Unlicensed Home Providers/Foster Families** are individualized shared-living arrangements for children and adults, offered within a home provider/foster family's home. Home providers/foster families are contracted workers and are not considered staff in their role as contracted provider.

Transportation

- I01 Transportation** services are only for the necessary transportation of individuals covered by Medicaid to and from an agency facility in order to receive Medicaid-reimbursable Clinic, Rehabilitation or Targeted Case Management 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.

Examples and/or expanded interpretation for CRT programs:

- *Agency sponsored transportation services only.*

Peer Provider or Recovery Services (Day Services)

- L01 Peer Provider or Recovery Services** are group recovery-oriented activities in a facility milieu to promote wellness, empowerment, and a sense of community, personal responsibility, self-esteem and hope. These activities are client-centered. This service provides socialization, skills development, and crisis support and promotes self-advocacy.

L01 and E04 service codes may not be used simultaneously.

L01 and GO1/GO2 service codes may not be used simultaneously.

- ***Staff Qualification for L01 is limited to peer providers employed by the agency or clinical staff.***

Examples and/or expanded interpretation for CRT programs.

Peer provider or clinical staff recovery services are identified by skill-building opportunities provided in a facility (no limit on clients served).

- *Direct staff time with clients spent in meetings and committee activities.*
- *Staff time spent with clients to train and supervise them to operate warm lines or other organized peer-support activities.*
- *Client support groups led by staff or peers paid by the designated agency.*

DA Use Only

- X01 Hold for DA use for non-DMH-reportable service activities.**

II. Evidence-Based Practices - Description, Major Characteristics, Major Staff Activities

A. ASSERTIVE COMMUNITY TREATMENT (ACT)

Description

ACT is a multidisciplinary clinical team approach providing comprehensive mental health and rehabilitation services. Team members provide long-term intensive care in natural community settings. The team provides all services rather than referring clients to different providers, programs, or other agencies.

Major Characteristics

- The treatment team is multidisciplinary (practitioners have training in psychiatry, nursing, social work, substance abuse, employment, and housing). Team members provide services 24 hours a day, 7 days a week.
- The team is the primary provider of services (not brokered): fixed point of responsibility with a clearly identified population.
- The majority of services are provided out of office; services are in locations where the problems occur and support is needed.
- Staff to client ratio of 1 team member for each 10 people receiving services.
- Shared rather than individual case assignment.
- The range of services is comprehensive and flexible.
- Structured protocols for treatment planning, team member briefing, and outreach.

Major Staff Activities

Activity	MSR Service Coding
<u>Client-specific team treatment planning</u> : team meets daily to plan services, assess clients' clinical and community status and share information to coordinate services.	A01 (client-specific)
<u>Coordination with collaterals</u> (such as healthcare, entitlements, and other providers)	A01
<u>Individual supports</u> : for activities of daily living, educational opportunities, housing assistance, individual illness management/recovery, financial management, skills training, medication supports (non-medical staff), and family coordination.	B01
<u>Group supports</u> (four or fewer clients) for activities mentioned above.	B02
<u>Support to find, get, and keep employment.</u>	C01, C02, C03, and C04
<u>Medication supports.</u>	E05
<u>Individual clinical interventions</u> (such as therapy, diagnosis, and assessment).	E01, E02
<u>Group clinical interventions</u> such as substance abuse treatment groups and recovery education groups following a developed/planned curriculum.	E04
<u>Crisis supports.</u>	G01

B. SUPPORTED EMPLOYMENT (SE)**Description**

The goals of SE are to help people with the most severe disabilities participate in the competitive labor market, work in jobs they prefer with the level of professional help they need and to help people advance in their careers.

Major Characteristics

- The goal is competitive employment rather than sheltered employment or work crews.
- Job search and matching occurs rapidly after program entry, limited "pre-vocational phase."
- Job finding is individualized, based on client's job preferences.
- Follow-along supports are maintained as long as needed.
- Any client interested in working is eligible for SE services. There are no exclusionary criteria such as job readiness, substance abuse, history of violent behavior, minimal intellectual functioning, or symptomology.
- Services are targeted to the most severely disabled.
- Job options are diverse and are in different settings.
- Employment supports are integrated with mental health treatment. Employment specialists attend regular treatment team meetings with shared decision-making in treatment planning and the provision of services.

Major Activities

Activity	MSR Service Coding
<u>Employment assessment</u> : engagement and assessment occur primarily in the community. Assessment is based on a person's interests, skills, and prior experience.	C01
<u>Employer and job development</u> : community-based employer contact and helping the client to find a job (or another job). Helping to develop job opportunities for specific clients with employers.	C02
<u>Job training</u> : assists the individual to begin work, learn the job, and interact appropriately with co-workers, customers, and supervisors (coaching, teaching, assistive technology, and accommodations).	C03
<u>Ongoing support to maintain employment</u> : career development, access to educational opportunities, coaching, vocational education classes, job counseling, transportation, changes in the treatment plan, and assertive outreach to client. Examples of ongoing support include: community/work site visits, telephone contact, and mail. (Case managers providing any of these supports should code here.)	C04
<u>Coordination with other care providers</u> : including case managers, Vocational Rehabilitation counselors, benefits counselors, psychiatrists, et alia. Also includes coordination of	A01

advancement/educational opportunities, benefits, medications, networked supports (friends/family/social, crisis staff, and housing). Also includes participation in unit employment meeting: once per week to review clients and provide supervision.

C. PHARMACOLOGICAL TREATMENT

Description

A systematic approach that translates the latest available knowledge about medications into practical pharmacotherapy suggestions and promotes the optimal recovery in the client population.

Major Characteristics

- This service is provided by medical personnel. The focus is specific to people with a diagnosis of mental illness, which includes psychotic disorders, mood disorders, and certain anxiety disorders (panic disorder, post-traumatic stress disorder, and obsessive compulsive disorder).
- There are four categories of guidelines used for pharmacological treatment: Recommendations, comprehensive treatment options, medication algorithms, and expert consensus.
- A systematic set of rules called an algorithm is applied to prescribing medications and solving a problem. The algorithm sets describe the features that are critical for measuring quality (therapeutic goals, necessary therapist training/education including measurement of symptoms and uniform charting, associated support services, and contraindications). Medication Algorithms are a subset of practice guidelines.
- Research data are supported by substantial evidence of efficacy.

Major Activities

The following major activities described under medication supports should be coded E05.

- Medication evaluation: to make an accurate diagnosis and specify target symptoms and initial severity.
- Medication prescription: prescribe the type and dose of medication(s) designed to alleviate the symptoms identified above.
- Medication monitoring: monitoring changes in symptoms and occurrence and tolerability of side effects. Review of data used in making medication decisions.
- Individual client education: to increase client knowledge and understanding of the symptoms being treated, medications being prescribed, the expected benefits, impact on symptoms, and identification of side effects.
- Group education: A group format used to increase client knowledge and understanding of the symptoms being treated, medications being prescribed, the expected benefits, impact on symptoms, and identification of side effects.

D. FAMILY PSYCHOEDUCATION AND SUPPORT

Description

An approach where the clinician establishes a rapport or bond with a client and his/her family members to help the family system develop increasingly sophisticated coping skills for handling problems posed by mental illness in a family member.

Major Characteristics

- A planned curriculum/sequential educational package including problem-solving skills.
- Active involvement of family members in treatment and management by establishing rapport between the family and the treatment team to alleviate suffering and gain support for efforts aiding in the recovery of their loved ones.
- Family is defined as anyone committed to the care and support of a person diagnosed with a mental illness (regardless of whether they are a relative, or live in the same house).
- The process helps families establish relationships with other families (creating social supports).
- Single-family or multi-family group sessions. Covers family's reaction to the treatment and behaviors, feeling of loss, goals for the future, and provides coping strategies.
- Ongoing supportive and problem-solving sessions: in a multi-family or single-family format.

Major Activities

Activity	MSR Service Coding
<u>Individual family counseling</u> : to review illness history, warning signs, coping strategies, and concerns, then develop goals.	E03
<u>Multi-family psychoeducation</u> : to review illness history, warning signs, coping strategies, and concerns, then develop goals.	E04
<u>Family treatment planning</u> : Active involvement of family members in the planning and input of setting goals and treatment.	A01
<u>Family supports</u> : To help families support their loved ones who have mental illness in their recovery.	B01

E. RECOVERY EDUCATION AND ILLNESS MANAGEMENT

Description

Recovery Education and Illness Management are a broad set of strategies designed to help individuals with serious mental illness manage their mental illness, to reduce their susceptibility to the illness, to cope effectively with their symptoms, to identify the supports that are effective

for them, and to advocate for receiving these supports. Recovery Education and Illness Self-Management are educational approaches that promote hope, healing, and empowerment.

Major Characteristics

- A planned, sequential educational curriculum and skill-development package.

- Clients are active participants in self-help/self-management activities.
- Practitioners and peers work collaboratively with individuals using behavioral techniques and reinforcement, learning how to effectively practice personalized strategies for managing their illness, preventing relapses, understanding practical facts about treatment, and achieving personal goals.

Major Activities

Activity	MSR Service Coding
<u>Individual skills/illness self-management training</u> : focuses on improving social-functioning skills and includes cognitive-behavioral (learning-oriented) interventions including modeling, role-playing, practice, homework, shaping, and reinforcement.	B01 - Client-specific skill-building activities provided in the community L01 – Client-specific activities provided in facility milieu
<u>Individual counseling</u> : teaching individuals how their thinking styles and beliefs influence their feelings, and helping them to evaluate and change thoughts that lead to depression, anxiety, and anger. Also focuses on taking medications as prescribed.	E02
<u>Group therapy</u> : cognitive-behavioral strategies to reduce severity and distress of persistent symptoms and promote personal insight within a group dynamic.	E04
<u>Recovery Education</u> : psychoeducational sessions that improve people's knowledge of mental illness, management of their illness, and behavioral tailoring to manage symptoms.	E04
<u>Support to develop a crisis plan</u> : including identification of early warning signs of crisis and details about preferred supports.	B01
<u>Client-specific therapist consultation meeting</u> : Focuses on assisting each therapist in effectively conducting treatment by discussing specific targets, providing a balance between the treatment strategies, offering support, and review of cases.	A01

F. **DIALECTICAL BEHAVIORAL THERAPY (DBT)**

Description

Dialectical Behavioral Therapy is designed to reduce self-harming behaviors, impulsivity, and treatment interfering behaviors. It involves a manualized structured, cognitive-behavioral approach to treating individuals diagnosed with a borderline personality disorder. The focus of DBT is on behavioral change balanced with acceptance, compassion, and validation of the client. DBT treatment requires individual therapy, a skills development group, brief coaching by the therapist to reinforce the use of skills, and a consultation group for all staff involved in DBT treatment.

Major Characteristics

- A planned curriculum/sequential educational package.
- A focus on acceptance and validation of behaviors and feelings while motivating a person to change these.

- An emphasis on treating therapy-interfering behaviors of both client and therapist.
- An emphasis on the therapeutic relationship as essential to treatment, and a focus on dialectical processes.
- Services are targeted to a specific group of individuals diagnosed with Borderline Personality Disorder who use self-harming behaviors.

Major Activities

Activity	MSR Service Coding
<u>Individual therapy</u> : Involves addressing a hierarchical series of problem behaviors, contingency clarification, and behavioral analysis in the context of compassion and radical acceptance.	E02
<u>DBT skills group</u> : Requires the development of skill to address emotional, interpersonal, behavioral, and cognitive self-dysregulation. The skills taught are: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.	E04
<u>Individual skills coaching</u> : To assist in the generalization of new skills to the natural environment and to ensure that the therapeutic relationship remains intact. This activity is frequently done on the telephone.	B01
<u>Consultation meeting</u> : Focuses on assisting each therapist in effectively conducting treatment by discussing specific targets, providing a balance between the treatment strategies, offering support, and review of cases.	A01

G. INTEGRATED MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT (IDDT)

Description

Integrated Mental Health and Substance Abuse Treatment is an approach in which both disorders are treated simultaneously by the same team. Treatment interventions are conceptualized in stages. Individual and group supports are used in addition to assertive case management.

Major Characteristics

- Treatment for the diagnosis of mental illness and substance abuse occur simultaneously (assume both illnesses are primary).
- Critical components of effective programs include a long-term, staged approach to recovery.
- Assertive outreach to engage clients in treatment.
- Interventions are tailored for each stage of client change: engagement, persuasion, active treatment and relapse prevention.

Major Activities

Activity	MSR Service Coding
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<u>Assessment</u> : To assess substance use, mental illness, and the impact of co-occurring disorders. Also to identify which stage of change the client is in, in relation to his/her substance use and mental illness.	E01
<u>Outreach</u> : Includes motivational-based interventions, outreach, and practical assistance, with the goal of engaging the client in treatment.	B01
<u>Group therapy</u> : Groups designed to reflect each stage of change including engagement, persuasion, active treatment, and relapse prevention.	E04
<u>Medication management</u> : To treat psychiatric symptoms and to help maintain abstinence.	E05
<u>Family supports</u> : Social-network building, or family interventions to increase clients' general support.	B01
<u>Client specific planning and services coordination with family members and other collaterals</u> : To effectively conduct treatment, identify specific targets, balance treatment strategies of support and contingencies, and offer support to significantly involved others.	A01
<u>Individual therapy</u> : Involves addressing a hierarchical series of problem behaviors, contingency clarification, and behavioral analysis in the context of compassion and radical acceptance.	E02

III. PROCEDURES FOR CODING AND DOCUMENTING STAFF TIME/CLIENT TIME

CRT service parameters are expanded to include some activities that have previously been coded as "indirect" to support use of Evidence-Based Practices. Not all activities will have a reporting mechanism to assure categorizing to "direct" rather than "indirect." The current DMH case rate structure and unit costing for services have been determined with routine "indirect" service costs already included. Examples accompanying general coding issues are intended as guides to support greater uniformity in the way in which the community mental health centers report staff service time to the MSR.

EXAMPLES:

◆ **One Staff/One Client**

When you have one client and one staff, the staff codes his/her entire time with the client as direct service. The client profile (monthly service report) would indicate the same amount of time.

e.g., Community Supports - B01: One staff sees one client in the community to provide assistance with daily living (B01). The staff would record one hour of direct service time and the client is recorded as receiving one hour of Community Supports.

◆ **Two or More Staff/One Client**

When you have one client and two or more staff, one staff would code his/her time as direct service and the other staff would code his/her time under an indirect service code. The client profile (monthly services report) would show the actual amount of time the client received services.

e.g., Service Planning and Coordination - A01: When multiple staff discuss treatment planning with one client and his/her family members in a two-hour meeting, one lead staff would record two hours

of direct service time, the other staff would record indirect service time. The client profile (monthly services report) would show two hours of actual time spent determining the service plan.

◆ **One Staff/Two or More Clients**

When there are two or more clients working with one staff for an hour of treatment, the staff codes the time spent in the activity as one hour. The monthly client services report would show, for each client, one hour of service (i.e., when there is one staff for two clients meeting for one hour; the staff codes the one hour spent in the activity; each client profile in the monthly services report would show one hour of time having received services).

e.g., Group Community Support - B02: One staff sees four clients in a community support activity for two hours. The staff records two hours of direct service. Each client profile would indicate receiving two hours of Group Community Support services.

◆ **Multiple Staff (Group Activities)/Multiple Clients** When there are two or more clients and two or more staff, the staff decide (at the time of service) who should record the service for each client (in most cases it would be the primary staff working with the client). The direct service time is split according to how much time was focused on each client. Staff who are not recording a direct service would record their time as indirect time.

e.g., Service Planning and Coordination - A01: The Treatment Team meeting (three staff discussing ten clients) is held for three hours. Each staff member would report his/her respective client discussed in excess of 15 minutes to the MSR under an A01 service code. In this case, the team estimates the time spent on each client to be: two clients are coded as over 15 minutes but less than 31 minutes (2 units), five clients are coded as over 15 minutes but less than 30 minutes (2 units again), and three clients as less than 15 minutes (no units). All A01 service units reported to the MSR for seven out of the ten clients would not exceed fourteen units for the three hours (12 units) of service for the ten clients. All staff members not reporting A01 services would continue to report their time as indirect time.

e.g., Recovery Skills Training - E04: Two staff members are meeting for two hours with five clients for a group skills-training group. Each client may be coded for two hours of service. One staff member might code the time for two clients and the other staff member might code time for three clients.

ATTACHMENT 6: CRT Special Services Funding Summary



State of Vermont
Department of Mental Health
Office of the Commissioner
Redstone Building
Montpelier, VT 05609-1101
www.mentalhealth.vermont.gov

[phone] 802-828-3824
[Legal] 802-828-2385
[fax] 802-828-3823
[tty] 800-253-0191

Agency of Human Services

DEPARTMENT OF MENTAL HEALTH

ADULT SPECIAL SERVICES FUND FOR COMMUNITY REHABILITATION AND TREATMENT CLIENTS

The Department of Mental Health's Adult Unit administers an Adult Special Services Fund for one-time expenses for CRT clients. It is earmarked for unmet needs and service costs that might have a negative effect on overall treatment stability **when no other funding source is available**. Such needs might include dental work, eyeglasses, personal needs, adaptive devices, respite, car repair, utility costs, and household furnishings. **Requests for Special Services funding should be directed to Pamela Shover at the Department of Mental Health, 280 State Drive NOB 2 North, Waterbury 05671-2010 or fax to: (802) 241-0100**, using copies of the Special Services funding application form for (1) dental work **OR** (2) other expenses. It is important to complete **all** information on the form. The CRT Director must sign it after checking for accuracy and completeness of information provided.

For requests for dental work, the dentist should send you an American Dental Association-approved Dental Claim Form, filled out by the dentist, for pre-authorization by the Department of Mental health. **It is important to send this form before the dental work is done**. Attach the dental form to the Special Services request form. Only individual dental services for which Medicaid will not pay any portion of the procedure may be submitted for CRT Special Services funding.

Below are the guidelines for using the CRT Special Services Fund.

- These funds are for individuals enrolled in CRT.
- There is a limit of \$3,000 for dental services per client, per state fiscal year (July 1-June 30)
- The fund is to be used only for expenditures for which no other funding source is available. It is expected that alternative resources will be explored and denied prior to a request for Special Services funding.
- This fund does not limit the types of funding requests but distributes available funds in the following order:
 - (1) unmet health needs (primarily dental and vision care)
 - (2) safety
 - (3) stability
 - (4) personal care
 - (5) access
 - (6) self-development
 - (7) other needs



ATTACHMENT 7: CRT Special Services Funding Request

COMMUNITY REHABILITATION & TREATMENT SERVICES (CRT) SPECIAL SERVICES FUNDING REQUEST

Special Services Funding is requested for needs and/or services necessary and supporting the approved Individual Plan of Care (IPC) for the following **enrolled CRT client**.

Client Name (full): _____

Date of Birth _____ Social Security Number _____

Agency _____

Diagnosis: DSM-IV Code _____ Diagnosis _____

Financial Status: No benefits SSI SSDI General Assist.
 Medicaid Medicare Other Insurance
 Other (specify) _____
 Applied for benefits (specify) _____ When? _____

Brief description of client: _____

Brief description of need and how it supports IPC: _____

Describe resources already explored: _____

Specific Request: \$ _____ For _____
 One-time cost Ongoing need (if ongoing, how will it be funded in the future?)

Has client received special funds previously? _____ If yes, when? _____

Name of person to contact with questions regarding this form: _____

Phone Number: _____

CRT Director's Name: _____

(Type or Print)

CRT Director's Signature: _____ Date: _____

ATTACHMENT 8: CRT Special Services Funding Authorization Invoice (Non-Dental)

CRT SPECIAL SERVICES FUNDING AUTHORIZATION/ INVOICE FORM (OTHER THAN DENTAL CARE)

Designated Agency _____

Client Initials _____

Services	Start Date	End Date	Cost
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL COST:			\$ _____

DESIGNATED AGENCY CERTIFICATION

I certify to the best of my knowledge and belief that these services are necessary as an extraordinary expense not covered by reimbursement through any other grant or contract.

Name of person to contact with questions regarding this form: _____

Phone Number : _____

Name of CRT Director: _____

(Type or Print)

Signature: _____ Date: _____

Phone Number: _____

THIS SPACE FOR DEPARTMENT OF MENTAL HEALTH AUTHORIZATION

Total payment Amount Approved: \$ _____

Authorized by: _____ Date: _____

(Signature)

(Title)