

Interim Certification Process for CT MRO Providers



Agenda



- Why MHRS Certification?
- Application Process
- Certification Requirements
- Next Steps

Background

- Federal Medicaid regulations require that *any willing and qualified* provider can deliver Medicaid services.
- In CT, the path to determining which providers are qualified is done through a certification process.
- Any provider that applies for and meets certification standards will be able to deliver and bill Medicaid for that service. Being certified does NOT guarantee DMHAS funding.
- DMHAS will use the same certification standards for grant-supported rehabilitation services – one system regardless of benefit package.

Interim Certification

- DMHAS is using an interim certification process prior to the actual transition to Medicaid billing. Goals include:
 - Field test of certification standards
 - Provider planning opportunity for eventual transition
 - Clarity of probable initial provider base for services – identification of gaps
- Continues to reinforce the movement of the service system to a recovery orientation

Overview of Process

- Today: training on the standards and the process
- November through January 24: Providers develop plans for how they will meet the certification standards; complete certification applications; Assistance available in planning.
- January-February: Certification application review.
- Post-February: Assistance to providers in preparing for MRO implementation.

If you need help with process:

- For affiliates of state-operated LMHA's, contact your main contact person from the LMHA or network.
- For PNP LMHAs, or affiliates of PNP LMHAs, contact Dan Olshansky.
- Dan.Olshansky@po.state.ct.us

Interim Applications

- Providers are not currently doing the requirements for MRO certification, so cannot be judged on current operations.
- Therefore, applications asks providers to develop plans that indicate how they will meet the standards, how they make the transition, and what resources they will need.

Interim Applications

- Application Packets for Core and Specialty Providers
- Require specific information such as insurance, staffing, licenses, etc.
- Require development & submission of plans outlining how agency will meet the standards.

MH Group Homes

- Not being included in this Interim Certification Process.
- FUTURE: Residential Rehab in Group Homes will be incorporated into Certification Package so that all MRO services are certified together. May be delivered by Core or Specialty Provider.

Provider Types

- Core Providers
 - Clinical home
 - Must have national accreditation
 - Clinical services: med management, diagnosis, treatment planning, counseling
 - Community Support Team
 - Crisis response capability
- Specialty Provider
 - Community Support Team

Two Services Included

- Assertive Community Treatment
 - Available to Core provider
- Community Support Team
 - All Core Providers Must Include
 - Specialty providers may offer

Consumer Choice

- All clients receiving MHRS shall have free choice of DMHAS-certified MHRS providers.
- Affirmative responsibility to inform client of choices, inform them of providers that offer the service, and encourage them to make a choice.
- Core and Specialty providers must have Consumer Choice policies.

Core Provider Requirements

Core Providers

- Serve as the clinical home for all clients involved in MHRS.
 - Thus, each client will have a designated Clinical Home/Core Provider.
 - May be an LMHA or another provider that meets the qualifications.

Minimum Requirements

- Accredited
- On staff, have the direct capacity to provide:
 - Diagnosis by a Licensed Practitioner of the Healing Arts (LPHA)
 - Comprehensive Assessment, including biopsychosocial, psychiatric, addictions, and functional abilities
 - Master treatment planning
 - Master treatment plan coordination, monitoring, review and updating in coordination with all providers delivering service and in accordance with the client's recovery goals.
 - Psychiatric medication assessment, prescription, and ongoing medication management.
 - Counseling and/or psychotherapy.
 - Community Support Team.
 - Either directly or through contract, access to a clinician for review of any crisis on a 24 hour, 7-day a week, and 365-day a year basis to enrolled clients. Ability to link with ACT and CST providers.

Minimum Requirements - 2

- Participating Medicaid provider in good standing in the State of Connecticut.
- Meet timelines for treatment planning, assessment, and authorizations both internally and externally
- Enter into affiliation agreements with specialty providers
- Have a primary contact person for each enrolled consumer
- Maintain listings and data as required by DMHAS

Core Provider Staffing

- A Medical Director who is a board-certified or board-eligible psychiatrist.
- Clinical Director who is licensed.
- All staffing for individual services.

Core: Service Accessibility

- Accessible business hours
- Same-day assessments for urgent situations
- Assessments within 7 days for routine situations
- Appointments for MTP updates NO LATER than 2 weeks prior to expiration
- Updated MTP sent to Specialty provider no later than due date.

Specialty Providers

Specialty Minimum Requirements

- Accredited OR meet additional requirements in Appendix B.
- Ability to contribute to and/or coordinate treatment planning with the Core Provider, develop specialty service-specific objectives with the client, use functional assessment and other appropriate tools and assist in building client-centered specialty-service objectives and interventions.
- Affiliation Agreements

Specialty Staffing

- A Clinical Director who is a licensed clinician with overall responsibility for oversight of the MHRS program of the specialty provider.
- The Clinical Director may also serve as the CST Leader if there is only one CST and one MHRS service provided by the Specialty provider AND the team leader is a licensed clinician.
- All staffing for individual services.

Requirements for Both

Required of Both

- Coordination with Other Providers
 - Central Communication & Coordination Link.
 - Treatment Planning Collaboration.
- Annual financial audit
- Affiliation Agreements
- Clinical Management & Information System

Required of Both - 2

- Recovery Competence Plan
- Cultural and Language Competence
- Consumer Protections
- Insurance coverage
- Billing & payment
- Sliding Fee Scale
- Corporate Compliance Program
- Records Retention

Treatment Planning

Recovery Plan

Each client's Recovery Plan shall consist of their Master Treatment Plan and a Rehabilitation Plan that includes details about service-specific objectives, interventions, and plans that support the attainment of the MTP goals, and anything else the client incorporates to support their recovery

Treatment Planning

- Core Provider has the overall responsibility for developing, reviewing, and maintaining each enrolled client's Master Treatment Plan in conjunction with the client.
- Specialty Providers are responsible for working with the client to expand the goals on the Master Treatment Plan into a service-specific rehabilitation plan.

Master Treatment Plan

- Built by Core Provider with Consumer
- Based on a Diagnostic Assessment that includes functional assessment
- Serves as "order" for MHRS Services
- Reviewed and updated every 90-days

Rehabilitation Plan

- Every MHRS client will have a rehab plan that addresses one of the MHRS services.
- If the Core agency is also delivering the services, the Rehab Plan and the MTP may be the same
- For clients receiving services from both a Core and Specialty Organization, there may be both a MTP and a Rehabilitation Plan

Documentation

- Medical Record meeting HIPAA privacy requirements
- ACT and CST both require encounter notes for each encounter
- Monthly progress notes summarize client progress toward goals & objectives and are signed by ACT or CST Team leader.

Assertive Community Treatment

General Requirements

- ACT must be at Core Agency
- An individual may receive ACT services from only one ACT provider at a time.
- ACT is a comprehensive team intervention and most other Medicaid, DMHAS, and SAGA services are excluded. However, Opioid Treatment can be provided concurrently with ACT.

General Requirements

- ACT operates at least 12 hours per day M-F. Provides at least 8 hours of direct service each weekend day or holiday. Team member on call for all other hours.
- ACT team members are expected to provide the primary point of coordination for crisis response to ACT recipients

General Requirements

- 60% of all staff contacts must be face-to-face with the ACT clients. Remaining time may be phone or collateral. At least 75% of all team contacts occur out of the office. On average, at least three face-to face contacts per week are provided for ACT clients.
- Services may be delivered by a single team member to two ACT clients at the same time if their goals are compatible

General Requirements: Groups

- The only scenario in which ACT may be offered to *more than* two people is when a curriculum-based therapeutic group is offered (such as DBT, Trauma, IDDT groups).
- Must be an identified cohort of ACT participants whose clinical needs and recovery goals justify intervention by staff trained in the implementation of a specific curriculum-based method. The group may be offered to no more than eight ACT participants at one time and must be directed by no fewer than two ACT staff in order to be billed as ACT. This may be offered no more than two hours in any given week.

ACT Staffing

- FT Team Leader – licensed
- Psychiatrist works 8 hours/week for every 25 ACT clients
- FT Nurse
- Master's level clinician
- Recovery Specialists (voc, peer, co-occurring)
- FT Administrative Support
- RATIO of 1:10 (excluding clerk and MD)

Community Support Team

General Requirements

- Core Provider or Specialty Provider with affiliation agreement with Core Provider
- Occurs during times and locations that reasonably accommodate the individual's needs for services in community locations and other natural settings, and at hours that do not interfere with the individual's work, educational, and other community activities

General Requirements

- An individual may receive Community Support services from only one provider at a time.
 - Exception for Specialty-Core
- 60% of all billable community support contacts must be face-to-face
- 60% of all community support services must be outside of the agency, in community settings.

Staffing

- Team Leader can be any of the following:
 - A licensed or licensed-eligible mental health professional (see definitions at end); OR
 - A person with a Master's degree in a behavioral health area and two years of mental health experience; OR
 - A person with a Master's degree in a behavioral health area and certification for USPRA; OR
 - A person with a Master's degree in a behavioral health area and a CADC.

CST Staff shall hold either:

- a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR
- have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR
- be a Certified Peer Specialist.

CS Staffing

- Community Support services are provided by a team of staff that is responsible for an assigned group of individuals.
- Each individual must have a clearly identified primary community support staff member who is responsible for coordinating and monitoring the treatment plan with the individual, the community support team, and with other providers.
- Services are delivered under the supervision of a licensed professional (see definitions at end) who may be the team leader or a member of the team.

Non-Accredited Specialty Providers

- Appendix B Contains additional requirements including:
 - Medical Records
 - Credentialing
 - Business Practices
 - HR Practices
 - Finance
 - Quality Improvement and More

Next Steps

- Most current Interim Certification Standards will be on website.
- Agencies should institute an internal planning process to:
 - Determine what kind of provider certification
 - Determine which services
 - Develop a plan for meeting the standards including a transition plan
- Submit a letter of intent BY NOVEMBER 20, 2006
- Agencies submit interim certification applications

Some More Thoughts . . .



- Certification looks at the infrastructure and general planning to deliver services. It does not look at how or how well services are provided. Those will be covered in the implementation training, TA, and resources.
- Be real. Use plain English. Say what you really think you will do. This is a planning process for both DMHAS and the providers. The more concrete we all are, the easier it will be to see where we need help and to help.