

FAQ's from MRO Meetings, version 11-15-06

| Type of Issue | Questions   | Answers  |
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| Certification | Accreditation is for specific services and there is nothing that states that the credentialing is for the Rehab Option. How does this fit with the Certification process? | In the accreditation process of a program, the basic policies and procedures of an agency or facility are reviewed. An agency that has CARF or JCAHO accreditation should therefore have the components required as part of the certification process. |
| Certification | Can any Provider provide ACT services?  | No, only Core Providers can provide ACT, but Core Providers do not need to provide ACT.  |
| Certification | Can Core providers use existing crisis teams to provide the 24 hour overlap, or do they have to purchase the service?   | The Certification document specifies the need to providers to have crisis coverage; it does not specify the business relationship for this coverage.   |
| Certification | Can individuals be Rehab Certified?   | No. It is an agency that is certified. DMHAS will not be certifying individual clinicians.   |
| Certification | Can providers join together to meet a specific certification requirement?   | Yes  |
| Certification | Do agencies need to submit one application per program?   | No, applications need only be one per agency, not per program.   |
| Certification | Do Specialty Providers need to have National Accreditation, such as JCAHO?  | No, they can meet the accreditation requirements through other documentation.  |
| Certification | Do State-operated also need to do the certification process?  | Yes  |
| Certification | Does CARF credential for rehab services?  | CARF accreditation for any service will meet certification standards.  |
| Certification | How can we meet the requirements for intake and urgent appointments based on current staffing?  | This will require operational changes by agencies so they can meet the requirements.   |
| Certification | How do we complete the application if there are no specialty providers with whom we do business?  | DMHAS will contact providers if there are other providers who have submitted letters of intent.  |
| Certification | How do we meet the various requirements of the Medicaid MRO if we cannot go beyond the 18% overhead program?  | This will be a struggle for many agencies, but it remains a requirement based on the various regulations.  |
| Certification | How long can a program go without meeting staffing standards and still be certified?  | Vacancies are expected to be met within reasonable time periods; Agencies will be expected to show diligence in maintaining staffing expectations.   |
| Certification | How long does interim certification last?   | It lasts until the final certification occurs.   |
| Certification | If a provider is certified to provide CS, do they have to provide the service?  | No.  |

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| Certification | Are the certification requirements for intake times for just Medicaid clients or all clients served by a given program?   | This will affect the business practices for all clients at the provider.  |
| Certification | Some of the Rehab Option standards are less than the Medicare standards, is that ok?  | Yes. Different payers often have different requirements. Agencies that are used to meeting Medicare requirements should have little difficulty meeting Medicaid requirements for Rehab Options. |
| Certification | Why are the service expectations for clients so low, especially for CS?   | The service expectations for clients are minimums. The assumption is that actual client intervention will generally be greater than those minimum figures.                                      |
| Certification | Does the provision for crisis capacity require a financial contract with another provider?  | It can be a MOU, legal contract, or other mechanism that provides the necessary coverage.   |
| Certification | What are the consequences if a provider does not see a provider within 7 days, especially if the Core provider has to see the provider before the Specialty provider? |   |
| Certification | What is the expectation to be able to see new clients when an agency is above a certain capacity?   | If the agency cannot see new clients, they need to refer immediately to another provider.   |
| Certification | Where can I view the ACT standards?   | They are on the DMHAS web site at the following URL: <a href="http://www.dmhas.state.ct.us/medicaid/ACT.htm">http://www.dmhas.state.ct.us/medicaid/ACT.htm</a>                                  |
| Certification | Where do I get or obtain affiliation agreements with other agencies?  | DMHAS will provide some templates of Affiliation Agreements as samples. Agencies can use these or develop their own documents.  |
| Certification | Where do the specifications for ACT come from?  | The ACT specifications are based on the standards from the Technical Assistance Program on ACT, housed at NAMI.   |
| Certification | Where do the urgent and routine appointment timelines come from?  | These are standards that have been adopted by managed care and other States for these types of services.  |
| Certification | Who defines what is an urgent, emergency, or routine appointment?   | These are defined by the agency's own policies. These definitions should be in alignment with DMHAS, DPH and other requirements.  |
| Certification | Whom do I call for help with Certification questions?   | For affiliates of LMHA's, contact your usual contact at LMHA. For PNP-LMHA's and State-operated, Dan Olshansky is contact person.   |

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| Certification  | Why can some types of licensed clinicians oversee Teams but not sign the Master Treatment Plan (MTP)?  | The authority to sign the MTP is dictated by a particular State's statutes regarding who qualifies as a Licensed Practitioner of the Healing Arts (LPHA). Medicaid regulations require a LPHA sign the MTP. DMHAS can be more inclusive in allowing additional licensed clinicians to oversee treatment teams. |
| Certification  | Will supportive housing programs be included under the Rehab Option project?   | It will be a case-by-case basis.   |
| Certification  | What are the requirements for appointments for Specialty programs? Are they the same as for Core Providers?  | They were omitted. Watch the future rendition of Standards.  |
| Miscellaneous  | Could there be more flexibility in allowing licensed clinicians, who have been licensed in other States, to be licensed in CT?                       | Clinicians can apply for reciprocity for licensing in Connecticut now.   |
| Miscellaneous  | Will there still be case management programs funded by DMHAS?  | Yes, several program types will continue that are not under Rehab Option service system. The billing of TCM is still a question.   |
| System of Care | Are LMHA's required to provide services to clients in their catchment area?  | Yes, as DMHAS and the Federal Government requires coverage for everyone. Additionally, it does not lessen the safety net function of LMHA's.   |
| System of Care | Can a client go to a private psychiatrist and get an assessment and treatment plan from a Core provider? If so, does this create duplicate services? | It would not be duplicate services as only a DMHAS certified provider can order or provide ACT or CS services. These services cannot be duplicated between providers.  |
| System of Care | Can business affiliations between Core and Specialty providers be a MOU or does it need to be a contract?  | It can be an MOU.  |
| System of Care | Can there be more than one Core provider in a catchment area?  | Yes  |
| System of Care | Do specialty provider programs that work with a Core Provider have to have Medicaid certification.   | Yes  |
| System of Care | How do we coordinate services when providers are geographically diverse?   | Through the Affiliation Agreements, agencies will develop their relationships and methods of coordination of services. Agencies will decide on the geographic limits of their collaboration due to the logistical issues of coordinating care over long distances.   |
| System of Care | How will a given provider know who the other providers   | There will be rosters of provider agencies that will clarify this on   |

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|                | are?  | the DMHAS web site.   |
| System of Care | If a client from another catchment area takes non-reimbursed services, those services do not follow the client. At some point, will they follow the client? | At present, contract dollars will not follow clients from other catchment areas. This is not thought to be necessary due to most clients still being served in the same catchment area as their grant dollars. This phenomenon will be reviewed as the MRO is rolled out. |
| System of Care | If we are a Core Provider, can we serve clients who are part of another Core provider?  | Yes, an agency can provide specialty services for clients who have their clinical home with another provider.   |
| System of Care | Is it just specialty providers with whom you need to have affiliation agreements or Core providers too?   | It is both, as CS can occur with Core providers.  |
| System of Care | What does a program do if a client does not want information to be shared with an affiliate?  | In some cases, this will prohibit the ability of a specialty provider from being able to provide care to a client. For instance, if a Core and Specialty provider cannot collaborate on treatment planning, the Specialty provider cannot be reimbursed for the care.     |
| System of Care | What if some providers of a client's are not DMHAS providers? Can they still serve the client?  | It is the same as now. Other, non-DMHAS providers can and do provide care.  |
| System of Care | What if the current clinical provider does not apply to become a provider in the new system?  | Providers of ACT and most Case Management services are required to convert to the new programmatic model in order to provide these services. If they do not, they are not eligible for grant dollars for these particular services.                                       |
| System of Care | What is the incentive for a LMHA to work with affiliates?   | DMHAS has a value in maintaining a range of providers in both geography and size. Consumers may choose to work with specialty providers and so LMHA's will need to work with them.  |
| System of Care | What is the relationship between the Master Treatment Plan to the treatment plan for the specialty provider?  | The Master Treatment plan is the medical order for the specialty provider's services. The specialty provider should develop specific Rehab goals based on the goals of the Master Treatment Plan.   |
| System of Care | Will access standards be aligned with other parts of the state system, especially those of the BHP?   | That will be explored.  |
| System of Care | Will the MRO change the guarantee of client referrals as  | Due to client choice, clients may go out of catchment for   |

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|                   | dictated by the catchment area?   | services. Experiences with other States show that clients typically do not change providers early in the process.  |
| System of Care    | Will there still be catchment areas for client care? Can agencies choose to not serve a client if the client does not live nearby and there are clinical and logistical issues for serving the clients?                                       | Essentially no, clients have the right to obtain client care wherever they choose. However, agencies may have policies that limit the distance they will reasonably travel to serve clients. |
| Technical-Billing | Are calculations for face-to-face contacts for ACT based on actual visits or attempts at visits?  | They are based on actual visits. It is understood that during certain phases of treatment, especially during engagement, that visits may be lower than the standards.                        |
| Technical-Billing | Are there different rates for ACT?  | We expect that ACT will bill one integrated rate for all services by all ACT staff. The exceptions will be for group services.   |
| Technical-Billing | Because Medicaid and Medicare regulations are different, it allows for agencies to have different sign-off processes for Treatment plans. Doesn't this create potential confusion if agencies adopt different methods for treatment planning? | It could create confusion, but it also allows greater flexibility in allowing other licensed clinicians to sign the treatment plans.   |
| Technical-Billing | Can a Provider have a licensed clinician oversee and signoff for another non-licensed clinician on an assessment?   | Diagnostic Assessments are not MRO services, so need to be conducted in alignment with the regulations of the payor for those services.  |
| Technical-Billing | Can different agencies bill for CS with a client for the same time period, such as at a treatment-planning meeting?   | Only one claim can be submitted for a specific time period.  |
| Technical-Billing | Do crisis clinicians have to be licensed?   | It is not required as part of the Medicaid Rehab model. However, other regulations may require it.   |
| Technical-Billing | Do rehab services allow for multiple services in the same day, as opposed to Clinic Services?   | Yes. The services for a given day may have to be rolled up into one service record. This will be determined later.   |
| Technical-Billing | Does upload of data still need to specify the Program the client is admitted to? This requires collecting billable information in an episode of care. Non-behavioral health Billing systems typically do not collect data in this manner.     | The program designation for a client is important to maintain for the collecting the grant-related services and dollars associated with non-MRO services.                                    |
| Technical-Billing | Have do we handle TCM and MRO billing?  | We expect that clients receiving MRO services will not also be   |

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|                   |  | receiving TCM services.  |
| Technical-Billing | How do State-operated agencies handle sliding fee scales?  | TBD  |
| Technical-Billing | If an overseeing agency found in an audit that there was a lack of compliance with billing requirements, what would the consequences be?   | It could be a range from corrective action planning to paybacks to referral for further investigation, depending on the extent of the problem.         |
| Technical-Billing | If the Core Provider does not meet the documentation requirements for billing, can a Core or Specialty provider bill the DMHAS contract for services?  | No. Grant dollars are for non-reimbursed services and non-insured clients. They are not for billing deficiencies.                                      |
| Technical-Billing | Is Case Management the same as the Community Support program?  | No, they represent different services with different assessment, treatment plan, and clinical services. CS is oriented to skill building with clients. |
| Technical-Billing | Is there an expectation that ACT is time limited?  | The expectation is that clients can be transitioned to a lesser level of services over time.   |
| Technical-Billing | There is TCM billing in Supported Housing Program. What type of billing should occur with the 9 demonstration projects that are treated differently than the other supported housing programs? | TBD  |
| Technical-Billing | There was a request to have one process for authorization for all Medicaid clients, for those that are receiving Community Support Program or those funded under the Clinic option.            | To be explored.  |
| Technical-Billing | Under Medicare, APRN's cannot write Treatment Plans. Under Medicaid, they can. Why the difference?   | There are different requirements for Medicaid versus Medicare.   |
| Technical-Billing | What are the codes for billing for groups? Are there other special codes needed for provider agencies?   | Billing codes will be addressed in specific billing training closer to the time of implementation.   |
| Technical-Billing | What are the location codes for client care? How do you code for work in the community versus in office, and work with collaterals?  | Billing codes will be addressed in specific billing training closer to the time of implementation.   |
| Technical-Billing | What are the needed data elements for both DPAS and the Rehab Option?  | These data elements have not been defined yet. Agencies will be given many months to comply with data requirements.                                    |
| Technical-Billing | What are the units for billing?  | We anticipate 15 minute units.   |
| Technical-Billing | What information changes have to occur with BHIS and   | A committee will be established to help identify the issues and  |

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|                   | state-operated?   | aid in this process.  |
| Technical-Billing | What is the format for the data if it is submitted to DMHAS?  | The format for data submission to DMHAS has not been determined.  |
| Technical-Billing | What is the interface with TCM and Rehab Option training and can clients be involved in both services?  | At present, clients cannot have ACT and CS at the same time they have TCM services. These are mutually exclusive services.  |
| Technical-Billing | What is the requirement for record retention for Medical Records under Rehab Option?  | <p>From the “State Agencies’ Retention/Disposition Schedule S4: HEALTH INFORMATION MANAGEMENT RECORDS AND CASE FILES” under section S4-145, it states that “Free-standing mental health day treatment facilities, intermediate treatment facilities, psychiatric outpatient clinics for adults and case management, and community liaison services” should retain their records for 7 years after termination or closure of case.</p> <p>In-patient and institutional record retention is for 25 years, as noted in S4-185.</p> |
| Technical-Billing | When there are dually insured clients (Medicare and Medicaid), receiving Rehab Option services, does the bill have to go to Medicare before it can be billed to Medicaid? | No, as Medicare does not pay for Rehab Option services, the bill can go directly to Medicaid.   |
| Technical-Billing | When will we know the rates for ACT and CSP? There is a concern about how many clinicians the rate will support.  | Several steps have to occur before this is known. A State Plan Amendment has to be submitted and accepted by the Federal Government.  |
| Technical-Billing | Why do agencies need a sliding fee scale?   | Medicaid requires that it not be charged more than other payers for the same service. Thus, all services must have a fee. To reduce the liability for clients, a sliding fee scale can be used.   |
| Technical-Billing | Will data go to DMHAS, to ASO, or both?   | The process for submission of data has not yet been determined.   |
| Technical-Billing | Will there be caps on the amount of services a provider can provide?  | There are no specific service caps. However, services are authorized and may be limited through the UM process. Lastly,   |

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|                         |  | services should always follow medical necessity based on the assessment and treatment plan.  |
| Technical-Billing       | With sliding fee scales, do the fees contribute to the 'spend-down'?   | Yes  |
| Technical-Documentation | Can the Master Treatment plan be the same as the authorization plan and process?   | TBD  |
| Technical-Documentation | Can there be one integrated treatment plan that incorporates the client's recovery plan?                                 | Yes.   |
| Technical-Documentation | Does staff have to be credentialed to write encounter notes?   | Yes, they are credentialed by the agency as part of the program.   |
| Technical-Documentation | Does client need to sign Tx plan in order to be able to bill?  | No, but a note explaining the lack of a signature and the attempt to obtain a client signature is required.  |
| Technical-Documentation | How are assessments different for MRO?   | The assessment for MRO has to include functional assessment that is not usually part of a typical clinical assessment.   |
| Technical-Documentation | What are the specific details of the Functional Assessment? How do I get involved in creating the Functional Assessment? | The specific elements of the Functional Assessment have not been developed. Sue Graham from DMHAS will be organizing a team to develop the functional assessment. She can be reached at <a href="mailto:Susan.Graham@po.state.ct.us">Susan.Graham@po.state.ct.us</a> . |
| Technical-Documentation | How do you create a treatment plan when the client's goals are different than the providers?                             | This issue will be addressed in future discussions with providers.   |
| Technical-Documentation | Is the monthly progress note redundant with the Treatment Plan?  | No, it represents the progress toward to goals as stated in the treatment plan. There should be overlap between the two.   |
| Technical-Documentation | Should the Rehab Tx Plan be reviewed every 90 days as the Master Treatment Plan?   | Yes  |
| Technical-Documentation | What is the detail of the functional assessment? How much detail has to be there?  | This will be determined.   |
| Technical-Documentation | Who signs off on the Master Treatment Plan for the agency?   | It has to be an LPHA. An LPC could sign off the Rehab Plan.  |