

Connecting With Medicaid: Strategies and Options for Providers of Services to People who are Homeless



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Linking people who are homeless to Medicaid – the health insurance program for low-income Americans – has become an increasingly important federal priority. The U.S. Interagency Council on Homelessness recently stated that Medicaid is the “secret weapon in the fight against homelessness.”ⁱ Specifically, the case management, substance use, mental health, and primary health care services covered by Medicaid can play a critical role in helping many people who are homeless regain stability, both physical and residential.ⁱⁱ

With the enactment of the Affordable Care Act (ACA) in 2010, changes to the Medicaid program will increase the value of this resource in meeting the health and behavioral health needs of people who are homeless and those people at risk of homelessness (see box). As a result of these changes, organizations who work with people who are homeless may be interested in providing Medicaid covered services such as case management, Assertive Community Treatment (ACT), or supported employment; but are not current Medicaid providers and are daunted by the process or are not sure where to start. Other organizations may not want to directly provide Medicaid services, but are interested in identifying concrete strategies for connecting people who are homeless with the services and supports offered by Medicaid. This brief will summarize various options for providers interested in establishing clearer pathways or connections with Medicaid, including key questions to consider for providers interested in delivering Medicaid services.

As a result of health care reform, Medicaid eligibility will be broadened to include more low-income individuals. As of January 2014, states will be required to cover single adults under 65 with incomes up to 138% of the federal poverty level (approximately \$14,400 per year or 32% of the area median income in 2010) through their Medicaid program.

This is the second in a series of briefs developed by the Technical Assistance Collaborative, Inc. (TAC) intended to assist advocates who work on behalf of people who are homeless, providers, and policy makers understand and capitalize upon opportunities in the ACA to prevent and end homelessness.

OPTION 1: **BECOMING A MEDICAID PROVIDER**

Becoming an established Medicaid provider can seem like an intimidating process and many organizations are unsure of where to begin. Medicaid is a complex program with a myriad of rules and regulations that can be difficult to navigate. A good place to start is by learning about the Medicaid program in your state. While the federal government shares in the cost of each state’s Medicaid program and sets general guidelines that state’s must follow, states have broad discretion about what services are covered, who can deliver

those services, and who is eligible.ⁱⁱⁱ This is why the Medicaid program in Florida looks very different from the Medicaid program in Oregon. At the most basic level, you can see this state-to-state variation reflected in the names of the Medicaid program across the country; some states refer to it as, Medical Assistance (MA), some call it simply Medicaid, while others have unique names: TennCare (Tennessee), MassHealth (Massachusetts), SoonerCare (Oklahoma), and Medi-Cal (California).

Structural Elements

There are some key features of your state's Medicaid program that are important to understand. First, find out about the *structure* of the Medicaid delivery system in your state. Most states have multiple service delivery systems that include both traditional Medicaid fee-for-service systems and managed care. In fee-for-service Medicaid, providers are reimbursed for the services they provide directly by the state. In managed care systems, providers must become part of the provider network for that managed care company(s) in order to receive reimbursement for services they provide. The state of Alaska for example does not operate a Medicaid managed care system. Providers in Alaska who want to

deliver Medicaid covered services apply directly to the state's Medicaid agency to become a provider and receive reimbursement directly from the state. Ohio (as is the case in most states) has both managed care and traditional fee-for-service delivery systems. In this scenario, providers (who meet the qualifications for the service(s) they want to deliver -- see section on provider qualifications below) can be both a Medicaid fee-for-service provider and a managed care network provider or fee-for-service only or managed care only. This would mean that the provider would need to apply directly with the Medicaid agency and complete a separate application process for each managed care company for which they want to provide services.

To determine whether to pursue becoming a fee-for-service provider or a managed care provider or both, you should learn who is served through primarily (or only) through the fee-for-service system and who is served through managed care. Typically, different populations of Medicaid covered individuals are served through the fee for service structure and the managed care structure. Some states require certain populations such as low-income families with children to enroll in managed care. Other populations, such as people who are dually eligible for Medicare and Medicaid, are exempted from enrollment in managed care.

Medicaid Managed Care Enrollment Brokers

Some states use an “enrollment broker” to help people enroll in managed care. If your state uses an enrollment broker the website for this broker often provides very clear information about who can (and cannot) enroll in managed care. The website for the enrollment broker for the state of Illinois offers a good example of this:

<http://www.illinoisceb.com/whomust enroll.aspx>.

Depending on the population your organization serves (e.g. families experiencing homelessness, individual adults receiving SSI who are homeless, etc.) it might make sense to only pursue becoming a Medicaid managed care provider or only a fee-for-service provider. Typically the information about who is required to enroll in managed care and who is “exempt” can be found on the website of the state’s Medicaid agency. States sometimes also offer easily accessible statistics on the percentage of Medicaid beneficiaries covered by managed care and those who remain in fee-for-service. This information is sometimes useful to help you decide which delivery system in which you want to participate.

Learning about what services are provided primarily through managed care or fee-for-service will also help you decide whether to enroll as a fee-for-service or managed care provider or both. Some services might only be covered under managed care while others are only available through the traditional Medicaid fee-for-service system. For example, in many states Medicaid mental health and substance use benefits are “carved-out” of the traditional fee-for-service Medicaid program and covered through a managed behavioral healthcare organization (MBHO). Iowa has this type of arrangement for its Medicaid mental health benefits. In other states, like Rhode Island and Tennessee, there might be multiple managed care companies operating in a particular area, each with a separate process for becoming a network provider. The state Medicaid agency (and/or its contracted managed care enrollment broker) should have information on their website identifying the managed care organization(s) serving the state.^{iv}

State Medicaid agencies can also delegate operation of certain Medicaid benefits or programs to another state agency or to county governments. This is often the case for developmental disability services, behavioral health (mental health and substance use) benefits, and certain 1915(c) home and community-based services waiver programs. For example, in Pennsylvania, the state Medicaid agency delegates responsibility for administration of Medicaid mental health and substance use benefits to the state Office of Mental Health and Substance Abuse Services (OMHSAS). OMHSAS then negotiated contracts with 31 county governments to provide Medicaid behavioral health services at the local level.^v These county governments in turn each subcontract with a managed behavioral health organization to administer the behavioral health benefits for that county. So in this scenario, organizations interested in becoming a Medicaid provider of one or more behavioral health services in a particular county apply directly with the county’s contracted behavioral health organization.

Sound complicated? It can be. Often the most efficient way to learn about who to approach about becoming a Medicaid provider is to reach-out to a familiar provider in your area. As an established provider of Medicaid services they have successfully navigated the system and can tell you the best place to start.

Provider Qualifications

Regardless of the delivery system, all Medicaid services have requirements, sometimes referred to as “credentialing criteria” that describe the qualifications necessary to provide any given

Medicaid service. There are several places you can locate the provider qualifications for a service you want to provide. The provider qualifications for fee-for-service Medicaid providers are typically located in a state's Medicaid plan, a state's Medicaid provider manual, and/or in a state's regulations governing their Medicaid program. As you will see in the example from Virginia's Medicaid provider manual, often one of the requirements for providing Medicaid covered services is that the organization (and/or individual) providing a service must first be licensed or certified by another state entity (e.g. Department of Public Health, Department of Mental Health, etc.). It is often these licensing or certification requirements that are the biggest hurdle for some providers.

It is important to distinguish here the *provider type* (e.g. clinic, hospital, nursing home, individual provider, etc.) from the *practitioners* who can deliver the service (e.g. licensed social workers, physicians, nurses, etc.). Sometimes there are multiple provider types eligible to deliver a given Medicaid service. For example, in some states outpatient mental health therapy services can be provided by mental health professionals in a *licensed outpatient clinic* and by a *licensed individual* (in this case the acceptable *provider types* are outpatient facilities AND individual practitioners). Other times there might be only one allowed provider type (e.g. hospital) for a given service. In Virginia for example, providers of mental health case management must meet the qualifications outlined below. The *practitioners* who Licensed Case Management providers in Virginia can then hire to directly deliver the case management service in Virginia are located in the box below. Both the allowed provider type and

practitioner requirements are important to learn about for a particular service.

If your organization is interested in becoming a managed care provider you should contact the managed care company(s) in your area to learn about their provider credentialing process. In most cases, if you want to be a Medicaid managed care provider only you do not have to make a separate application to the state Medicaid agency, though you will still have to meet the provider qualifications they set (e.g. licensed mental health clinic). Sometimes the MCO will have additional criteria that a provider must meet in order to gain entry into that MCO's network. For example, a MCO might require that the organization be accredited by the Joint Commission or the Council on Accreditation (CoA) or carry a certain amount of malpractice insurance.

Infrastructure Requirements

In addition to the provider qualifications above, there are some other organizational infrastructure requirements for providers who want to deliver Medicaid reimbursable services. Providers must develop systems for billing, documentation, supervision of staff, monitoring quality of care, and measuring and monitoring staff productivity. These additional organizational competencies can sometimes be difficult to implement, especially for smaller organizations that do not have the resources to devote to developing these capacities. Again, talking with an established Medicaid provider will offer you a good sense of what is required in order to be a successful provider. The self-assessment found at the end of this document also provides some additional information about

Provider Qualifications for Medicaid Mental Health Case Management in Virginia

The mental health case management provider *must be a Community Services Board member and licensed by the Department of Behavioral Health and Development Services (DBHDS)*. To qualify as a provider of services through DMAS for Rehabilitative Mental Health Case Management for adults with serious mental illness and children and adolescents with serious emotional disturbance, the provider must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements;
- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;
- The services shall be in accordance with the *Virginia Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services*; and
- The provider must be licensed as a provider of Case Management Services by DBHDS.

In order to obtain this license the provider must complete the following steps:

1. Submit and receive preliminary approval of the Initial Provider Application [and required attachments].
2. Submit, receive approval of, and demonstrate knowledge of required licensing policies, procedures and forms.
3. Submit and receive approval of required Human Rights Policies and Procedures.
4. Affiliate with a Local Human Rights Committee, (LHRC).
5. Request the LHRC to approve their Human Rights Policies and Procedures.
6. Set up an account and request criminal history and central registry background investigations for identified staff as required by Virginia Code §37.2-405 and submit Child Protective Services reference checks.
7. Have an on-site review of the physical plant, to include interviews with applicants over the content of their service description and policies and procedures, as well as compliance with other regulations, and copies of forms and sample client and personnel records.

Only once the steps above have been completed can the provider apply to deliver Medicaid Mental Health Case Management. To view a copy of the application go to: https://www.virginiamedicaid.dmas.virginia.gov/wps/PA_VAPProviderServices/VAPdfRenderServlet?selectedCode=A41

Practitioner Qualifications Mental Health Case Management

Persons providing case management services must have knowledge of:

- Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;
- The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;
- Different types of assessments, including functional assessments, and their uses in service planning;
- Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;
- The service planning process and major components of a service plan;
- The use of medications in the care or treatment of the population served; and
- All applicable federal and state laws, regulations, and local ordinances.

Persons providing case management services must have skills in:

- Identifying and documenting an individual's needs for resources, services, and other supports;
- Using information from assessments, evaluations, observation, and interviews to develop ISPs;
- Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and
- Coordinating the provision of services by public and private providers.

Persons providing case management services must have abilities to:

- Work with team members, maintaining effective inter- and intra-agency working relationships;
- Work independently, performing position duties under general supervision; and
- Engage and sustain ongoing relationships with individuals receiving services.

selected organizational infrastructure requirements for Medicaid providers.

For organizations that remain interested in becoming a Medicaid provider, the steps outlined on page 8 will help your organization begin a self-assessment process to determine if becoming a Medicaid provider makes sense for your organization.

OPTION 2: SUBCONTRACTING WITH A MEDICAID PROVIDER

After reviewing the list of requirements, some providers might feel overwhelmed or discouraged about the prospect of becoming a Medicaid provider. For providers who want to deliver a service, but either are not eligible or do not have enough clients to develop and support the necessary infrastructure, subcontracting with an established Medicaid provider could be a viable option. This arrangement would allow an organization to deliver services without having to devote resources to developing a billing infrastructure for example, because billing would be done by the contracted provider. Under this type of arrangement an organization would still have to deliver the service in accordance with any established service requirements (see an example of this in Appendix B). It also does not waive requirements for the type of staff persons who can deliver a service (e.g. licensed social worker, nurse, etc.). However, subcontracting arrangements are often a good option for smaller organizations with experience in working with special or underserved populations. For example, an organization with expertise in working with people who are deaf or hard of hearing might have the expertise to provide

Medicaid reimbursable peer support services to people who are seriously mentally ill and also deaf; but otherwise might not meet the qualifications to be a Medicaid provider (e.g. the state requires the provider to be a community mental health center). Even if such a provider met the Medicaid provider qualifications, it is also unlikely that the small volume of clients that the organization could serve through this program could generate enough Medicaid billing revenue to develop the necessary infrastructure (e.g. billing, documentation, etc.). In this case, subcontracting with a Medicaid provider who has a contract to provide peer support services, would make it possible for the provider to deliver this service without directly becoming a Medicaid provider.

As part of its own health care reform efforts, Massachusetts provided multi-year grants to 51 community-based organizations including community-health centers, hospitals, and multi-service centers to hire outreach workers who offer education about health insurance, conduct outreach to potentially enrollees, and assist people with health insurance enrollment and re-enrollment. New York State operates a similar program where community-based organizations provide “facilitated enrollment” in the state’s health insurance programs for low-income persons including Medicaid.

OPTION 3: MAKING CONNECTIONS

Many organizations simply do not want to directly provide Medicaid services or might not have the necessary infrastructure or qualifications to do so. However, most organizations that work with people who are homeless recognize the important role Medicaid services play in addressing homelessness.

One option is to dedicate staff or other resources to facilitating people's enrollment in Medicaid. Some states offer grants to community-based organizations so they can hire staff people to conduct Medicaid outreach and enrollment activities (see box). Other states like Oklahoma, offer free trainings and technical assistance to community organizations who can then participate as "SoonerEnroll" partners. As a result of health care reform, there are likely to be a variety of new opportunities for community-based organizations and other groups who work with "hard-to-reach" populations, such as people who are homeless, to connect people with Medicaid. States are actively planning for and designing their health insurance

What is a Health Insurance Exchange?

The ACA requires states to establish a health insurance Exchange by 2014. An Exchange is a "virtual marketplace" where consumers can go to shop for approved health plans.

These Exchanges must also be coordinated with Medicaid to allow eligible people to apply for Medicaid through a state's Exchange.

Exchanges and activities related to the expansion of Medicaid, both slated for 2014. Learning about your state's plans for health insurance outreach and enrollment is critical to ensuring that the needs of persons who are homeless are considered in the design and development of these systems. More information about the expansion of the Medicaid program and its impact on people who are homeless can be found in TAC's first ACA issue brief: *How Healthcare Reform Strengthens Medicaid's Role in Ending and Preventing Homelessness: The Medicaid Eligibility Expansion*.

Supplemental Security Income (SSI) is often another pathway to Medicaid for people with disabilities, including people who are homeless. Several states have built capacity within the homeless service provider network to assist people with serious mental illness through the SSI determination process using the SSI/SSDI, Outreach, Access, and Recovery (SOAR) model.^{vi} Given the many benefits of SSI, including the potential for access to a more robust Medicaid benefit assisting people who are homeless with the SSI process is an important strategy for accessing Medicaid services. To learn more about SOAR in your state go to: <http://www.prainc.com/SOAR/default.asp>

CONCLUSION

The services and supports covered by Medicaid play a critical role in preventing and ending homelessness. Health care reform makes the benefits of Medicaid more accessible to many people who are homeless. There are a variety of strategies that can be utilized by homeless providers to connect homeless people to

Medicaid—from helping to facilitate enrollment in Medicaid to directly providing Medicaid services. The approach your organization ultimately selects will depend on a variety of factors including your organization’s mission, available resources, and

existing infrastructure. Regardless of the path you select, by helping people access the benefits of Medicaid, your organizations can also help people attain and sustain housing.

What is a benchmark plan?

The ACA only requires States to extend a “benchmark or benchmark equivalent plan” to the newly eligible “expansion” population. These benchmark plans may offer less robust coverage than a state’s traditional Medicaid plan; though fortunately mental health and substance use services must be included in a state’s benchmark plan. Certain groups of Medicaid eligible individuals cannot be required to enroll in a benchmark plan, including those people with disabilities. This is why in most states, pursuing enrollment in Medicaid through SSI for people who are homeless with serious disabilities will continue to be an important strategy for accessing the full-range of Medicaid benefits.

Self Assessment for Evaluating Organizational Capacity and Readiness to Become a Medicaid Provider

Step 1: Identify Those Services that are Covered by Medicaid in Your State

The first activity will be to clarify what services are currently covered by Medicaid in your state. You can locate this information in your state's "State Medicaid Plan". Each state that operates a Medicaid program must have a state plan that serves as a "master document" outlining the features and functioning of that state's Medicaid program. However, the state plan is not the only place to locate information about a state's covered services nor should it be your only source of information. This is because states do not always have their plan available online. Even when they do, the plan might not always be up-to-date and can be difficult to navigate. In states with Medicaid managed care, a managed care organization's provider manual and website, might offer more accessible information about benefits for Medicaid enrollees.^{vii} A state or county's Medicaid provider manual or regulations governing the operation of their Medicaid fee-for-service program, can also provide the necessary details about Medicaid covered services. These manuals can usually be found on the state Medicaid agency's website. The state of Florida's Medicaid provider manuals located at: http://www.baccinc.org/medi/Opening_Page.htm#allprovider offers a good example of this. Conducting interviews with existing Medicaid providers, Medicaid staff, or a local trade or advocacy organization (e.g. the National Association of Social Workers, the local chapter of the National Alliance on Mental Illness will also yield valuable information about a state's Medicaid covered services and benefits.

For each service you should gather the following information:

- **Who is eligible for the service?** Some services are only available to persons of a certain age (e.g., youth under 21) or gender (e.g., pregnant women). The clinical eligibility, sometimes referred to as the "medical necessity criteria" for a particular service is also important to learn about. Medical necessity criteria describe the characteristics or clinical features that a person must exhibit or have experienced in order to be eligible for a service (e.g. the person must have experienced multiple psychiatric hospitalizations). See Appendix A for a sample of the medical necessity criteria for Intensive In-Home Services in Virginia.
- **What are the necessary provider qualifications?** Is the service limited to providers in certain categories such as hospitals, licensed clinics, or community mental health centers? It is important to distinguish here the *provider type* (e.g. clinic, hospital, nursing home, etc.) from the *practitioners* who can deliver the service (e.g. licensed social workers, physicians, nurses, etc.). For a service such as

Targeted Case Management, eligible *providers* might be limited to those who are certified by a state's Departmental of Mental Health as a community mental health center (CMHC). The *practitioners* who the CMHC can then employ to deliver TCM services might then be further defined as those persons with a master's degree or above in a mental health related field. Both the allowed provider type and practitioner requirements are important to learn about for a particular service. In states with managed care, learning the requirements of the managed care organization (MCO) for becoming a provider of the service is also important. Sometimes the MCO will have additional criteria that a provider must meet in order to gain entry into that MCO's network. See the section on provider qualifications earlier in this document for a more in-depth description about provider qualification requirements.

- **Where can the service(s) be provided/delivered?** Some services can only be provided in a clinic or a hospital setting. Other services can be provided in homes and other community-based locations, such as shelters.
- **How must the service be performed?** Some states and Medicaid MCOs have created specific operational protocols or specifications that detail the particular activities that must be performed by the practitioners of a service, such as completing a diagnostic assessment or developing an individualized service plan. As mentioned earlier, there are some activities that providers of a Medicaid service must perform, while other activities are not permissible. Cross-walking these service descriptions with the activities performed by your organization will help you understand what adjustments will need to be made to how your organization currently delivers the service. See Appendix B for a description of the required activities for the Intensive In-Home Services in Virginia.
- **What is the current rate for the service and in what increments is the service billed (e.g. 15 minutes, per day, per hour, etc.)?** Knowing this information will help your organization develop a budget and business plan. It is important to note here that Medicaid managed care organizations set their own rates for the services they cover. If your organization is interested in contracting with more than one Medicaid managed care company, you should be aware that rates for the same service are likely to vary from company to company.

Step 2: Identify and Inventory Services Your Organization Offers

The next step is to crosswalk the services offered now by your organization with those that are reimbursable under Medicaid. In conducting this inventory of current services, you will need to clearly identify the various activities that are associated with each service. For example, if your organization provides "case management" services, what activities do staff perform as part of that service? Do they create a plan of care? Do they take people to doctor's appointments? Do they help people search for

housing? Understanding these components is critical because within a particular Medicaid service category there are some activities that must be performed. Under the Medicaid Targeted Case Management (TCM) option for example, case managers are required to perform certain activities, such as conducting an assessment to determine service needs and developing an individualized plan of care. There are also activities that *cannot* be performed. For example, some providers offer assistance with job search, employment coaching and support, and pre-vocational counseling. Some of these activities may be reimbursable, depending on your state's Medicaid plan; however, certain activities, such as teaching job specific skills, are never permissible under Medicaid.

Step 3: Learn about the Necessary Organizational Infrastructure

In addition to developing a picture of the Medicaid services and necessary provider characteristics, it is also important to learn about the associated activities and infrastructure that are required in order to successfully provide Medicaid services. Some organizations might need to make substantial adjustments to their operations and infrastructure in order to deliver Medicaid services. Some of these requirements include:

- **Record-keeping and service documentation:** All Medicaid providers must have a system (e.g. paper or electronic) for documenting Medicaid service activity. A state's Medicaid provider manual and/or regulations can provide you with the requirements for maintaining medical records (to see a copy of the documentation requirements for outpatient mental health and substance abuse services in Virginia go to:

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/psych/chapterIV_psy.pdf

All Medicaid providers are subject to audits by the state Medicaid authority as well any Medicaid managed care organizations you contract with. Providers that do not follow the requirements for maintaining these records are at risk of possible sanctions and/or re-payment.

- **Third-party billing:** For providers typically used to providing services under cost-reimbursement contracts or grant funding, learning how to bill Medicaid under a fee-for-service system can be challenging. Providers will need to have the necessary infrastructure and staff to: submit claims (sometimes to multiple Medicaid MCOs with different submission procedures); monitor service use against number of visits authorized or permitted; and manage and monitor staff productivity.
- **Insurance verification and eligibility monitoring:** In order for a provider to receive reimbursement for a Medicaid service, the individual who was the beneficiary of the service must

be eligible and enrolled in Medicaid at the time the service was delivered. Unfortunately it is common for people to lose their Medicaid eligibility or experience a temporary gap in coverage. Rhode Island's Medicaid agency recently reported that 1 in 4 Medicaid enrollees experienced a gap in coverage during a 12 month period.^{viii} Providers must develop systems for keeping track of the Medicaid eligibility of the people they serve or risk having claims denied and money lost.

- **Quality management and compliance monitoring:** Medicaid providers must have strategies for monitoring the quality of services they deliver. Medicaid managed care organization's contracts with providers contain provisions related to quality. Some require providers to collect and report data on a client's clinical functioning using standardized outcomes tools, or conduct regular client satisfaction surveys. In addition, due to the high risk of sanctions or financial penalties resulting from inadequate documentation, providers must devote resources to reviewing client records and training staff on proper billing and documentation procedures. In fact, under health care reform, as a condition of enrollment in the Medicaid program, providers must develop a compliance program

Step 4: Next Steps

If after reading this document and performing this self-assessment, your organization still wants to pursue becoming a provider of Medicaid services you should:

- Develop a leadership team at your organization who will help you prepare applications, compile information, get ready for site visits, and identify and plan for any necessary structural or personnel changes. This group should also serve as champions of your effort. It is not too early to begin talking with management and other employees about why (e.g. the vision and purpose) your organization is pursuing becoming a Medicaid provider and helping them prepare for upcoming changes to the workplace.
- Obtain copies of any necessary licensing applications or provider enrollment packets. These should be used as a guide to help you develop a work plan. You should also contact your Medicaid agency to see if there are any information sessions or readiness materials. Most Medicaid agencies operate a Provider Services Center that is available to assist providers with questions.
- If you intend to pursue becoming a Medicaid managed care provider, contact the managed care company(s) to learn about their credentialing and application processes.

Appendix A:

Medical Necessity Criteria for Intensive In-Home Services in Virginia

Members of Intensive In-Home (IIH) Services must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the client's functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Individuals must demonstrate a clinical necessity arising from a **severe** condition due to **mental, behavioral, or emotional illness** that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community; and/or
2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; and/or
3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example is at risk for acting out in such a fashion that will cause harm to themselves or others.

Services shall be used when there is a risk of out-of-home placement, due to the clinical needs of the child, and either:

1. Services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or
2. The child's residence, as the setting for services, is more likely to be successful than a clinic.

With respect to both 1 and 2, the IIH assessment must describe how services in the child's residence are more likely to be successful than an outpatient clinic

Appendix B:

Required Activities for Intensive In-Home Services in Virginia

Prior to admission, a face-to-face assessment must be conducted and documented. A LMHP or a license-eligible mental health professional must perform the assessment. If a license-eligible professional performs the assessment, the assessment must be reviewed with the LMHP within one business day of conducting the assessment to collaboratively determine the client's diagnosis. The assessment must be conducted in the beneficiary's home unless there is documented safety or privacy issue. Providers must include within their assessment documentation of specific assessment item justifying medical necessity for recipients to receive IIH treatment. The assessment must list assessments completed in the 6 months prior to the IIH assessment (i.e. psychological testing, psychiatric evaluations, FAPT team referrals and CSB involvement). The assessment must also indicate the specifics of how the child meets the service eligibility criteria, is at risk an out of home placement related to their behavioral health issues, and that service needs can best be met through intensive in-home services. The IIH assessment must list treatments that have been tried or explored within the last 30 days. The assessment (H0031) must include the items specified by DMAS.

Assessment Items for DMAS Reimbursed Intensive In-Home:

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms. Identify precipitating events/stressors, relevant history.) If child is at risk of out of home placement, state specific reason.

2. Mental Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses, including the types of interventions that have been provided to the member. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past.

3. Medical Profile: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. As needed, an Individualized Fall Risk Assessment: Does client have any physical conditions or other impairments that put her/him at risk for falling for children 10 years or younger, the risk should be greater than that of other children the same age.

4. Developmental History: Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. Educational/Vocational Status: School, grade, special ed. /IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships.
6. Current Living Situation and Family History and Relationships: Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning list all family members.
7. Legal Status: Indicate client's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations
8. Drug and Alcohol Profile: Substance use / abuse of client / family members. Type of Substance, Frequency/Duration
9. Resources and Strengths: Verbalize member's strengths. Extracurricular activities, church, extended family
10. Mental Status Profile
11. Diagnosis: Diagnosis- Includes DSM-IV Code & Description—Diagnosis must be made by an LMHP.
12. Professional Assessment Summary/ Clinical Formulation: Documentation of the need for services.
13. Recommended Treatment Goals

An ISP must be completed by the QMHP within 30 days of the initiation of services and must document the need for services. The ISP will demonstrate the need for a minimum of three hours a week of IIH Service. If the minimum three hours is not provided, there must be documentation of a valid reason. IIH services below the three-hour-per-week minimum may be covered when services are being tapered off prior to discharge. However, variations in the pattern of service delivery must be consistent with the frequency of services specified for the goals and objectives of the service plan. Service plans must incorporate a discharge plan, which identifies transition from intensive in-home to less intensive or non-home-based services. The duration of weeks with fewer than 3 hours of services due to planned discharge may occur within the last 2 weeks of IIH treatment. The ISP plans must be cosigned by the member and/or parent /guardian participating in treatment.

- Services include: crisis treatment, individual and family counseling, communication skills counseling (to assist the child and parents in practicing appropriate problem-solving, anger management, interpersonal interaction, etc.), case management activities, coordination with other required services, and 24-hour emergency response.
- Services must be delivered primarily in the child's home with the child present. If it is determined that the content of the session is inappropriate for the child to be present, this must be documented. Documentation must reflect the necessity of providing services without the child present. In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community instead of the home, if this is supported by the assessment and the ISP.
- Direct clinical services must be provided by a QMHP, QMHP eligible, LMHP or a licensed-eligible mental health professional.
- “Licensed mental health professional (LMHP)” refers to a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, or a psychiatric clinical nurse specialist. If psychotherapy is to be billed by the LMHP, the therapist must comply with the outpatient psychotherapy criteria outlined in Chapters II, VI, V, and VI of the Psychiatric Services Provider Manual.
- “Licensed eligible mental health professional refers to an individual who has completed his or her graduate degree from an accredited program and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards licensure in the State of Virginia and be supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.
- A Licensed Mental Health Professional (LMHP) or a license-eligible mental health professional must provide clinical supervision at regular intervals. The full-time work schedule is 32 hours or more per week. Full time LMHP or the licensed-eligible mental health professional can supervise up to 10 staff; Halftime staff whose work schedule 16 to 31.9 hours per week can supervise up to five (5) supervisees. If a supervisor works less than half time, the supervision limit is two (2) counselors. License-eligible is defined as an individual who has completed his or her graduate degree, is registered with their appropriate licensing board, and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards Virginia licensure and must be registered with the appropriate Licensing Board.

- LMHP or a license-eligible mental health professional must provide clinical supervision weekly, with individual face to face supervision occurring at least every other week. Group supervision may occur on the other weeks. If the supervisor is on leave for one episode that is more than two weeks, a substitute supervisor must provide clinical supervision.
- The clinical supervisor (LMHP or a license-eligible mental health professional) must be available for consultation as needed.
- Supervision must be documented by the LMHP or a license-eligible mental health professional providing the supervision activity. A supervision log or note must be placed in the client's file documenting that supervision was provided. A more detailed note written by the supervisor summarizing the meeting and noting any recommendations must be maintained in a separate file.
- A QMHP can only provide administrative supervision. LMHP or a license eligible mental health professional must provide clinical supervision.
- Because Intensive In-Home Services are an EPSDT service, a referral should be made to the child's health care provider for a well child or EPSDT screening.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member's receipt of community mental health rehabilitative services.

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- i. Ho, Jennifer M. (September, 2010). Using Health Reform to Prevent and End Homelessness. United States Interagency Council on Homelessness. Retrieved from: <http://www.usich.gov/HealthReform.html>
 - ii. Medicaid covered services vary greatly from state to state. To identify what services are covered in your state contact your state's Medicaid authority.
 - iii. There are some mandatory services and populations that state Medicaid programs must cover but a wide array of optional services and populations that can also be covered at the option of each state.
 - iv. In states like Tennessee that have managed care organizations (MCO) that are responsible for providing coverage of both physical and behavioral health benefits, sometimes the Medicaid contracted MCO will subcontract with a managed behavioral health organization (MBHO) to manage the behavioral health portion of the benefit. For example, Neighborhood Health Plan (NHP), one of three Medicaid MCOs in Boston, subcontracts with Beacon Health Strategies, a MBHO, to cover behavioral health benefits. Providers

who want to deliver mental health services to NHP members, must apply to become a network provider directly with Beacon.

v. There are two counties where the county chose not to enter into a contract with OMHSAS to administer these services. In those cases, OMHSAS contracted directly with managed care organizations to cover MH/SUD benefits for Medicaid beneficiaries living in those counties.

vi. Perret, Y., Lupfer, K., Lassiter, M. & Dennis, D. (Nov, 2010). PATH and SOAR: An Effective Partnership. Policy Research Associates. Retrieved from: http://www.prainc.com/SOAR/community/pdfs/path_soar.pdf

vii. There are usually at least two Medicaid managed care organizations operating in a state or jurisdiction. Sometimes the mental health and substance use services are “carved-out” or subcontracted to another organization known as a managed behavioral health care organization.

viii. Summer, L. and Mann, C. (2006). Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies. The Commonwealth Fund.