NEW YORK STATE
MEDICAID PROGRAM

OFFICE OF MENTAL HEALTH
REHABILITATION IN COMMUNITY RESIDENCES

POLICY GUIDELINES

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Section I - Requirements for Participation in Medicaid

Providers of services must be certified by the Office of Mental Health (OMH). They must be operating in compliance with all pertinent OMH regulations. Currently Medicaid reimbursable Community Rehabilitation services are provided in the following Licensed Residential/Housing Programs:

- Community Residences (CR) for adults and children;
- Family Based Treatment (FBT) for children;
- Teaching Family Homes (TFH) for children

Client Eligibility

A client must have a primary or secondary diagnosis of severe and persistent mental illness or, for children and adolescents, age 5 through 17, serious emotional disturbance, as defined by the Commissioner of Mental Health.

To establish the need for rehabilitation services, a written authorization by a physician after a face-to-face visit is required. This authorization is to be kept in the client's records. Periodic written re-authorization by a physician is required for rehabilitation services.

Physician Authorization/Reauthorization

Each client prior to or upon admission into a Licensed Residential/Housing Program (which includes CR, FBT and TFH) must be seen by a licensed physician who makes a determination that services are appropriate and signs a written authorization which is kept on file by the provider.

Prior to the expiration of authorization, re-authorization must be obtained. For re-authorization purposes a physician may authorize the services for adults based upon the last quarterly review of the patient's service plan or, if necessary, may request the patient's case record to complete the re-authorization assessment.

For adults living in CR congregate settings, re-authorization is required at least every six months. For adults living in apartments, re-authorization is required once a year.

Re-authorization for recipients who transfer from congregate to apartment settings is required with the expiration of the current authorization.

Re-authorization for recipients who transfer from apartment to congregate settings is required within six months of admission to the new program or the expiration of the

current authorization, whichever comes first. Under no circumstance can an adult go beyond twelve months without re-authorization.
Re-authorization for all children and adolescent programs is every six months and must include a face-to-face contact with the physician.

Service Plan

A written service plan for each client in any Licensed Residential/Housing Program is required. This plan should state the needs, goals and objectives, specific services needed, and identify the staff responsible for providing and overseeing services for the client.

All residents must have an opportunity to participate in, comment on, and sign their service plan. All plans must be reviewed and signed by a Qualified Mental Health Staff person.

Progress notes shall be rendered by licensed residential/housing staff members who are authorized by the program. In order to qualify for Medicaid reimbursement, written documentation must identify 1.) the date service(s) are rendered and 2.) the specific rehabilitation service(s) provided.

Quarterly Review of Service Plan/Progress Notes
The service plan review shall be conducted at least every 3 months and include the participation of staff involved in service delivery, the resident and, if appropriate, collaterals.

The review should cover individual progress in meeting current goals, objectives and/or lack of progress.

The review should reflect changes in overall goals as appropriate.

The review should be dated and signed by the Qualified Mental Health Staff person.

Staffing

The rehabilitation services in Licensed Residential/Housing Programs are provided by a Qualified Mental Health staff person or a direct care staff person supervised by a Qualified Mental Health staff person.

Staffing in Adult CR
A Qualified Mental Health Staff person may be one of the following:

- A licensed physician;
- A licensed psychologist;

- A certified social worker;
- A registered nurse;
- An individual having education, experience and demonstrated competence, as defined below:
  - ► A Masters or Bachelors degree in a human services-related field; or
  - ► An Associate degree in a health services-related field and 3 years experience in human services; or
  - ► High school diploma and 5 years experience in human services; or
  - ► Other professional disciplines which receive the written approval of the Office of Mental Health.

Direct Care Staff
Direct Care Staff includes all staff providing direct care, other than those designated as Qualified Mental Health Staff, who have a high school diploma and have received training appropriate to their area of responsibility.

Staffing in Children and Adolescent Programs (CR, FBT, TFH)
A Qualified Mental Health Staff person may be one of the following:

- A licensed physician;
- A licensed psychologist;
- A certified social worker;
- A registered nurse;
- An individual having a Master's or Bachelor's degree in a human services related field;
- An individual with another professional discipline which receives the written approval of the OMH. (e.g., Family Care Specialists are approved disciplines for FBT; Teaching Parents are approved disciplines for TFH.)

Direct Care Staff
Direct Care Staff includes all staff providing direct care, other than those designated as Qualified Mental Health Staff, who have a high school diploma and have received training appropriate to their area of responsibility.

Section II - OMH Certified Rehabilitation Services

Rehabilitation Services as defined in the Federal Regulations at 42 CFR 440.130(d) "include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State Law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level".

Scope of Services Reimbursable Under Medicaid Community Residences of Sixteen Beds or Less

Rehabilitation services in CR are interventions, therapies and activities which are medically necessary for the maximum reduction of functional and adaptive behavior deficits associated with the person's mental illness.

Adult Services
CR for adults may be either a congregate-type arrangement or apartment-based. CR programs of sixteen beds or less serving adults must offer the following eleven services as defined by OMH regulations:

1. Assertiveness/Self Advocacy Training;
2. Community Integration Services/Resource Development;
3. Daily Living Skills Training;
4. Health Services;
5. Medication Management;
6. Parenting Training;
7. Rehabilitation Counseling;
8. Skill Development Services;
9. Socialization;
10. Substance Abuse Services;
11. Symptom Management.

Children and Adolescents Services
Children and adolescents admitted to a CR must be determined to have a serious emotional disturbance, as defined by the Commissioner of OMH. CR programs of

sixteen beds or less serving children must offer the following eight services as defined by OMH regulations:

1. Behavior Management Training;
2. Counseling Services;
3. Daily Living Skills Training;
4. Family Support Services;
5. Health Services;
6. Independent Living Skills Training;
7. Medication Management and Training;
8. Socialization.

Family Based Treatment
FBT programs are also for seriously emotionally disturbed children and adolescents as an alternative to institutional treatment or CR. The services provided under these programs are the same eight mentioned above. However, the setting in which the services are rendered differs. The purpose of these programs is to have surrogate professional parents maintain and treat up to two seriously emotionally disturbed children or youth in their homes with the ultimate goal of returning the child back to its natural family environment.

Voluntary agencies, licensed by OMH, oversee the management of a cluster of six family homes and individually inspect and approve them. Under the FBT construct, five homes take one child and the sixth family acts as respite.

A family specialist, employed by the voluntary agency that oversees the families, coordinates the planning and treatment for each child, and consults with the professional parents on an ongoing basis. This staff person acts as a coordinator of services and as an advocate for the child with community agencies and schools.

Teaching Family Homes
TFH programs have the same target population, services and goals as FBT. The difference lies in the "family" environment in which the child lives. Some children are not able to tolerate the family closeness of FBT Programs, and, are more appropriately treated in TFH. An FBT residence can have up to two children while a TFH residence can have up to four children.

Those children determined eligible for admission are placed in either FBT or TFH for care and treatment. Initial referral to the program and subsequent annual

reauthorization by a physician must be in writing, based on a face-to-face meeting with the child.

Providers are expected to maintain a network with other health care and mental health service providers and refer clients as and when needed. Providers are also expected to develop a service plan for each client and follow the physician's advice and plan. Record keeping for all required activities (services) is the responsibility of the surrogate parents.

TFH parents must be certified by the National Association of Teaching Parents.

Section III - Basis of Payment for Services Provided

To receive reimbursement for the provision of rehabilitation services to Medicaid recipients residing within Licensed Residential/Housing Programs, each individual must have a service plan which documents the delivery of appropriate rehabilitation services which have been authorized by a physician.

Reimbursement will be based upon monthly and half-monthly fees. Such fees shall be paid based upon a minimum number of face-to-face contacts between an eligible resident of a Licensed Residential/Housing Program and a staff person of an approved provider of rehabilitation services. Requirements for billing include the following:

Rehabilitation Services to Residents of Community Residences

- Full month billing requires as a minimum:
  - ► Four face-to-face contacts (one contact/day of at least 15 minutes duration).
  - ► Four different rehabilitation services.
  - ► 21 days in residence (excluding discharge day, days in a hospital or in any other Medicaid reimbursable facility).
- Half month billing requires as a minimum:
  - ► Two face-to-face contacts (one contact/day).
  - ► Two different rehabilitation services.
  - ► 11 days in residence (excluding discharge day, days in hospital or in any other Medicaid reimbursable facility).

Rehabilitation Services to Children and Adolescents in Family Based Treatment and Teaching Family Homes Programs

- Full month billing requires as a minimum:
  - ► Eleven recorded contacts, at least three of which must be provided by an authorized person other than the professional family.
  - ► Four different rehabilitation services.
  - ► 21 days in residence (excluding discharged day, days in hospital or in any other Medicaid reimbursable facility).

- Half month billing requires as a minimum:
  - ► Six recorded contacts, at least two of which must be provided by an authorized person other than the professional family.
  - ► Two different rehabilitation services.
  - ► 11 days in residence (excluding discharge day, days in hospital or in any other Medicaid reimbursable facility).

A contact is a face-to-face interaction of at least 15 minutes in duration, between the patient and an authorized staff person.

In order to receive monthly or semi-monthly reimbursement, documentation that at least the minimum number of rehabilitation services were rendered must be reported on the eMedNY claim form.

Rehabilitation services within Licensed Residential/Housing Programs may occur away from the residence, but not in other Medicaid reimbursable facilities such as hospitals. All services and contacts must be recorded for audit purposes.