	Mental Health and Substance Abuse Services Bulletin COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE		
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Subject	By
Resource Coordination: Implementation	**Ford S. Thompson** Deputy Secretary for Mental Health

SCOPE:

County MH/MR Administrators

PURPOSE:

The Department of Public Welfare, Office of Mental Health, is establishing Resource Coordination as a new service under the MH/MR Act of 1966, which will be eligible for Medicaid reimbursement and 100% state financial participation effective April 1, 1993. Since Resource Coordination is being implemented prior to the publication of final regulations which will govern the service, this bulletin transmits the information necessary for the provision and reimbursement of services until final regulations are published and codified.

BACKGROUND:

In March, 1989, the Department established intensive case management as a new service under the MH/MR Act of 1966, targeted to assist adults with serious mental illnesses and children with serious mental illnesses or serious emotional disturbance to gain access to needed resources and services. Within two years of implementation the service was available statewide. Caseloads were limited to a maximum of 30; however, they have averaged much lower in order for intensive case managers to meet the complex needs of persons being served. Intensive case management has grown to a $26 million program, employing approximately 930 intensive case managers and supervisors, and serving more than 8,600 children and adults.

Service management has been the only other case management option for persons in the mental health system. Caseloads for service management average more than 300, allowing for minimal direct, proactive intervention. Although many persons who are eligible for intensive case management do not need the frequency and intensity of the service, they do need more support than service management can provide. Also, the lack of a less intensive, but supportive level of case management has impeded some recipients of intensive case management from moving onto greater independence with continued support. These consumers could benefit from another level of care, freeing intensive case management to serve persons with greater need.

Creating additional levels of case management is included as an implementation strategy for Objective 1.1 in the Pennsylvania State Mental Health Plan. In February, 1992, a workgroup which included representatives of consumers, family members, county administrators, and provider organizations, was convened by the Office of Mental Health to help guide the development and implementation of a less intensive level of case management. The workgroup recommended standards for the new service, named Resource Coordination. In order to maximize funding available to implement this new level, the Department applied for and received approval to include Resource Coordination under our Medicaid State Plan Amendment covering targeted case management services.

Proposed regulations for Resource Coordination services have been drafted and will be entered into the regulatory approval process during the next several weeks. Publication of the proposed regulations in the Pennsylvania Bulletin is anticipated by late 1993. Final regulations should be published and effective in 1994. While Resource Coordination services are not required at this time, agencies identified as providers of Resource Coordination services will be required to meet the standards set forth in the final regulations upon publication. Until that time, the Department intends for identified providers of Resource Coordination services to adhere to the guidelines set forth in this bulletin.

There are three attachments to this bulletin: Attachment "A" describes fiscal issues associated with the provision of resource coordination services; Attachment "B" describes the procedures that will enable providers to enroll with Medicaid; and Attachment "C" provides service guidelines for the provision of Resource Coordination services until final regulations are promulgated. Providers identified in an approved 92-93 rebudget that meet the guidelines set forth in Attachment "C" may bill for Resource Coordination services retroactively to April 1, 1993. Providers identified in an approved 93-94 budget or rebudget that meet the guidelines may bill for Resource Coordination services effective the date of approval by the Area Office of Mental Health.

ATTACHMENT A
FISCAL ISSUES

The Office of Mental Health (OMH) will reimburse Resource Coordination Services using a county negotiated, cost-based, Departmentally approved, fee-for-service method of payment. To do this, the OMH has developed a rate setting package to be completed by each agency identified in a county rebudget/mental health plan as a provider of Resource Coordination Services. A separate rate will be negotiated for each provider of service. Rates may be based on a 67% productivity level for each resource coordinator during the first fiscal year of employment, and must be based on a 75% productivity level during subsequent fiscal years. Rate setting information will be completed by the provider and reviewed by the county office as a prudent buyer of service. Rates endorsed by the county will then be forwarded to the Area OMH for final approval.

Information on the conditions for payment can be found in Attachment C, Guidelines. Billing for Resource Coordination Services will occur using the standard invoice for Medical Assistance (refer to the MA Handbook for Resource Coordination services for further details). State dollars required to match federal Medicaid revenues and to reimburse services not eligible for MA reimbursement will be administered by the MH/MR County Program. Administrative Costs may be claimed in accordance with procedures set forth in Mental Health Bulletin OMH-93-07.

ATTACHMENT B
ENROLLMENT

With the implementation of Resource Coordination (RC) as a Medicaid reimbursable service, counties have been asked to identify their providers of RC services through the rebudget process. Identification of service providers begins the provider enrollment process. That process is outlined as follows:

1. Counties identify provider (s) of RC services and outline a plan of service in the rebudget. Guidelines for the '92-'93 rebudget were distributed in January, 1993. Guidelines for FY '93-'94 were included with the Tentative Allocations.
2. The Area OMH reviews the county rebudget to determine acceptability.
3. The OMH distributes rate setting packages to each county.
4. The Area OMH distributes an MA enrollment package to each provider agency identified in the county's rebudget after it has been accepted.
5. The provider agency submits a completed rate setting package to the county for approval.
6. The county reviews the rate submitted and verifies that costs are in line with other services provided in the geographic area, acknowledges its ability to provide the match necessary to support the proposed budget, and forwards the rate to the Area OMH for final review and approval by the Area Director.
7. The provider completes the MA enrollment package and returns it to the Area Office.
8. The Area Office schedules a site visit to review and approve the Resource Coordination program.
9. The Area Director approves the rate.
10. The Area Office submits the approved rate setting package, completed enrollment package and a copy of the letter approving the agency to provide resource coordination services to the Central Office.
11. The Central Office receives the rate setting and enrollment information and approval letter and enrolls the provider.
12. The Central Office notifies the provider and/or county administrator of the enrollment, approved rate and effective date of billing, and forwards the provider handbook and related materials.
13. Providers may begin billing for services retroactively to the effective date of enrollment in accordance with the instructions outlined in the provider handbook.

ATTACHMENT C
GUIDELINES

These guidelines establish standards for the provision of Mental Health Resource Coordination Services under provisions of the approved Medicaid State Plan. The guidelines are intended to enhance consistency and uniformity of application of statutory authority. It is the intent of the Department that providers adhere to the guidelines in providing resource coordination services. However, individual circumstances may warrant flexibility in application of the standards as long as provisions of the approved Medicaid State Plan Amendment are met. Any deviation from the guidelines must be approved by the Director of the appropriate Area Office of Mental Health. Providers may bill under procedures set forth in this bulletin until final regulations are promulgated.

GENERAL PROVISIONS

Service Description - Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who do not need the intensity and frequency of contacts provided through intensive case management, but who do need assistance in accessing, and

coordination and monitoring of, resources and services. Services are provided to assess individual's strengths and needs, and to assist them in accessing resources and services that build upon strengths and meet needs in order to achieve stability in the community. Resource coordination is similar to intensive case management in that the activities are the same. However, since resource coordination is targeted for persons with less complex needs, caseload limits are larger and there is no requirement for 24-hour service availability. Resource coordination is established as an additional level of case management, and is not intended to replace intensive case management. The implementation of Resource Coordination services is optional at this time.

Organization - The Resource Coordination Program must be organized or identified as a separate service within the organization of the agency. A director shall be identified to provide supervision of the Resource Coordination Program. There shall be a full-time supervisor to provide individual supervision for every 10 resource coordinators. If a full-time supervisor is not required, a supervisor may have other duties but must devote 1/10th of available hours per week to supervising each resource coordinator. The caseload size for adults is a minimum of 30 and a maximum of 75. The caseload size for children and adolescents is a minimum of 20 and a maximum of 40. Resource coordinators are required to work full-time in the program unless an exception is granted by the OMH Area Director.

ELIGIBILITY

Provider Participation - Providers must be identified in a county mental health plan or rebudget which has been accepted by the Department, and must meet all other applicable standards. Providers must be enrolled as specified in Chapter 1101, relating to Medical Assistance General Provisions, to receive the Federal share of Medical Assistance reimbursements. Providers must meet the conditions of these guidelines, and receive on-sight approval to provide resource coordination prior to billing for services. When in conflict, these guidelines shall prevail over requirements established in other regulations.

Consumer Eligibility - Services under these guidelines are reimbursable when provided to an adult, or child or adolescent and his/her family, who meet the following criteria:

A. Adults who have a serious mental illness as defined by meeting the criteria for Diagnosis, Treatment History **and** Functioning Level:
   1. **Diagnosis**
      Diagnosis within DSM III R (or succeeding revisions thereafter), excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code.
   2. **Treatment History**
      Shall be established when **one** of the following criteria are met:
      a. Six or more days of psychiatric inpatient treatment in the past twelve months; or
      b. Met standards for involuntary treatment within the past twelve months; or
      c. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, etc.; or
      d. At least 3 missed community mental health service appointments, or two or more face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months, or documentation that the consumer has not maintained his/her medication regimen for a period of at least 30 days.
   3. **Functioning Level**
      Global Assessment of Functioning Scale (DSM III R, Pages 12 and 20) ratings of 60 and below.

B. Adults who were receiving resource coordination services as children and were recommended by the provider and approved by the County Administrator as needing resource coordination services beyond the date of transition from child to adult.

C. Children who have a mental illness or serious emotional disturbance as defined by meeting the criteria for Diagnosis, Treatment History and Functioning Level:
   1. **Diagnosis**
      Diagnosis within DSM III R (or succeeding revisions thereafter) excluding those with a principal diagnosis of mental retardation, psychoactive substance abuse, organic brain syndrome or a V-Code.
   2. **Treatment History**
      Shall be established when one of the following criteria are met:
      a. Six or more days of psychiatric inpatient treatment in the past twelve months; or
      b. Without resource coordination services would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster homes or juvenile court placements;
      c. Currently receiving or in need of mental health services and receiving or in need of services from two or more human service agencies or public systems such as Education, Child Welfare, Juvenile Justice, etc.
   3. **Functioning Level**
      Global Assessment of Functioning Scale (DSM III R, Pages 12 and 20) rating of 70 and below.

D. An adult, child or adolescent who currently receives intensive case management services.
   An adult, child or adolescent who needs to receive resource coordination services but who does not meet the requirements identified above may be eligible for resource coordination upon review and recommendation by the County Administrator and written approval by the Department's Area Office of Mental Health.

RESPONSIBILITIES

Responsibilities of County Administrators - County Mental Health Administrators are responsible for identifying the need for

resource coordination services and for developing a program and fiscal plan to address that need. County Administrators are required to monitor the compliance of resource coordination providers under their jurisdiction with provisions of these guidelines as well as to provide fiscal and program reports to the Department. Administrators must certify that state funds are available for matching Medicaid compensable services and must ensure that sufficient state funds are available for non-Medicaid compensable services.

Responsibilities of Providers - Providers must adhere to requirements set forth in these guidelines and submit reports as required by the Department and the County Administrator. Providers must assist consumers or the parents, if the consumer is a child, in accessing appropriate mental health services and in obtaining and maintaining culturally appropriate basic living needs and skills. Services must be provided within the context of the consumer's and the family's culture. Providers must provide services in accordance with a written, consumer-specific, service plan which is goal and outcome oriented. The initial plan must be developed within 30 days of admission to resource coordination, and must be reviewed and updated at least every 12 months. Outcomes shall be reported to the Department on an annual basis via the Consolidated Community Reporting System. Providers must deliver services as needed in the place where the consumer resides or needs the service. Services may also be provided at the Resource Coordinator's office when off-site interventions would not be more appropriate. Providers must contact the consumer or the parents, if the consumer is a child or adolescent, at least once a month. Face-to-face contact with a child or adolescent consumer shall be made **at least** once a month. Face-to-face contact with an adult consumer shall be made at least every two months. If the consumer cannot be contacted face-to-face, the attempt to contact shall be documented. The provider must establish protocols to ensure that resource coordination staff attend orientation and ongoing training sessions. Providers must ensure that the principles established by the Pennsylvania Child and Adolescent Service System Program (CASSP), to include Cultural Competence, are followed in providing services for consumers who are children or adolescents and their families, and that Community Support Program (CSP) principles are followed in providing services for adult consumers. See Appendix A.

REQUIREMENTS

Staff Requirements - In accordance with educational and experiential standards recently approved by the Health Care Finance Administration, the following minimal requirements must be met by supervisors of resource coordination services:

A. A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, nursing, other related social sciences, criminal justice, theology, counseling, or education, and have two years mental health direct care experience; or
B. A registered nurse with three years mental health direct care experience.

A resource coordination staff person must meet one of the following criteria;

A. A bachelor's degree with major course work in sociology, social welfare, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, counseling, or education; or,
B. A registered nurse; or
C. A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years experience in direct contact with mental health consumers; or
D. A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

Mental health direct care experience is working directly with mental health service consumers (adults, children or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Recordkeeping - Records must be maintained which verify compliance with the requirements of these guidelines. Consistent with regulations at 55 PA Code 1101.51(e) (Medical Assistance General Provisions) records must be kept for a minimum of four years. Site survey reports, employee schedules, payroll records, job descriptions, documents verfiying employee qualifications and training, policies and protocols, fees or charges, records of supervision and training, letters of agreement with referral sources and service agencies and a grievance and appeals process are examples of records that must be kept to verify compliance with these guidelines.

Case Records - Each recipient of resource coordination services shall have a case record which is identified and maintained apart from other service records, and which contains at a minimum:

A. Intake information which identifies the reason for referral to the service and that the consumer is eligible for the service.
B. Written assessments and evaluations identifying medical, psychiatric and social strengths, needs and interests, on which to base the service plan.
C. An individualized service plan which is developed within 30 days of admission to resource coordination based upon the intake and assessment information, and which is updated at least every 12 months thereafter. The plan must be signed by the consumer, the family if the consumer is a child, the resource coordinator and others as determined appropriate by the consumer and the resource coordinator.
D. Documentation of each contact indicating the date and time (beginning and end) of service, purpose of the contact, staff person(s) involved, service(s) provided and the outcome(s) of the contact.

E. Termination summary, to be completed within 30 days of discharge from the program. The summary must identify the services provided, the goals attained through involvment with resource coordination, goals not completed and why, the reason for closure, and a recommended after-care plan. The summary must be signed by the consumer, the family if the consumer is a child or adolescent, and involved others, if obtainable.

Quality Assurance and Utilization Review - The quality and appropriateness of services must be monitored at the agency and county levels. Monitoring must occur according to an annual quality assurance/utilization review plan, to be developed by each provider of resource coordination services, and to be reviewed and approved by the County MH/MR Administrator or designee. The plan shall address the implementation of concurrent utilization review, peer review, consumer and family member satisfaction surveys, and self-evaluation of compliance with standards set forth in this chapter. Services are subject to reviews by federal and state authorities as provided in Medical Assistance General Provisions, Sections 1101.71-75 (relating to utilization control, invoice adjustment, provider misutilization and abuse, provider fraud and provider prohibited acts) and by agents of the county.

Conflict of Interest - Providers of resource coordination services must assure consumers the freedom to choose among any available providers of needed services and resources. The resource coordinator must also assist the consumer in accessing these services.

CONSUMER RIGHTS

Consumer Participation - Consumers have a right to terminate services without prejudice to other mental health services or future services. Consumers must receive assurances of nondiscrimination, right of appeal and individual civil rights. The Mental Health Procedures Act, 50 P.S. §7101 et seq., provides for an adolescent's right to seek or reject services. Parents must be involved in service planning for a child, and should be involved in service planning for adolescents over 14 unless the adolescent objects. Consumers cannot be terminated from services for non-compliant or non-participatory behavior that results from a mental illness or emotional disorder.

Notice of Confidentiality - There must be an assurance of confidentiality to individuals receiving resource coordination services as provided by Departmental regulations at 55 PA Code 5100.31-39. The right to confidentiality shall serve to protect the consumer's dignity and well-being, and not to create a barrier to appropriate treatment and services.

PAYMENT

Payment - These guidelines establish criteria for payment for resource coordination services under provisions of 55 PA Code 4300 (the County MH/MR Fiscal Manual). When conditions of these guidelines are met, services paid from county mental health allocations are eligible for 100% State financial participation. Providers must bill the Medical Assistance Program for eligible services provided to eligible recipients. Payment for a quarter-hour, or major portion thereof, unit of service will be made at a county negotiated, Departmentally approved, cost-based fee-for-service rate. Non-direct services (such as staff meetings, completing paperwork and attending training) are not billable, with the exception of staff time spent in necessary travel which results in billable resource coordination services. The maximum number of units that may be billed during a quarter-hour period shall equal the number of staff persons involved or the number of consumers being served, whichever is smaller. Payment will be made for assessment service planning informal support network building, assistance in gaining access to needed services and resources, linking, monitoring, and life support and problem resolution activities. See Appendix A for activity descriptions.

APPENDIX A

RESOURCE COORDINATION ACTIVITIES

Resource coordination is a service for adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disorders and their families, who do not need the intensity and frequency of contacts provided through intensive case management, but who do need assistance in accessing, and coordination and monitoring of, resources and services. Services are provided to assess individual's strengths and needs, and to assist them in accessing resources and services that build upon strengths and meet needs in order to achieve stability in the community. Activities undertaken by staff providing resource coordination services shall include:

Assessment - A review of clinical information and a general discussion with the consumer and the family, if the consumer is a child, to understand the consumer's history and present life situation.

Service Planning - The development of goals and objectives with the consumer and the family, if the consumer is a child, based on strengths and desires identified through the assessment, to include any activities necessary to enable the consumer to live as an integral part of the community.

Linking with Services - Assisting the consumer and the family, if the consumer is a child, in locating and obtaining services specified in the treatment/services plan including arranging for the consumer to be established with the appropriate service provider.

Gaining Access to Services - Aggressive and creative attempts to help the consumer and the family, if the consumer is a child, obtain resources and services identified in the treatment/service plan. This may include home and community visits and

other efforts, as needed. Home and community shall be defined broadly to include but not be limited to field contacts which may take place on the street, in the person's residence, at school or place of work, and in psychiatric treatment facilities, rehabilitation programs and other agencies where support or entitlements are available to the recipient. (Refer to the special conditions under which Medicaid can be billed for case management services to persons in inpatient settings. Medicaid cannot be billed for persons in jail.)

Monitoring of Service Delivery - Ongoing review of the person's receipt of, and participation in, services. Contact with the consumer and the family, if the consumer is a child, must be made on a regular basis to determine his or her opinion on progress, satisfaction with the service or provider, and any needed revisions to the treatment/service plan. Contact with provider/program staff must be made on a regular basis to determine if the person is progressing on issues identified in the treatment/service plan and if specific services continue to be needed and appropriate. A process must be developed for resolution between staff members with levels of appeal to be pursued when there is clinical disagreement on the nature and extent of progress a particular consumer is making. Regular contacts must be made with other public agencies serving the consumer and with parents, if the consumer is a child.

Problem Resolution - Direct, active efforts in advocacy to assist the consumer and family, if the consumer is a child, in gaining access to needed services and entitlements. Staff shall have easy access to communicate with agency and county MH/MR administrators for the purpose of obtaining assistance in resolving issues which prevent a person from receiving needed treatment, rehabilitation and support services. On a systems level, this may include providing information to help plan modifications to existing services or implement new services to meet identified needs and providing information to help plan modifications for accessing resources.

Informal Support Network Building - Contact with the person's family (not family counseling or therapy) and friends (with the permission and cooperation of the adult consumer) to enhance the person's informal support network and alleviate dependency on the resource coordinator.

Use of Community Resources - Assistance to persons in identifying, accessing and **assessing their ability to use** community resources appropriately to meet daily living needs. This may include the use of public transportation, recreation facilities, stores, etc.