State of Vermont
Health and Human Services Enterprise (HSE)
Medicaid Management Information Systems (MMIS)
Specialized Programs Project

Ad Hoc Report: Coverage and Reimbursement Policy Review Mental Health & Specialized Medicaid Programs

Submitted to:

THE AGENCY OF HUMAN SERVICES and
THE DEPARTMENT OF VERMONT HEALTH ACCESS

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SECTION ONE: INTRODUCTION

The Agency of Human Services (AHS), its Departments, and the Agency of Education (AoE) collectively operate and oversee numerous programs designed to directly or indirectly address Vermonters' health needs.

The AHS Department of Vermont Health Access (DVHA) is responsible for management of Vermont's publically funded health insurance programs, including the Medicaid program. DVHA directly manages a broad array of Medicaid services, including those delivered by traditional providers such as hospitals, doctors, other practitioners and home health agencies.

Vermont has developed many Specialized Programs to serve Vermonters with unique and complex needs. Other Departments within AHS are responsible for oversight of many of these Specialized Programs, including the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), the Vermont Department of Health (VDH), the Department for Children and Families (DCF). Vermont's Agency of Education also oversees Specialized Programs.

Similar or identical services frequently are billed across multiple programs and Departments with different reimbursement rates and/or coverage policies. Limited documentation currently exists to clarify whether these differences result from the unique needs of participants or how Vermont manages its programs and provider systems.

In some cases, Specialized Programs offer services that are similar in name and purpose, but targeted to a unique group based on age, disability type and program goals. For example, case management or service coordination is offered in all Specialized Programs and almost universally involves a person-centered assessment, gaining access to and coordination and monitoring of necessary services across medical, social, educational, and other life domains. However, appropriate service coordination within a given program may require highly unique and specialized staff skills and may include interventions specifically geared for a given target group. Thus, similar services may have very different coverage policies, payment models, and purposes.

In other cases, reimbursement, coverage policies and funding are determined by source of care rather than clinical need. While Vermont's Designated Agencies and Specialized Service Agencies (DAs/SSAs) are responsible for providing services on behalf of individuals who participate in several Specialized Programs, DAs/SSAs also serve individuals in their communities who have mental health and substance abuse treatment needs but do not meet

the clinical criteria for Specialized Program participation. Individuals also may access similar services from other providers, such as independently practicing psychiatrists and psychologists.

Purpose

The purpose of this report is to provide a policy analysis of mental health related services and their overlaps across Medicaid-funded programs. This analysis is an important first step as Vermont undertakes broad payment reform as well as modernization of its claims processing and other systems.

This analysis provides a foundation for identifying areas that may benefit from changes in policy, including reimbursement, coverage and how services are funded across Departments. Program staff agreed that documentation and a better understanding of payment policies would be important in determining whether practices across or within programs need to be revised.

In addition to providing an analysis of specific services, this report presents an overview of various programs that utilize all-inclusive or bundled payment methodologies as alternatives to traditional fee for service payment models.

Methodology

PHPG reviewed Medicaid claims data with dates of service within Calendar Year 2014 to identify claims that were associated with a mental health diagnosis code. Procedure codes were then analyzed by Fund Source (i.e., Department responsible for payment). Codes were identified for possible review if they represented more than $5,000.00 in payments by two or more Departments. Exhibit 1 provides an overview of the Fund Sources identified and their departmental groupings (as listed in the HP Tables Manual) for purposes of this analysis.

Exhibit 1.1 Fund Source Code Summary

Fund Source Summary		
Dept.	**Fund Source**	**Fund Source Description**
ADAP	K	Alcohol and Drug Abuse Programs (ADAP) – Medicaid
AOE	H	IEP-Related Medicaid in Schools
DAIL	B	Developmental Services
	L	Medicaid (Adult Services and TBI)
DCF	I	Medicaid (Treatment Services)
	C	General Assistance (GA)
DMH	G	Mental Health Medicaid
	S	CRT Case Rate
DVHA	A	Department of Vermont Health Access – Medicaid
	M	ESIA VHAP
	O	Pharmacy Drug Program
	P	VHAP Limited - Fee for Service Limited Expanded Eligibles
	U	PCPlus VHAP Managed Care
	V	PCPlus Traditional Managed Care
	X	Healthy Babies Kids and Families and Family Infant Toddler Program
	Y	Civil Unions
	5	ESI Only & CHAP
VDH	J	Department of Health - Medicaid

Following the identification of procedure codes that were paid by two or more Departments, subsequent claims analysis provided a profile for each procedure code, including: provider type and specialty, average amount paid per claim and rates on file for each department. PHPG worked with State staff to identify codes for further review and analysis. PHPG then reviewed provider manuals to gather information needed to complete a review of payment and coverage policies for each code. Where documentation was limited, PHPG worked with Specialized Program staff to review policies and understand operational differences in coverage policies. Policies that could not be ascertained with information available to PHPG are documented as To Be Determined (TBD) and may require review at the individual claim level.

Additionally, information was collected for programs that employ an all-inclusive or bundled payment methodology to support specific specialized services. Information was collected on the services included in the payment.

Operational policies and manuals reviewed for this report include:

- DMH Medicaid Fee for Service Manual (July 1, 2014)
- DMH Community Rehabilitation and Treatment Provider Manual (Draft Dec. 28, 2015)

- DMH Fee Schedule SFY15 and SFY16
- DVHA Fee Schedule July 2014 and July 2015
- ADAP Fee Schedule SFY15
- DAIL Fee Schedule July 2014
- DDS Fee for Service Fee Schedule SFY16
- HP Tables Manual (June 2015)

Exhibit 1.2 on the following page provides an overview of claims with mental health diagnosis by each procedure code identified for review.

Exhibit 1.2 Summary of Claims with Mental Health Diagnosis and Procedure Codes (Dates of Service CY2014)

Procedure Code	Description	ADAP	AOE	DAIL	DCF	DMH	DVHA	VDH	Total
90791	Psychiatric Diagnostic Examination	$10,132		$8,319		$135,143	$1,138,017		$1,291,611
90792	Psychiatric Diagnostic Examination w/Medical Services	$1,240		$66		$23,536	$257,250		$282,092
90832	Psychotherapy, 30 minutes with patient or family member	$1,218				$9,201	$271,528		$281,947
90833	Psychotherapy, 30 minutes with evaluation and management	$7,206				$4,152	$266,515		$277,873
90834	Psychotherapy, 45 minutes	$14,561				$25,698	$4,348,195		$4,388,454
90837	Psychotherapy, 60 minutes	$23,693				$269,402	$15,302,457		$15,595,552
90853	Group Psychotherapy, other than multi-family	$314				$16,848	$1,760,562		$1,777,723
92526	Treatment of Swallowing Dysfunction/Oral Function for				$800		$549		$1,349
97530	Physical Therapy Activities				$75,645		$89,339		$164,985
99213	Established Patient Visit	$7,083				$22,069	$2,053,512		$2,082,664
99214	Established Patient Visit, Moderate Complexity	$2,269				$34,478	$2,410,049		$2,446,796
99231	Subsequent Hospital Care, Low Complexity					$29,812	$109,018		$138,830
99232	Subsequent Hospital Care, Per Day, for the Evaluation, moderate complexity	$229				$57,319	$286,733		$344,281
99233	Subsequent Hospital Care, Per Day, for the Evaluation, new/worsening problem					$42,051	$586,374		$628,426
99285	Emergency Dept. Visit						$127,220		$127,220
G9012	Other Specified Case Management				$10,449,991		$1,726		$10,451,716
H0019	Behavioral Health Residential				$11,514,893	$4,204,713	$658,621		$16,378,226
H2011	Crisis Intervention, per 15 minutes			$1,877		$1,093,821	$914,494		$2,010,191
H2022	Community Based Wraparound Services, per diem			$162,049,676		$73,699,281			$235,748,957
S5125	Attendant Care Services			$2,948					$2,948
T1013	Sign Language or Oral Interpretation, per 15 minutes			$360		$5,902	$90,779		$97,041
T1016	Case Management, each 15 minutes			$304					$304
T1017	Targeted Case Management			$1,907,662		$5,056,637	$789		$6,965,089
T1020	Personal Care Services, per diem			$686,505			$7,990,690		$8,677,194
T1024	Evaluation and Treatment by Integrated Specialty Team)		$2,972,967		$3,538,175			$27,492	$6,538,635
T1027	Family Training & Counseling for Child Development, per 15				$2,301,656		$544	$1,421,952	$3,724,152
T2025	Waiver services, not otherwise specified					$8,016,363	$10,642		$8,027,004
T2038	Community Transition, Waiver			$45,109					$45,109
	Total	**$67,945**	**$2,972,967**	**$164,702,827**	**$27,881,160**	**$92,746,425**	**$38,675,602**	**$1,449,444**	**$328,496,370**

SECTION TWO: OVERVIEW OF FINDINGS

Until the inception of the Global Commitment to Health Section 1115 Medicaid Demonstration in 2005, Medicaid programs across the AHS operated under separate and discrete Medicaid waivers and budget limitations. These Specialized Programs were designed to support vulnerable Vermonters including persons with a severe and persistent mental illness, children experiencing a serious emotional disturbance, young children with developmental delays, individuals with intellectual and developmental disabilities of all ages, children in the State's custody, older Vermonters and persons with disabilities.

For purposes of this analysis, Procedure Codes were grouped into the following categories: evaluation and management, psychiatric and psychotherapy; behavioral health residential providers (i.e., private non-medical institution); crisis intervention; home and community based waiver services; targeted case management; and personal care. A summary of findings for each of these categories follows.

Evaluation and Management, Psychiatric and Psychotherapy Services

DMH, DAIL, DVHA and ADAP support publically funded mental health services through reimbursement for outpatient evaluation and management, psychiatric, and psychotherapy services. In addition, DAIL and DCF Fund Sources include payments for mental health services; however expenditures for dates of service in 2014 total less than $10,000. Findings for each department are described below.

DMH Programs

DMH maintains a separate rate structure for outpatient mental health services provided by Designated and Specialized Service Agencies. These expenditures are allocated into two separate budget categories, Fund Sources S and G. Fund Source S represents expenditures for mental health related services for persons in the CRT program. Fund Source G represents expenditures for all other DMH programs including general outpatient services to adults, children and families, intensive treatment programs for children, adolescents and families as well as emergency services.

Claims for Designated Agency and Specialized Service Providers (DA/SSA), approved by DMH, for outpatient, emergency and children's mental health programs are billed to DMH Fund Sources by using the Provider Type 037 (Mental Health Clinic) and a variety of specialized DA/SSA children's provider codes in the MMIS. Outpatient mental health fee for service reimbursements for DA/SSA programs are capped at $775 per day per enrollee, regardless of service type.

DMH manages two programs specifically tailored to meet the needs of persons who require intensive treatment services. These programs are Community Rehabilitation and Treatment (CRT) program for adults with a severe and persistent mental illness and the Enhanced Family

Treatment (EFT) program for children experiencing a serious emotional disturbance and their families. CRT and EFT payments to the DA/SSA are designed to be all-inclusive for specialized services, but do allow for consumer choice in non-DA/SSA providers for certain outpatient mental health services.

In the CRT program, the DA/SSA may sub-contract with independent providers to provide services not available through the DA/SSA or to support an already existing therapeutic relationship for enrollees. In these situations, the DA/SSA pays the practitioner from funds received through the CRT payment. However, if a sub-contractual relationship does not exist and the client wishes to receive outpatient therapy services outside of the DA/SSA system, their provider must be an enrolled Medicaid provider, accept Medicaid rates and agree to coordinate care and information with the DA/SSA treatment team. For individuals enrolled in the CRT program, these non-DA/SSA claims default to the DVHA payment rate and expenditures are allocated to the DMH Fund Source S.

Along these lines, the children's EFT program allows enrollees to receive outpatient therapy services outside of the DA/SSA system. However these services are paid by traditional Medicaid coverage through DVHA, other insurance, or by the family.

ADAP Programs

Findings showed approximately $67,945 in CY2014 expenditures from Fund Source "K" (ADAP). ADAP staff report that these billings were in error by ADAP preferred providers. Effective January 1, 2015 edits and audits have been included in the HP system to avoid further use of these procedure codes with ADAP Fund Source K.

DAIL Programs

DAIL reimburses for psychiatric diagnostic examinations for enrollees who have an intellectual or developmental disability that also have co-occurring psychiatric or mental health service needs. DAIL maintains a separate fee for service rate structure for these services. Claims are only reimbursed by DAIL for Provider Type 038 (MR Clinic). These codes represented approximately $8,400 in CY2014 expenditures from Fund Source "B" (Developmental Services).

Exhibit 2.1 on the following page provides a summary of expenditures for evaluation and management, psychiatric and psychotherapy procedure codes paid to DA/SSA providers by both DMH and DVHA.

Exhibit 2.1 DA/SSA Evaluation and Management, Psychiatric and Psychotherapy Procedure Code Overlaps DMH, DVHA

DMH DVHA Overlaps in Evaluation and Management, Psychiatric and Psychotherapy Procedure Codes							
Code	Description	Allowed Rate on File July 2014		Expenditures by Fund Source and Provider Type		
		DMH Fund Source G	DMH Fund Source S & DVHA	DMH Fund G Provider Type 037	DMH Fund S (Non-DA/SSA Providers)	DVHA All Funds Provider Type 040
90791	Psychiatric Diagnostic Examination	$99.70	$106.28	$129,934	$6,099	$260,999
90792	Psychiatric Diagnostic Examination w/Medical Services	$102.91	$114.61	$22,056	$1,480	$49,019
90832	Psychotherapy, 30 minutes w/family	$41.66	$51.55	0	$9,201	$75,014
90833	Psychotherapy, 30 minutes w/E&M	$35.06	$52.51	$2,579	$1,572	$72,830
90834	Psychotherapy, 45 minutes	$97.19	$68.08	0	$25,698	$1,226,038
90837	Psychotherapy, 60 minutes	$129.59	$101.94	$1,249	$268,153	$1,533,565
90853	Group Psychotherapy	$10.28*	$10.47	$10,599	$6,249	$262,580
99213	Established Patient Visit	$42.05	$57.97	$20,851	$1,218	$193,975
99214	Established Patient Visit – Moderate Complexity	$64.91	$85.56	$31,237	$3,241	$202,074
99231	Evaluation and Management Hospital Follow-Up-Low Complexity	N/A	N/A	0	$29,812	0
99232	Evaluation and Management Hospital Follow-Up-Moderate Complexity	N/A	N/A	0	$57,319	0
99233	Evaluation and Management Hospital Follow-Up-New or Worsening Condition	N/A	N/A	0	$42,051	0
	Total			$218,505	$452,093	$3,876,094

*SFY2015 DMH moved to session rate $41/session

Behavioral Health Residential - Private Non-Medical Institution (PNMI)

DMH and DCF reimburse residential treatment services for youth who meet program criteria and who have been prior approved by both the Act 264 Case Review Committee and by a Department Placement Specialist. DVHA reimburses for program services for two providers, the Northeastern Family Institute and Howard Center (Baird Center). Both these providers operate hospital diversion and crisis stabilization programs. All PNMI program providers engage in an independent rate setting process through the AHS Rate Setting Division and all AHS payers reimburse using the approved rate on file for each provider.

Crisis Intervention

Crisis Intervention Services, per 15 minutes (H2011) is a procedure code used by DMH and DAIL providers. Designated and Specialized Service Agencies approved by DMH and DAIL are required to provide disability-specific mental health crisis services 24/7 for any Vermonter residing in their catchment area. Program requirements are unique to DMH and DAIL and are not typically required by other payers. DMH and DAIL support these programs through a variety of funds (general fund and federal) and through Medicaid fee for service reimbursement. DA/SSA's are assigned specific Provider Type codes in the HP system. A summary of coverage policies and expenditures is provided in Exhibit 2.2 below.

Exhibit 2.2 Summary of DA/SSA Crisis Intervention Overlaps CY2014

Summary of Provider Type Payments and Rate Procedure Code H2011 (Crisis Intervention)				
Department	Allowed Rate July 2014	Coverage	Expenditures	Provider Type
DMH	$58.17	DA/SSA; approved agency staff only; $775 Day limit	$1,093,821	037 (MH Clinic)
DVHA	$56.43	Licensed Staff	$914,494	040 (MH/DS VHAP)
DAIL	$74.00	DA/SSA; approved agency staff only	$1,876	038 (MR Clinic)

Community Based Family and Wrap-Around Care

Person centered individualized budgeting and service planning is at the core of most Specialized Programs. Reimbursement strategies for most programs are rooted in their original and separate 1915 (c) or Section 1115 waiver approvals prior to the start of the Global Commitment Demonstration in 2005. These coverage policies have been memorialized in provider and program operational manuals, legislative guidance and System of Care documents. For Agency of Education (AoE) programs, all programs adhere to the approved State Plan and legislative requirements. A comprehensive School Based Health Program Manual for IEP-related services and related coverage policies are available online at the AoE website. A summary of coverage policies and expenditures unique to each Specialized Program is provided in Exhibit 2.3 on the following page.

Exhibit 2.3 Summary of Community Wrap-Around Overlaps CY2014

Summary of Community Wrap-Around Provider Type Payments					
Dept.	**July 2014 Rate Method**	**Coverage**	**Expenditures**	**Fund**	**Provider Type(s)**
DMH –CRT (H2022)	N/A	Sub-capitated payment from DVHA to DMH	$71,397,934	G	T34 (DMH Fiscal Office)
DMH (H2022, T2025, T2038)	Person-Centered Budget	Prior Approved	$11,434,325	G	039 (NFI/Baird) 037 (MH Clinic DA/SSA) T19 (TBI Voc Rehab Agency) T20 (SRS) T23 (PNMI)
DVHA (T1027)	DVHA	TBD	$544	V	17 (Licensed Therapist OT PT)
DVHA CFC (T2025)	Person Centered Flexible Choices	Prior Approved	$9,296	A	T14 (Aged/Disabled Waiver)
DVHA Civil Union (T2025)	Person Centered Flexible Choices	Prior Approved	$1,346	Y	37 (MH-Clinic DA/SSA)
DAIL DS (H2022)	Person-Centered Budget	Prior Approved	$162,049,676	B	042 (MR Waiver)
DAIL TBI (T2038)	Person-Centered Budget	Prior Approved	$45,109	L	T19 (TBI Voc Rehab Agency)
DCF (T1024, T1027)	Part C, Early Intervention Teams; IFBS Post Adoption	Prior Approved	$5,839,831	I	17 (Licensed Therapist OT PT) T21 (Children's Medical Services) T20 (SRS)
VDH T1024, T1027	DVHA	VDH Child Development and Orthopedic Clinics	$1,449,444	J	T18 (Developmental Disability Agency VDH)
AOE IEP Related (T1024)	2008 Level of Care Rates	LEA & IEP only; Prorated for school day & year	$2,972,967	H	T27 (Agency of Education)

Case Management

Person centered planning and case management is required in all specialized programs. When not included in an all-inclusive or bundled payment, specific expenditures are attributed to the specialized program based on Provider Type and Procedure Code assignment. Exhibit 2.4 below provides an overview of CY2014 expenditures.

Exhibit 2.4 Summary of Case Management Overlaps CY2014

Summary of Case Management Payments					
Dept.	**July 2014 Rate**	**Coverage**	**Expenditures**	**Fund**	**Provider Type(s)**
DMH T1017	$24.66	DA/SSA; Specialized Rehab	$5,056,637	G	037 (MH Clinic DA/SSA)
					T19 (TBI Voc Rehab Agency)
DAIL-DS T1017	$12.50	DA/SSA & OPG only	$1,907,662	B	038 (MR Clinic)
	$216.67				T16 (Targeted Case Mgt)-DAIL OPG only*
DAIL-TBI T1016	$12.50	TBI Rehab Providers; Prior Approved	$304	L	T19 (TBI Voc Rehab Agency)
DVHA T1017	TBD	TBD	$789	Y	037 (MH Clinic DA/SSA)
DCF G9012	Cost-Based	DCF Staff Only	10,449,991	I	T20 (SRS)
DVHA G9012	TBD	TBD	$1,726		T20 (SRS)
* Office of Public Guardian (OPG) is no longer billing case management					

Personal Care

DVHA and DAIL reimburse for personal care and attendant care respectively for persons who meet criteria and who have been prior approved by the State. Specific expenditures are attributed to DVHA or DAIL based on Provider Type and Procedure Code T1020. DAIL expenditures represent reimbursement unique to adults enrolled in the DAIL Traumatic Brain Injury (TBI) program and is prior approved by DAIL based on an individual assessment and needs identified during treatment planning. Services are authorized for six month periods.

Sign Language/Oral Interpretation

All departments authorize the use of this code and all providers follow DVHA coverage and reimbursement rules. DA/SSA specific expenditures are attributed to DAIL or DMH based on Provider Type (MH clinic or MR clinic) and services for CRT clients by non-DA/SSA providers are attributed the CRT Fund based on the recipient's enrollment in the CRT program.

Rate Setting Policies

All specialized programs determine rates based on a combination of legislative appropriations, utilization and/or current DVHA assigned Medicaid rates. A summary of rate setting policies is outlined in Exhibit 2.5 on the following pages.

Exhibit 2.5 Summary of 2016 Rate Setting Policy for Overlapping Codes by Department

Overview of Rate Setting by Department						
Procedure Code	**DVHA**	**DMH**	**DAIL**	**ADAP**	**DCF**	**VDH**
90791 Psychiatric Diagnostic Examination 90792 Psychiatric Diagnostic Examination with Medical Services	RBRVS	*"G" Fund*: 2013 conversion to 1.83% of DVHA rate, adjusted annually based on utilization and current year legislative appropriation. *CRT "S" Fund*: DVHA	Appropriation	No longer uses code	N/A	N/A
90832 Psychotherapy, 30 minutes with patient or family member 90833 Psychotherapy, 30 minutes with evaluation and management 90834 Psychotherapy, 45 minutes 90837 Psychotherapy, 60 minutes	RBRVS	Same as above	N/A	No longer uses code	N/A	N/A
90853 Group Psychotherapy, other than multi-family	RBRVS	Appropriation; per session encounter rate for provider type 037 (MH Clinic)	N/A	No longer uses code	N/A	N/A
92526 Treatment of swallowing dysfunction/oral function for feeding 97530 Physical Therapy Activities	RBRVS	N/A	N/A	N/A	DVHA Rate	CSHN: No longer uses code
99213 Established Patient Visit 99214 Established Patient Visit, Moderate Complexity 99231, 99232, 99233 Evaluation and Management Hospital Follow-Up	RBRVS	2013 conversion to 1.83% of DVHA rate, adjusted annually based on utilization and current year legislative appropriation for Provider Type 037; all others use DVHA rate	N/A	No longer uses code	N/A	N/A
G9012 Other Specified Case Management	Time Study & Cost	TBD	N/A	N/A	State Staff Time Study	N/A
H0019 Behavioral Health Residential	PNMI Rule	PNMI Rule	N/A	N/A	PNMI Rule	N/A
H2011 Crisis Intervention, per 15 minutes	RBRVS	Appropriation	Appropriation	N/A	N/A	N/A
H2022 Community Based Wraparound Services, per diem	N/A	Appropriation; prior approved person-centered budget (EFT)	Appropriation; prior approved person-centered budget (DDS)	N/A	N/A	N/A
T1013 Sign Language or Oral Interpretation	DVHA Rate	DVHA Rate	DVHA Rate	DVHA Rate	DVHA Rate	DVHA Rate
T1017 Targeted Case Management	Rate on file	Appropriation*	Appropriation; (a) Provider contract; (b) Staff Cost	N/A	N/A	N/A

Overview of Rate Setting by Department						
Procedure Code	**DVHA**	**DMH**	**DAIL**	**ADAP**	**DCF**	**VDH**
T1020 Personal Care Services, per diem	Rate on file	N/A	Appropriation; prior approved (TBI)	N/A	N/A	N/A
T1024 Evaluation and Treatment by Integrated Specialty Team**	N/A	N/A	N/A	N/A	Appropriation; Provider Contract and Capacity Agreement (CIS)	*Children's Orthopedic Clinic:* Prior year actual cost and caseload DVHA
T1027 Family Training & Counseling for Child Development, per 15 minutes	TBD	N/A	N/A	N/A	IFBS Post Adoption Appropriation and Provider Contract and Capacity Agreement	*Child Development Clinic:* Same as above
T2025 Waiver services, not otherwise specified	Rate on file	Appropriation; prior approved person-centered budget	N/A	N/A	N/A	N/A
T2038 Community Transition, Waiver	N/A	N/A	Appropriation (TBI)	N/A	N/A	N/A

* T1017 Targeted Case Management represents expenditures for Specialized Rehabiltation services (service planning), there is currenlty no TCM State Plan group for DMH.
**T1024 is also used by Agency of Education specific to Medicaid Eligble children on an IEP.

Conclusion

Overlap in the use of procedure codes by AHS Programs, is most often explained by adherence to unique disability specific program rules and/or providers. Separate rates, where applicable, are typically based on legislative appropriation or a capacity based agreement with a certified provider for specific FTE staff or caseload targets. Current data analysis suggests that the only overlap whereby the same provider is paid different rates for the same service is in the evaluation and management, psychiatric, psychotherapy and crisis intervention codes between DVHA and DMH relative to the DA/SSA provider system.

This overlap is primarily based on the use of a MH/DS VHAP Provider Type code that was created in the late 1990's and early 2000 as DMH appropriations for general outpatient services were declining. The assignment of this code represented the State's commitment to maintaining some level of service for enrollees who did not meet eligibility criteria for CRT or other specialized children's programs. An additional benefit of augmenting DA/SSA provider billing was to support the sustainability of the specialized network and access to needed mental health services for low income and vulnerable Vermonters. A summary of the DA/SSA overlap by procedure code is presented in Exhibit 2.6 below.

Exhibit 2.6 Summary of Procedure Codes to Same Provider with Different Rates

Summary of Codes Paid to Same Provider, Different Rates					
		Allowed Amount July 2014		Total Paid CY2014	
Code	Description	DMH	DVHA	DMH (037)	DVHA (040)
90791	Psychiatric Diagnostic Examination	$99.70	$106.28	$129,935	$260,999
90792	Psychiatric Diagnostic Examination w/Medical Services	$102.91	$114.61	$22,056	$49,019
90832	Psychotherapy, 30 minutes w/family	$41.66	$51.55	0	$75,014
90833	Psychotherapy, 30 minutes w/E&M	$35.06	$52.51	$2,579	$72,830
90834	Psychotherapy, 45 minutes	$97.19	$68.08	0	$1,226,038
90837	Psychotherapy, 60 minutes	$129.59	$101.94	$1,249	$1,533,565
90853	Group Psychotherapy	$10.28*	$10.47	$10,598	$262,580
99213	Established Patient Visit	$42.05	$57.97	$20,851	$193,975
99214	Established Patient Visit – Moderate Complexity	$64.91	$85.56	$31,237	$202,074
99231	Evaluation and Management Hospital Follow-Up-Low Complexity	N/A	N/A	0	0
99232	Evaluation and Management Hospital Follow-Up-Moderate Complexity	N/A	N/A	0	0
99233	Evaluation and Management Hospital Follow-Up-New or Worsening Condition	N/A	N/A	0	0
	Sub-Total E& M, Psychiatric, Psychotherapy			$218,505	$3,876,094
H2011	Crisis Intervention, 15 minutes	$58.17	$56.43	$1,095,508	$923,092
	Grand Total			$1,314,013	$4,799,187

Payment and Policy Options

The DA/SSA providers are currently engaged in a work group with AHS staff and member departments to design and implement new reimbursement strategies to better support the integration of mental health, substance abuse treatment, physical health and long term services and supports across programs. Concurrently, the State of Vermont is developing an All-Payer Model supported through the use of Accountable Care Organizations. In recognition of the State's broad payment reform agenda, large-scale policy options are introduced, below. Should AHS and its Departments engage in a detailed review of these policy options, a preliminary listing of potential opportunities and challenges are provided as a starting point for these discussions.

1. Move Funding for All Mental Health Services Provided by DAs/SSAs to DMH Budget

Opportunities	Challenges
• Single Department responsible for oversight of DA/SSA mental health services and sustainability of DA/SSA system • May facilitate Legislature's ability to dedicate appropriate funding for mental health system • Consolidation of funding could address current discrepancies in reimbursement and coverage policies (within DA/SSA system) • Facilitates service delivery reform across full continuum of mental health services (outpatient, crisis services, CRT, CIS, family supports) • Recognizes higher acuity of individuals served by DAs/SSAs (including individuals who narrowly fail to meet clinical criteria for Specialized Programs)	• May foster continuation of a "capped" public mental health system (unless existing caps are removed and DMH budget is adjusted accordingly) • May be less supportive of All-Payer/ACO risk model, whereby service coverage responsibilities need to be clearly defined • Retention of separate funding stream outside the All-Payer Model may be less supportive of integration goals

2. Move Funding for Mental Health Outpatient Services to DVHA

Opportunities	Challenges
• Facilitates planning for All-Payer Model, including payment reform and integration of all health services • Specialized Program funding could be retained by other departments • May facilitate removal of capped funding for mental health services • Could streamline program administration related to certain providers (e.g., hospitals)	• Further divides responsibility for oversight and sustainability of DA/SSA system • Adoption of uniform rate schedule across DAs and other providers could compromise sustainability of DA system if support services currently offered through DA system are not funded • May compromise ability of DMH and public mental health system to develop continuum of care for individuals with mental health treatment needs • May adversely impact allocation of administrative costs

3. Move All Funding for Mental Health Services to a Single Budget

Opportunities	Challenges
• Single department responsible for monitoring and tracking all expenditures • Single set of rates and coverage policies	• Changes current alignment of responsibilities based on delivery system (e.g., hospital care, Designated Agency System) • May adversely impact allocation of administrative costs • May weaken link between policy development and fiscal management, unless both functions are consolidated

SECTION THREE: ALL INCLUSIVE AND BUNDLED PAYMENT MODELS

Since their inception, most AHS Specialized Programs have employed CMS approved all-inclusive bundled rate approaches for payments to approved providers. These programs were developed under 1915 (c) waive authority and/or Section 1115 demonstration authority to support highly individuated person centered budgets and provider payments. These include:

- Community Rehabilitation and Treatment Program
- DS HCBS Package
- Traumatic Brain Injury
- Enhanced Family Treatment
- Individualized Service Budgets/Wrap Arounds
- Concurrent to Education Rehabilitation & Treatment

In addition, using payment flexibilities under the Global Commitment to Health Public Managed Care Demonstration, the following programs were converted to monthly payment models after 2005 to support innovative programming and increased access to care for eligible members.

- Jump On Board for Success
- Success Beyond Six - School Based MH clinician
- Children's Integrated Services
- Runaway and Homeless Youth Crisis Stabilization Programs
- The Bridge (TCM) Program
- Integrating Family Services

The following programs currently utilize bundled or level of care payments through the traditional Medicaid State Plan authorities.

- Medication Assisted Treatment – Health Home Hub
- Medication Assisted Treatment – Buprenorphine Spoke
- School Based Health (IEP related) Services

A summary of each of these programs and the services included in the bundle is provided in Exhibit 3.1 on the following pages.

Exhibit 3.1 Summary of Specialized Medicaid Alternative to Fee for Service Payments

Summary of Specialized Programs Medicaid Bundled Payments							
Dept.	**Program**	**Provider**	**Procedure Code**	**Service(s) in Bundle**	**Authority**		**Rate Setting Methodology/Restrictions**
					Coverage	**Payment**	
DMH	Jump On Board for Success (JOBS)	DA/SSA	H0040	1. Specialized Rehabilitation	State Plan	GC	Monthly rate set based on FTE budget and provider caseload expectations. Quarterly revenue and expense review and annual budget adjustments.
	Enhanced Family Treatment	DA/SSA	H2022	1. Service Coordination 2. Respite 3. Psychotherapy 4. Diagnosis and Evaluation 5. Out-of-home support 6. Intensive in-home support	GC & EPSDT	GC	Daily rates created per individualized budget, prior authorization required, approved for six month period with reassessment and review prior to end date.
	Individualized Service Budgets/Wrap Arounds–	DA/SSA	H0046	1. Service Coordination 2. Psychotherapy 3. Diagnosis and Evaluation 4. Intensive in-home support	State Plan & EPSDT	GC	Daily rates created per individualized budget request, prior authorization required, period of approval varies based on need
	Success Beyond Six: School Based MH Clinician	DA/SSA	H2003 H20023 CG	1. Specialized Rehabilitation 2. Psychotherapy 3. Diagnosis and Evaluation	State Plan	GC	Monthly rate set based on FTE budget and provider caseload expectations. Rate differential for programs in schools that adopt Positive Behavioral Intervention Systems. Quarterly revenue and expense review and annual budget adjustments.
	Success Beyond Six: CERT	DA/SSA	H2020	1. Specialized Rehabilitation	State Plan	GC	Daily rate set based on FTE budget and provider caseload expectations. Revenue/expense review and annual budget adjustments.
	Community Rehabilitation and Treatment	DA/SSA	(Not billed by providers)	1. Service Planning & Coordination 2. Community Supports 3. Supported Employment 4. Clinical Interventions (e.g. assessment, therapies) 5. Medication, Medical Management and Consultation 6. Crisis Services 7. Transportation 8. Peer Recovery & Recovery Services	GC	GC	PMPM sub-capitated payment from DVHA to DMH; DMH global budget agreement with monthly and quarterly capacity payments to contract providers. Provider revenue/expense review and annual budget adjustments.

Summary of Specialized Programs Medicaid Bundled Payments							
Dept.	**Program**	**Provider**	**Procedure Code**	**Service(s) in Bundle**	**Authority**		**Rate Setting Methodology/Restrictions**
					Coverage	**Payment**	
DCF	Children's Integrated Services		T1024	1. Targeted Case Mgt (pregnant women and children up to 1 year) 2. Target Case Mgt (1-4 year olds) 3. Extended post-partum nursing visits 4. Mental Health Clinical Assessment 5. Mental Health Consultation and Education 6. Child Birth Education 7. Developmental Therapy	State Plan	GC	Monthly rate set based on FTE budget and provider caseload expectations. Annual budget adjustments.
	Runaway and Homeless Youth Crisis Stabilization Programs	VCRHYP (includes DA/SSA; YSB; PCC providers)	S5146	1. Intensive Family Based Services	State Plan	GC	Monthly rate set based on statewide network agreement and targeted FTE capacity, caseload and provider budget in each region expectations. Annual budget adjustments.
DAIL	Bridge	DA/SSA	T2022	1. Targeted Case Mgt	State Plan	GC	Monthly rate set based on FTE budget and provider caseload expectations. Revenue/expense review and annual budget adjustments.
	HCBS Package	DA/SSA	H2020	1. Respite 2. Accessible Transportation 3. ISO Support Services 4. Clinical Services 5. Crisis Intervention 6. Community Supports 7. Home Supports 8. Service Coordination 9. Employment Supports	GC	GC	Daily rates created per individualized budget, prior authorization required, approved annually. Revenue/expense review and annual budget adjustments.
DAIL	Traumatic Brain Injury	DA/SSA	T2017	1. Respite 2. Community Support 3. Case Management 4. Rehabilitation 5. Environmental & Assistive Technology	GC	GC	Daily rates created per individualized budget for DA/SSA hosted services only, prior authorization required, approved for six month periods. Majority of TBI services are billed FFS.

Summary of Specialized Programs Medicaid Bundled Payments							
Dept.	Program	Provider	Procedure Code	Service(s) in Bundle	Authority		Rate Setting Methodology/Restrictions
					Coverage	Payment	
				6. Crisis Support 7. Psychology & Counseling Support 8. Employment Support 9. Personal Care			
VDH	MAT Health Home Hub	ADAP Approved	H0020	1. Comprehensive care management for medication assisted opiate addiction treatment 2. Care coordination 3. Health promotion 4. Comprehensive transitional care and follow-up 5. Patient and family support 6. Referral to community and social support services	State Plan	State Plan	Approved Health Home SPA
All	IFS	Two Current Sites: DA/SSA; PCC	T2025HW	Any Combination of DMH, DAIL, DCF, ADAP State Plan and Specialized GC Services for children.	State Plan & GC	GC	Monthly rate set based on FTE budget and provider caseload expectations. Quarterly revenue and expense review and annual budget adjustments.

SECTION FOUR: PROCEDURE CODE DETAIL

This section provides a summary of claims paid by provider type and fund source for each procedure code reviewed. Data is based on claims that have a mental health diagnosis code and dates of services during calendar year 2014.

Exhibit 4.1 Procedure Code 90791 Psychiatric Diagnostic Examination

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90791 (Psychiatric Diagnostic Examination)	005	Physician	DMH	$1,568	$98.02
			DVHA	$148,658	$92.65
	019	MA Level Licensed Psychologist or Counselor	DMH	$3,796	$80.77
			DVHA	$596,908	$81.41
	030	Doctorate Psychologist	DMH	$735	$91.83
			DVHA	$121,652	$93.72
	037	MH Clinic	DMH	$129,044	$98.28
	038	MR Clinic	DAIL	$8,319	$169.77
	039	MH/NF Waiver, NFI, Baird	DVHA	$646	$80.77
	040	MH/DS Clinic VHAP	DVHA	$257,255	$93.00
	T06	Nurse Practitioner	DVHA	$11,929	$90.99
	T17	Case Manager/Social Worker	DVHA	$162	$80.77
	T21	Children's Medical Service	DVHA	$646	$80.77
	T25	OADAP Facility	ADAP	$10,132	$101.32
	T38	Certified OADAP Adolescent Counselor	DVHA	$162	$80.77

Exhibit 4.2 Procedure Code 90792 Psychiatric Diagnostic Examination with Medical Services

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90792 (Psychiatric Diagnostic Examination w/Medical Services)	005	Physician	DMH	$1,480	$113.81
			DVHA	$190,692	$113.91
	019	MA Level Licensed Psychologist or Counselor	DVHA	$229	$114.61
	037	MH Clinic	DMH	$22,056	$101.64
	038	MR Clinic	DAIL	$66	$66.47
	040	MH/DS Clinic VHAP	DVHA	$48,908	$111.66
	T06	Nurse Practitioner	DVHA	$17,421	$114.61
	T25	OADAP Facility	ADAP	$1,240	$112.72

Exhibit 4.3 Procedure Code 90832 Psychotherapy, 30 minutes with patient or family member

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90832(Psychotherapy, 30 minutes with patient or family member)	005	Physician	DMH	$2,371	$46.50
			DVHA	$47,665	$47.62
	019	MA Level Licensed Psychologist or Counselor	DMH	$2,745	$42.22
			DVHA	$137,190	$39.04
	030	Doctorate Psychologist	DMH	$4,085	$45.39
			DVHA	$13,190	$42.81
	039	MH/NF Waiver, NFI, Baird	DVHA	$39	$39.03
	040	MH/DS Clinic VHAP	DVHA	$75,014	$47.86
	T06	Nurse Practitioner	DVHA	$746	$49.71
	T17	Case Manager/Social Worker	DVHA	$156	$39.03
	T21	Children's Medical Service	DVHA	$195	$39.03
	T25	OADAP Facility	ADAP	$1,218	$50.77
			DVHA	$78	$39.03

Exhibit 4.4 Procedure Code 90833 Psychotherapy, 30 minutes with evaluation and management

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90833 (Psychotherapy, 30 minutes with Evaluation and Management)	005	Physician	DMH	$1,523	$52.50
			DVHA	$174,908	$52.15
	019	MA Level Licensed Psychologist or Counselor	DMH	$50	$50.00
			DVHA	$3,839	$48.60
	037	MH Clinic	DMH	$2,579	$34.39
	039	MH/NF Waiver, NFI, Baird	DVHA	$618	$47.57
	040	MH/DS Clinic VHAP	DVHA	$72,778	$52.21
	T06	Nurse Practitioner	DVHA	$14,372	$52.45
	T25	OADAP Facility	ADAP	$7,206	$52.22

Exhibit 4.5 Procedure Code 90834 Psychotherapy, 45 minutes

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90834(Psychotherapy, 45 minutes)	005	Physician	DMH	$870	$62.13
			DVHA	$544,784	$55.87
	019	MA Level Licensed Psychologist or Counselor	DMH	$19,280	$51.83
			DVHA	$2,036,722	$51.91
	030	Doctorate Psychologist	DMH	$5,548	$60.97
			DVHA	$521,246	$59.58
	039	MH/NF Waiver, NFI, Baird	DVHA	$5,980	$52.46
	040	MH/DS Clinic VHAP	DVHA	$1,224,060	$63.99
	T06	Nurse Practitioner	DVHA	$2,571	$48.51
	T17	Case Manager/Social Worker	DVHA	$12,780	$51.74
	T21	Children's Medical Service	DVHA	$52	$51.74
	T25	OADAP Facility	ADAP	$14,561	$63.59

Exhibit 4.6 Procedure Code 90837 Psychotherapy, 60 minutes

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90837(Psychotherapy, 60 minutes)	001	Hospital	DVHA	$448	$224.00
	005	Physician	DMH	$8,260	$86.04
			DVHA	$1,134,932	$89.96
	019	MA Level Licensed Psychologist or Counselor	DMH	$216,147	$77.44
			DVHA	$10,365,534	$77.36
	030	Doctorate Psychologist	DMH	$43,746	$89.10
			DVHA	$2,0677,391	$89.67
	037	MH Clinic	DMH	$1,249	$96.06
	039	MH/NF Waiver, NFI, Baird	DVHA	$6,353	$77.48
	040	MH/DS Clinic VHAP	DVHA	$1,530,295	$92.77
	T06	Nurse Practitioner	DVHA	$176,347	$84.06
	T17	Case Manager/Social Worker	DVHA	$2,944	$77.48
	T21	Children's Medical Service	DVHA	$4,959	$77.48
	T25	OADAP Facility	ADAP	$23,693	$92.19
			DVHA	$155	$77.48
	T38	Certified OADAP Adolescent Counselor	DVHA	$3,099	$77.48

Exhibit 4.7 Procedure Code 90853 Group Psychotherapy, other than multi-family

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
90853(Group Psychotherapy, other than multi-family)	001	Hospital	DVHA	$306	$305.94
	005	Physician	DMH	$444	$36.98
			DVHA	$695,577	$45.70
	019	MA Level Licensed Psychologist or Counselor	DMH	$4,408	$47.40
			DVHA	$673,614	$46.08
	030	Doctorate Psychologist	DMH	$1,397	$63.52
			DVHA	$126,200	$55.24
	037	MH Clinic	DMH	$10,598	$58.88
	040	MH/DS Clinic VHAP	DVHA	$262,580	$58.99
	T21	Children's Medical Service	DVHA	$2,220	$45.30
	T25	OADAP Facility	ADAP	$314	$52.35
			DVHA	$64	$31.83

Exhibit 4.8 Procedure Code 92526 Treatment of Swallowing Dysfunction/Oral Function for Feeding

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
92526 (Treatment of swallowing dysfunction/oral function for feeding)	017	Licensed Therapist or Anes Assistant	DCF	$800	$100.00
			DVHA	$549	$78.39

*DVHA rate unless specialty provider is prior approved by DCF

Exhibit 4.9 Procedure Code 97530 Physical Therapy Activities

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
97530 (Physical Therapy Activities)	017	Licensed Therapist or Anes Assistant	DCF	$75,645	$101.54
			DVHA	$89,339	$99.16

*DVHA rate unless specialty provider is prior approved by DCF

Exhibit 4.10 Procedure Code 99213 Established Patient Visit

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
99213(Established Patient Visit)	005	Physician	DMH	$1,160	$50.45
			DVHA	$1,807,575	$61.42
	007	Optometrist	DVHA	$348	$57.97
	018	Chiropractor	DVHA	$58	$57.97
	019	MA Level Licensed Psychologist or Counselor	DVHA	$4,628	$57.85
	037	MH Clinic	DMH	$20,851	$40.80
	039	MH/NF Waiver, NFI, Baird	DVHA	$348	$57.97
	040	MH/DS Clinic VHAP	DVHA	$193,673	$45.45
	043	Naturopathic Physician	DVHA	$9,217	$57.97
	T06	Nurse Practitioner	DMH	$58	$57.97
			DVHA	$37,665	$57.50
	T25	OADAP Facility	ADAP	$7,083	$40.94

Exhibit 4.11 Procedure Code 99214 Established Patient Visit, Moderate Complexity

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
99214 (Established Patient Visit, Moderate Complexity)	005	Physician	DMH	$2,899	$78.35
			DVHA	$2,048,910	$93.05
	007	Optometrist	DVHA	$513	$85.56
	018	Chiropractor	DVHA	$1,455	$85.56
	019	MA Level Licensed Psychologist or Counselor	DMH	$86	$85.56
			DVHA	$10,339	$82.71
	037	MH Clinic	DMH	$31,237	$63.10
	039	MH/NF Waiver, NFI, Baird	DVHA	$2,225	$85.56
	040	MH/DS Clinic VHAP	DVHA	$201,614	$67.89
	043	Naturopathic Physician	DVHA	$26,267	$85.56
	T06	Nurse Practitioner	DMH	$257	$85.56
			DVHA	$118,984	$84.20
	T25	OADAP Facility	ADAP	$2,269	$68.76

Exhibit 4.12 Procedure Code 99231, 99232, 99233 Evaluation and Management Hospital Follow-Up

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
99231 (Subsequent Hospital Care, Low Complexity)	005	Physician	DMH	$29,812	$31.02
			DVHA	$109,018	$31.28
99232 (Subsequent Hospital Care, Per Day, for the Evaluation, moderate complexity)	005	Physician	DMH	$57,319	$56.75
			DVHA	$286,733	$57.84
	T25	OADAP Facility	ADAP	$229	$57.21
99233 (Subsequent Hospital Care, Per Day, for the Evaluation, new or worsening problem)	005	Physician	DMH	$42,051	$82.45
			DVHA	$586,374	$82.77

Exhibit 4.13 Procedure Code 99285 Emergency Department Visit

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
99285 (Emergency Dept. Visit)	001	Hospital	DVHA	$1,035	$344.91
	005	Physician	DVHA	$126,185	$137.61

Exhibit 4.14 Procedure Code G9012 Other Specified Case Management

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
G9012 (Other Specified Case Management)	T20	SRS	DCF	$10,449,991	$454.60
			DVHA	$1,726	$431.38

Exhibit 4.15 Procedure Code H0019 Behavioral Health Residential (PNMI)

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
H0019 (Behavioral Health Residential)	039	MH/NF Waiver, NFI, Baird	DVHA	$641,333	$2,174.01
	T23	PNMI	DCF	$11,514,893	$5,514.80
			DMH	$4,204,713	$1,339.51
			DVHA	$17,288	$3,457.60

Exhibit 4.16 Procedure Code H2011 Crisis Intervention, per 15 minutes

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
H2011(Crisis Intervention, per 15 minutes)	037	MH Clinic	DMH	$1,093,821	$293.88
			DVHA	$462	$230.94
	038	MR Clinic	DAIL	$1,877	$117.28
	040	MH/DS Clinic VHAP	DVHA	$914,032	$343.17

Exhibit 4.17 Procedure Code H2022 Community Based Wraparound Services, per diem

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
H2022 (Community Based Wraparound Services, per diem)	039	MH/NF Waiver, NFI, Baird	DMH	$2,208,118	$1,122.01
	042	MR Waiver	DAIL	$162,049,676	$765.18
	T23	PNMI	DMH	$93,229	$15,538.19
	T34	DDMHS Case Rate	DMH	$71,397,934	$3,083.88

Exhibit 4.18 Procedure Code S5125 Attendant Care Services

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
S5125 (Attendant Care Services)	T04	Personal Care Aid/Assistant	DAIL	$2,948	$368.55

Exhibit 4.19 Procedure Code T1013 Sign Language or Oral Interpretation, per 15 minutes

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T1013 (Sign Language or Oral Interpretation, per 15 minutes)	005	Physician	DVHA	$23,275	$54.77
	019	MA Level Licensed Psychologist or Counselor	DVHA	$5,054	$60.16
	030	Doctorate Psychologist	DMH	$3,472	$58.85
			DVHA	$51,485	$60.01
	037	MH Clinic	DMH	$2,430	$43.39
	038	MR Clinic	DAIL	$360	$120.00
	040	MH/DS Clinic VHAP	DVHA	$8,475	$88.28
	T21	Children's Medical Service	DVHA	$2,490	$55.33

Exhibit 4.20 Procedure Code T1016 Case Management, each 15 minutes

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T1016 (Case Management, each 15 minutes)	T19	Vocational Rehabilitation Agency (TBI)	DAIL	$304	$304.25

Exhibit 4.21 Procedure Code T1017 Targeted Case Management

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T1017(Targeted Case Management)	037	MH Clinic	DMH	$5,056,637	$65.24
			DVHA	$789	$131.52
	038	MR Clinic	DAIL	$416,973	$47.43
	T16	Targeted Case Management	DAIL	$1,490,690	$216.67

Exhibit 4.22 Procedure Code T1020 Personal Care Services, per diem

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T1020 (Personal Care Services, per diem)	T04	Personal Care Aid/Assistant	DVHA	$7,990,690	$383.78
	T19	Vocational Rehabilitation Agency (TBI)	DAIL	$686,505	$1,485.94

Exhibit 4.23 Procedure Code T1024 Evaluation and Treatment by Integrated Specialty Team

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T1024 (Evaluation and Treatment by Integrated Specialty Team)	T18	Developmental Disability Agency VDH	VDH	$27,492	$1,446.95
	T21	Children's Medical Service	DCF	$3,538,175	$729.67
	T27	DOE	AOE	$2,972,967	$421.88

Exhibit 4.24 Procedure Code T1027 Family Training & Counseling for Child Development, per 15 minutes

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T1027 (Family Training & Counseling for Child Development, per 15 minutes)	017	Licensed Therapist or Anes Assistant	DCF	$1,343	$55.96
			DVHA	$544	$60.44
	T18	Developmental Disability Agency VDH	VDH	$1,421,952	$2,072.82
	T20	SRS	DCF	$2,300,313	$509.48

Exhibit 4.25 Procedure Code T2025 Waiver services, not otherwise specified

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T2025 (Waiver services, not otherwise specified)	037	MH Clinic	DMH	$7,389,709	$1,196.33
			DVHA	$1,346	$1,346.00
	T14	Aged/Disabled Waiver	DVHA	$9,296	$1,327.97
	T20	SRS	DMH	$626,654	$679.67

Exhibit 4.26 Procedure Code T2038 Community Transition, Waiver

Procedure Code	Provider Type	Provider Description	Dept.	CY2014 Expenditures	Average of Paid Claims
T2038 (Community Transition, waiver)	T19	Vocational Rehabilitation Agency (TBI)	DAIL	$45,109	$11,277.33