

Requirements for Provider Type 08 - Clinic

Specialty Code

Please choose from the following for specialty and code:

050- Home Health Agency	430 – Homemaker Agency
074- Mobile Mental Health Treatment	512 – Respite Care (home)
076- Peer Support Services	558 – Behavior Specialist for Children with Autism
080- Federally Qualified Health Center	800 – FQHC – Therapeutic Staff Support
081- Rural Health Clinic	801 – FQHC – Mobile Therapy
082- Independent Medical/Surgical Clinic	802 – FQHC – Behavioral Specialist Consultant
083- Family Planning Clinic	803 – FQHC – Summer Therapeutic Activity Program (STAP)
084- Methadone Maintenance	804 – RHC – Therapeutic Staff Support
085- Family Planning Clinic Women Services	805 – RHC – Mobile Therapy
086- Dental Clinic	806 – RHC – Behavioral Specialist Consultant
110- Psychiatric Outpatient	807 – RHC – Summer Therapeutic Activity Program (STAP)
184 – Outpatient Drug and Alcohol Clinic	808 – Psychiatric Outpatient Therapeutic Staff Support
370 – Tobacco Cessation	809 – Psychiatric Outpatient Mobile Therapy
410 – Adult Day Care	810 – Psychiatric Outpatient Behavioral Specialist Consultant
	811 – Psychiatric Outpatient Summer Therapeutic Activity Program (STAP)

Provider Eligibility Program (PEPs)

Please choose the appropriate PEP(s) from the following:

- Fee-For-Service
- Pennsylvania Department of Aging Waiver and Bridge Program
- Michael Dallas Waiver
- COMMCARE Waiver
- AIDS Waiver
- MR Base Program

Additional Required Documents for Provider Type 08:

The following documents and supporting information are required by the Bureau of Fee-For-Service Programs to enroll your facility as a provider:

- Completed Provider Enrollment Application
- **You MUST complete the Provider Disclosure/Ownership or Control interest form. This form can be found on the enrollment website or by following this link:**

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf

- Signed Outpatient Provider Agreement
- Copy of document generated by the Federal IRS that shows both name and tax ID of entity applying for enrollment.
- Completed “Ownership or Control Interest” form (attached) for all clinics
- Peer Support Services Addendum (For Specialty 076 only).
- Out of state providers- proof of home state Medicaid participation.
- **For Specialties 558** and 800 through 811, include the Service Description denoting approval by the Bureau of Children’s Behavioral Health Services, Office of Mental Health & Substance Abuse Services (OMHSAS). Contact the Bureau at RA-BHRS@pa.gov or 717-705-8289 for additional information or requirements.

For Family Planning Clinics only:

- The Name and 13-digit PROMISe™ provider number of the licensed Medical Director

For Independent Medical Clinics only:

- The “Additional Information for Independent Medical Clinic” form (attached).

For Federally Qualified Health Centers and Rural Health Clinics only:

In addition to the completed application and required documents, the following documents and supporting information are required by the Bureau of Fee-For-Service Programs to enroll your facility as a provider:

- Signed FQHC Provider Agreement (must be “FQHC Provider Agreement” not the “Provider Agreement for Outpatient Providers”).
- Copy of Medicare Rate Letter (If available)
- Copy of HRSA designation letter
- Copy of Fee Schedule charged to private patients and all third party payers.
- Copies of any contracts or agreements between the clinic and all licensed practitioners of all types relating to services provided by the clinic; as well as a statement indicating which practitioners, if any, are salaried to provide services outside the clinic.

For Drug and Alcohol Clinics only:

- A statement signed by the Medical Director (licensed physician enrolled with PA Medicaid) indicating their affiliation with the clinic.
- A copy of the Medical Director’s license
- A copy of the license from the Department of Health.

For Outpatient Psychiatric Clinics only:

- A copy of the Certificate of Compliance.
- A statement signed by the Medical Director (licensed physician enrolled with PA Medicaid) indicating their affiliation with the clinic.
- A copy of the Medical Director’s license.
- A copy of the OMHSAS-approved Mobile Mental Health Treatment service description (for Specialty Code 074 only)

For Hospital Based Medical Clinics only:

- Completed “Application for Clinic Reimbursement Rate” form (attached).

Submittal Address:

After completion of all enrollment documents (except for Peer Support Services enrollments), send the complete packet to:

DPW
Provider Enrollment Unit
PO Box 8045
Harrisburg, PA 17105-8045

For Peer Support Services Only:

Refer to attached “Addendum-Peer Support Services” which also includes submittal addresses.

ADDITIONAL INFORMATION FOR INDEPENDENT MEDICAL CLINIC ONLY

1. CLINIC NAME AND ADDRESS:

Name:

Street Address:

City:

State:

Zip Code:

2. TYPE OF STATE OR FEDERAL FUNDS RECEIVING OR INITIAL STARTUP FUNDS RECEIVED:

INITIAL START UP FUNDS RECEIVED/CURRENT FUNDS RECEIVING

<u>Fund Type</u>	<u>State or Federal Funds</u> (Please check one)	<u>Amount Received</u>
_____	<input type="checkbox"/> State <input type="checkbox"/> Federal	\$ _____
_____	<input type="checkbox"/> State <input type="checkbox"/> Federal	\$ _____
_____	<input type="checkbox"/> State <input type="checkbox"/> Federal	\$ _____
_____	<input type="checkbox"/> State <input type="checkbox"/> Federal	\$ _____
_____	<input type="checkbox"/> State <input type="checkbox"/> Federal	\$ _____

3. DOES CLINIC PROVIDE COMPREHENSIVE MEDICAL SERVICES FOR A MINIMUM OF FORTY (40) HOURS PER WEEK?

YES

NO

4. ARE SERVICES PROVIDED DIRECTLY BY A PHYSICIAN OR UNDER THE SUPERVISION OF A PHYSICIAN DURING SCHEDULED HOURS OF OPERATION?

YES

NO

5. IF A PHYSICIAN DOES NOT PROVIDE THE SERVICES DIRECTLY, ARE SERVICES PROVIDED BY A CERTIFIED REGISTERED NURSE PRACTITIONER OR A PHYSICIAN ASSISTANT DURING SCHEDULED HOURS OR OPERATION?

YES

NO

6. LIST OF PHYSICIANS, CERTIFIED REGISTERED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS WHO STAFF THE CLINIC:

Name:

Name:

6. (Cont'd.):

<u>Name:</u>	<u>Name:</u>

7. DO YOU HAVE A CURRENT FEE SCHEDULE FOR BILLING ALL THIRD PARTY AND PRIVATE PAYERS?

YES

NO

8. WHAT IS YOUR LOWEST CHARGE PER VISIT?

\$ _____

9. DO YOU LIMIT THE NUMBER OF PATIENTS YOU SERVE BY VIRTUE OF PAYMENT SOURCE?

YES

NO

10. INCLUDE A STATEMENT CONFIRMING THE PROCEDURE THE CLINIC FOLLOWS FOR A PATIENT REFERRAL PROCESS THAT ENSURES FOLLOW-UP TREATMENT BY OTHER PHYSICIANS OR APPROPRIATE SPECIALISTS.

11. INCLUDE A STATEMENT THAT THE CLINIC PROVIDES DIRECT EMERGENCY MEDICAL CARE, THROUGH FORMAL AGREEMENTS, AND PROVIDES FOR ACCESS TO HEALTH CARE FOR MEDICAL EMERGENCIES DURING AND AFTER THE CLINIC'S REGULARLY SCHEDULED HOURS.

9. List of physicians who staff the clinic.

10. Does the clinic provide comprehensive medical services for minimum of forty (40) hours per week? YES NO

11. Is a licensed physician present in the clinic at all times during scheduled hours of operation to perform medical services? YES NO

12. Do your clinic physicians have the authority to independently admit patients to the hospital? YES NO

If no, how is this accomplished? _____

13. Is the clinic operated by the hospital either directly or under contract with private physicians or corporations? YES NO

If no, how is the clinic operated? _____

14. If this is a new approval, do you want a separate service location for the clinic?

YES NO

If yes, please complete:

In care of, Attention, Building Name, P.O. Box, etc.

Street:

City State Zip Code

County (Area Code) Phone Number

Payment is to be made to this address: YES NO

15. I certify that the information on this application is true to the best of my knowledge.

SIGNATURE

DATE

HOSPITAL ADMINISTRATOR

ADDENDUM- PEER SUPPORT SERVICES (Specialty 076)

Required Documents:

- PROMISe™ Provider Enrollment Base Application
- Signed Outpatient Provider Agreement
- Copy of Tax Document generated by the IRS showing both the name and tax ID of the entity applying for enrollment
- Copy of Certificate of Compliance
- Copy of approved Peer Support Services service description
- Signed Supplemental Provider Agreement for Peer Support Services
- Copy of Subcontract Agreement (for subcontracted providers only)

Submit Enrollment Packet to the appropriate OMHSAS Field Office:

Northeast Field Office OMHSAS
Scranton State Office Bldg
100 Lackawanna Avenue Room 321
Scranton, PA 18503-1939

Southwest Field Office OMHSAS
Pittsburgh State Office Bldg
300 Liberty Avenue Room 413
Pittsburgh, PA 15222-1210

Southeast Field Office OMSHAS
Norristown State Hospital
1001 Sterigere Street B
Bldg 57 1st Floor Room 105
Norristown, PA 17401-5397

Central Field Office OMHSAS
Logan Vista Dome
PO Box 2675
Harrisburg, PA 17105-2675

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
Office of Medical Assistance Programs
SUPPLEMENTAL PROVIDER AGREEMENT FOR THE DELIVERY OF PEER SUPPORT SERVICES

This Supplemental Provider Agreement sets forth the responsibilities of the peer support services provider (“Provider”), which are in addition to those set forth in the Medical Assistance Outpatient Provider Agreement and addendums to that agreement, and the Provider handbooks and supplements.

Provider agrees to deliver services in accordance with the service description approved by the Office of Mental Health and Substance Abuse Services (“OMHSAS”).

Provider agrees to provide on-site services in a facility that:

- a. Affords adequate space, equipment and supplies in order that services be provided effectively and efficiently and with sufficient privacy when necessary.
- b. Is in a location that is accessible and convenient to the service population and is accessible to persons with disabilities.
- c. Meets applicable federal, state and local requirements for fire, safety and health.

Provider agrees to develop written policies, program guidelines and procedures relating to peer support services in accordance with the Peer Support Services Bulletin, Medical Assistance Provider Handbook, this Supplemental Provider Agreement and Provider’s approved service description.

Provider agrees to ensure that a Recovery-focused Individual Service Plan (“Individual Service Plan”) is developed by the individual, the peer specialist and the mental health professional within one month of enrollment and reviewed every six months thereafter and that the initial Individual Service Plan and each review are signed by the individual, the peer specialist and the mental health professional.

Provider agrees that each Individual Service Plan will specify individualized goals and objectives pertinent to the individual’s recovery and community integration in language that is outcome oriented and measurable; identify interventions directed to achieving the individualized goals and objectives; specify the peer specialist’s role in relating to the individual and involved others; and specify the frequency of peer support services to be delivered.

Provider agrees to deliver services in accordance with the Individual Service Plan. Provider agrees that in order to achieve the agreed-upon goals in the Individual Service Plan, and with the individual’s consent, the peer specialist will work with the individual’s family, service and treatment providers, rehabilitative programs and natural community supports.

Provider agrees that it will typically provide peer support services on an individual (1:1) basis but may offer group services for several individuals together when such services are beneficial, provided that group services may not include social, recreational or leisure activities. To receive peer support services in a group, individuals must share a common goal, and each individual must agree to participate in the group. Services such as psychoeducation or WRAP (Wellness Recovery Action Planning) are the types of services that may be provided in groups.

Provider agrees to insure that attempts are made to contact the individual according to the Individual Service Plan.

Provider agrees to administer and deliver peer support services in accordance with the following staffing and supervision requirements:

- a. Each peer support program will be identified separately from other services or programs offered by the provider and will have a designated supervisor and staff.
- b. Peer support staff, including supervisors, may work in another program or agency, but their time will be pro-rated and their hours of service in each service clearly and separately identified. No staff person may have duplicate or overlapping hours of service in a peer support program and another program or agency. Peer support staff will disclose (to appropriate program management/administration) when they are co-employed with another program or agency.

- c. The ratio of staff to individuals served is to be based upon the needs of the population served and program location (urban vs. rural).
- d. A mental health professional is to maintain clinical oversight of peer support services, which includes ensuring that services and supervision are provided consistent with the service requirements.
- e. A full time equivalent (“FTE”) supervisor may supervise no more than seven FTE peer specialists.
- f. Supervisors will conduct at least one face-to-face meeting with each peer specialist per week with additional support as needed or requested.
- g. Supervisors will maintain a log of supervisory meetings.
- h. Peer specialists will receive at least six hours of direct supervision and mentoring from the supervisor in the field before working independently off-site.

Provider agrees to ensure that Provider staff meet the following minimum qualifications:

- a. A supervisor of peer specialists is either a mental health professional who has completed the peer specialist supervisory training, which is offered in accordance with guidelines defined by the Department, or an individual who has the following minimum qualifications:
 - (i) A bachelor’s degree; and
 - (ii) Two years of mental health direct care experience, which may include experience in peer support services;

OR

 - (i) A high school diploma or general equivalency degree; and
 - (ii) Four years of mental health direct care experience, which may include experience in peer support services, and the completion of a peer specialist supervisory training curriculum approved by the Department within 6 months of assuming the position of peer support supervisor.
- b. A peer specialist is a self-identified individual who has received or is receiving state priority group services as defined in MH Bulletin OMH-94-04, Serious Mental Illness: Adult Priority Group, and who:
 - (i) Has a high school diploma or general equivalency degree; and
 - (ii) Within the last three (3) years, has maintained at least 12 months of successful full or part-time paid or voluntary work experience or obtained at least 24 credit hours of post-secondary education; and
 - (iii) Has completed a peer specialist certification training curriculum approved by the Department.

Provider agrees to develop a written staff training plan that ensures that each practitioner in the peer support program receives training appropriate to his or her identified needs and the position requirements specified in this paragraph. The training plan will identify training objectives that address the enhancement of knowledge and skills as well as the provision of services in an age-appropriate and culturally competent manner and ensure that staff attain and maintain peer specialist certification.

- a. Mental health professionals who assume responsibility for supervision of peer support services will complete a peer specialist supervisory orientation/training course approved by the Department.
- b. Supervisors who are not mental health professionals will complete a peer specialist supervisory orientation/training course approved by the Department.
- c. The supervisor’s orientation/training course will be completed within 6 months of assuming the position of peer specialist supervisor.
- d. Peer specialists will complete a peer specialist certification training curriculum approved by the Department before providing peer support services.
- e. Peer specialists will complete 18 hours of continuing education training per year with 12 hours specifically focused on peer support or Recovery practices, or both, in order to maintain peer specialist certification.

Provider agrees to maintain a written record of training attended by each peer support staff classification (Administrator/Program Director, Mental Health Professional, Peer Specialist Supervisor, Certified Peer Specialist).

Provider agrees to ensure that peer specialists within the agency are given opportunities to meet with or otherwise receive support from other peer specialists both within and outside the agency.

Provider agrees to have written protocols that address coordination of services with other appropriate mental health treatment, rehabilitation, and co-occurring disorder programs, including substance abuse services, as well as medical services, community resources and natural supports and document linkages with such other resources. With the individual's written consent, such coordination includes periodic peer support progress reports to the referral source and treatment providers.

Provider agrees to have written protocols that describe how the certified peer specialist and certified peer specialist supervisor will participate in and coordinate with treatment teams at the request of a consumer and the procedure for requesting team meetings.

Provider agrees to make available to participants a list of culturally competent resources related to housing, leisure, legal entitlements, emergency needs, physical health and wellness, mental health treatment and co-occurring disorders.

Provider agrees to make available to participants, based upon individual need, information regarding substance abuse services and support groups, including but not limited to Dual Recovery Anonymous, Alcoholics Anonymous and Narcotics Anonymous.

Provider agrees that its quality assurance plan will include a written Continuous Quality Improvement ("CQI") plan, as described in this paragraph, addressed to the delivery of peer support services, which is reviewed and updated annually. Provider agrees to include participation from individuals receiving peer support services in both the development of the CQI plan and the annual reviews.

- a. The CQI plan will describe how Provider will:
 - (i) Identify and work to eliminate organizational, systemic and community barriers that may interfere with the ability of the peer specialist to perform his or her primary job responsibilities.
 - (ii) Promote a spirit of collaboration and partnership among the provider, the peer specialist and community stakeholders.
- b. The CQI plan will describe procedures for ongoing review of the plan and for a systematic review of services and outcomes, including review of Individual Service Plans, to ensure quality, timeliness and appropriateness of services and individual satisfaction with services. The procedures will describe the types and frequency of reviews to be undertaken (e.g., quarterly professional staff conferences, peer reviews, case reviews conducted by internal or external individuals or entities).
- c. The CQI plan will include an annual report that describes the population served and the outcome of the reviews conducted through the year, including the progress made or not made in meeting the goals specified in the plan, and provider agrees to disseminate the report to OMHSAS, provider staff, the agency director, the County MH/MR Administrator, the behavioral health managed care organizations in which the provider is enrolled and consumers and their families.

Provider agrees to treat, and to insure that its staff treats, information about individuals who are receiving peer support services as confidential as required by regulations at 55 Pa. Code §§ 5100.31 - 5100.39 (relating to confidentiality of mental health records), and the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104-191, and accompanying regulations at 45 C.F.R. Part 164 (relating to security and privacy).

Provider agrees that it will make no service decisions in violation of the individual's civil rights as set forth in 55 Pa.Code §§ 5100.53 - 5100.56 (relating to patient rights).

Provider agrees to insure that individuals receiving peer support services are informed of their rights, including their right not to be discriminated against on the basis of age, race, sex, religion, ethnic origin, economic status, sexual preference, or diagnosis, and their right to appeal a decision to reduce or terminate peer support services over the individual's objection.

Provider agrees to submit reports as required by the Department, county MH/MR administrator and appropriate behavioral health managed care organizations.

If Provider is providing peer support services through a subcontractor that is not enrolled in the Medical Assistance Program, Provider agrees to be responsible for the clinical and administrative oversight of the services delivered by the subcontractor and for compliance with program requirements.

I hereby agree to comply with the terms of this Supplemental Provider Agreement, the Peer Support Services Bulletin, the Medical Assistance Provider Handbook, and all requirements that govern participation in the Medical Assistance Program:

Provider Name (please type or print)

Provider Signature

Date

Provider Address (please type or print)