State CFAC - Service Definitions Feedback (2-14-05)

MH/DD/SA Service Description	Page Numbers	Questions, Comments and Concerns
Community Support-Adult	1--6	**Questions:** In the Division's service definition training, it was stated that service units identified are minimum amounts. In the Utilization Management section, maximum rates are defined. Please clarify.
		Entrance Criteria: Consider using more consumer-friendly recovery-based language. Example: Entrance Criteria #D8: change "…in need of relapse prevention support" to "…in need of continuing recovery support."
Community Support-Children/Adolescents	7--11	**Issue: Consumers who are incarcerated.** At the service definition training, we were informed that IPRS or Medicaid could not be billed for incarcerated consumers. **Suggestion:** Develop a separate code to bill this service for incarcerated consumers or set up an edit that will not allow a location of a jail site to bill Medicaid or IPRS. It was recommended at the training that services be set up for incarcerated consumers via non-UCR. We prefer this not be the standard because of the additional tracking requirements for providers and LMEs. **Question:** When will the clock start for providers already in an LME's provider network to obtain the national accreditation? When will consumers, LMEs and providers be nofitied about which accrediting bodies have been chosen by the State. The accrediting process is lengthy therefore providers need this information as soon as possible. Will the State offer education to consumers about what an accrediting process is and what it means for them?
Mobile Crisis Management	12--15	**Question:** The service definition notes that a staff person must have experience in crisis management, assertive outreach, assertive community treatment or emergency management. Can a case manager qualify since many have been involved with assertive outreach activities? If not, clairfy the credentials. Can you provide examples of crisis intervention strategies? **Recommendation:** Includethe term "recovery education" in the list of expected outcomes in the first section. **Clarification/Suggestion:** In the Expected Outcomes section, it states that services are there to minimize "clinical crisis or situations." If crisis is defined by the consumer/family member in the person-centered plan, the word "clinical" should be removed.

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Diagnostic Assessment	16--18	**Staff Qualifications**: 1 QP (licensed or certified) and 1 must be an MD, DO, Nurse Practitioner, PA or Ph.D. Many providers have voiced difficulty in meeting this minimum requirement for enhanced services. If practitioners with these credentials cannot be hired in a local area, how will enhanced services be provided to consumers who qualify for them and need them? The State must assist LMEs to identify a contingency for providing these services if these staff cannot be hired. **Documentation Discrepancy: T**he first paragraph notes that the DA is for MH/SA consumers. However, in the program requirements, it notes it is for MH/DD/SA consumers. Which is correct?
Intensive In-Home Services	19--23	**Question Recommendation:** Is there funding available for IPRS and Medicaid to bill for services for consumers aged 18-20? If not, why set the age requirement to 20, instead of 17? **We support a higher age range particularly to support consumers in transition from child to adult services.** Many consumers will require a longer transition. **Issue:** What are the training components for this service? They are not defined in the definition. Appropriate training is very important for someone who will perform in-home services. **Question:** What is the reasoning for requiring a shift note and not a daily note, since this service is similar to ACT, MST, which require a daily note.
Multi-systematic Therapy (MST)	24--27	
Community Support Team	28--32	**Documentation Discrepancy:** On page 28 it notes a physician, licensed psychologist, physician assistant or nurse practitioner completes the service order. On page 30, it states a QP completes the service order. Clarify which is correct. Again, the requirement of have a higher level practitioner complete the service order may be very problematic in some communities. What is the reasoning that this is necessary? Doesn't this add to the cost of providing the service? **Question:** Some consumers may require more than eight (8) hours a day of service. What type of documentation is expected to support billing for more than eight (8) hours per day? If there is appropriate documentation, will those bills for services be paid. **Recommendation:** Use more recovery-centered language. Example: On page 28, in the first sentence under the "Service Definition and Required Components" section, include the term "wellness: "...in achieving wellness, rehabiliative and recovery goals."

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Assertive Community Treatment (ACTT)	33--39	**Issue:** The SD states that there must be an average of 3 contacts per week, a dramatic increase from the previous 4 per month. Is this based on the best practice model? If a provider does not reach this average one week out of the month, can (s)he still bill for the weeks he did average three contacts or would that jeopardize the entire month's billing? Providers are asking for clarification of how to bill an "average" number of visits. Also, this requirement creates a reimbursement issue for most providers delivering this service. Based on the number of contacts and the high level clinicians required, the service rate is not adequate. Consider increasing the rate or this service will not be cost effective and LMEs will be unable to keep or recruit providers. Also consider allowing some service overlaps for ACT consumers who require partial hospitalization or who would benefit from DMH Psychosocial Rehab.
Inpatient Hospital Psychiatric Treatment	40-43	
Psychosocial Rehabilitation	44--46	This service cannot be provided during the same authorization period with PH and ACT. **Challenge:** Again, this would eliminate some ACT consumers from receiving this service. Since these services cannot be billed on the same day as Community Support, it creates a dilemma for some of the consumers currently needing coordination of care. Consider some limited overlap of these services to provide the continuity of care these consumers most need.
Child and Adolescent Day Treatment	47--51	**Issue:** The SD states that case management services are part of the day tx service, however it should be provided separate from the consumer's residence. Case management should be provided at the consumer/family's convenience: the cm needs to coordinate care, meet with the consumer/legal guardian, get PCP signed, etc. It seems unreasonable that this can't be at the home. **Issue:** The client-to-staff ratio is 6:1. The licensure requirement is 8:1. It appears these ratios should agree and the smaller ratio is our preference.
Psychiatric Residential Treatment Facility (PRTF)	52--56	
Substance Abuse Services	57--79	
Detoxification Services	80--97	

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Developmental Therapy Services	88--91	**Note**: The SD states that DTS can be provided in a group setting but there is no group rate to accommodate billing a group service. Does the state plan to incorporate a group rate? What would be the criteria for a consumer to benefit from group therapy? Can a consumer participate in individual and group DTS at the same time if it can be demonstrated that it would benefit the consumer? **Question:** Define the time parameters for this service, otherwise this may be at the discretion of each provider. Shouldn't there a minimum time requirement for effective group therapy?
Targeted Case Management for Individuals w/DD	92--94	