

FINAL COMMUNITY SUPPORT DEFINITIONS HAVE BEEN PUBLISHED

The Guilford Center urges Community Support Services providers to carefully study the new definitions for Community Support – Adults and Community Support – Children/Adolescents published by Division of Medical Assistance in Clinical Coverage Policy 8A at <http://www.dhhs.state.nc.us/dma/bh/8A.pdf> (revised February 1, 2008, Effective March 1, 2008). Find the new service definitions on pages 24-43; there are no other changes in CCP 8A.

Community Support providers should also study Implementation Update #39, <http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/dmadmh2-6-08update39.pdf> and draft Appendix A, Community Support Comprehensive Service Provider Corporate Endorsement Standards at <http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/dmadmh39attach.doc>. The public comment period on Appendix A ends March 1, 2008.

Implementation Update #39 also formalizes the requirement for a review of the PCP with each authorization request.

SOME CHANGES IN THE SERVICE DEFINITIONS FOR COMMUNITY SUPPORT

- Service Definition and Required Components (pages 24 and 34) has been expanded from three paragraphs to more than one-and-one-half pages with much more emphasis that all services are related to diagnosis, symptoms of that diagnosis and effects of those symptoms on the individual consumer.
- The description of the role and duties of the QP has been expanded (pages 25 and 35)
- The list of services performed by the QP or the AP/PP has been expanded and amplified (pages 27 and 37)
- A QP must perform at least 15% of billable services for each individual served and the agency must document 25% aggregate service by a QP (pages 28 and 38). It is the understanding of the LME that these QP services must be among the services listed on pages 27 and 37 for the QP, i.e., the QP may not perform one-on-one services defined for the AP/PP and count this as part of the 15% or 25% of billed time. Each agency must develop a way to document the aggregate 25% of QP services. (In the draft service definitions the requirement was for 25% QP services for each individual served.)
- In the Entrance Criteria, life domains have been defined. The PCP must document significant impairment in two domains: emotional, social, safety, housing, medical/health, and legal (pages 28 and 38)
- The new definitions reduce other entrance criteria (D) from eight points to six. Unmet needs from multiple agencies must relate to a diagnosis of MH/SA (pages 29 and 39)
- Adults are limited to 4 unmanaged QP hours and children to 8 hours for the development of an introductory PCP and to organize a comprehensive clinical assessment. These unmanaged hours are available only to recipients new to the service system and not new to the provider (pages 29 and 39)
- Medicaid will authorize no more than 780 units/90 days (approximately 15 hours per week) and it is expected that the intensity will quickly decrease (pages 32 and 42)

CHANGES SPECIFIC TO COMMUNITY SUPPORT – ADULTS

- Community Support – Adults can be billed at the same time as Psychosocial Rehabilitation (page 32)

CHANGES SPECIFIC TO COMMUNITY SUPPORT – CHILDREN/ADOLESCENTS

- There is much more emphasis on the Child and Family Team to create, implement and update a plan (pages 35, 37, 39). DHHS expects that after the initial visits, the PCP will document participation by all service providers as well as natural community supports.

“Child and Family Teams are family members and their community supports that come together to create, implement and update a plan with the child, youth/student and family. The plan builds on the strengths of the child, youth and family and addresses their needs, desires and dreams.”

Endorsed by the NC State Collaborative for Children, Youth and Families, December 2007.