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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

September 11, 2017

TO: Interested Party

RE: Consultation Summary
Project #1705-CMH

Thank you for your comment(s) to the Medical Services Administration (MSA) relative to Project Number 1705-CMH. Your comment(s) has been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

Comment: Would this service have to be 24-7?

Response: Multiple comments were received regarding the hours that services need to be available. Services are not required to be provided 24-7. Please evaluate peak crisis usage times to determine when the services are most needed.

Comment: Is the intent of this service to be available to all youth in the catchment area despite insurance type or Medicaid only?

Response: The service must be provided to all who meet eligibility criteria for Prepaid Inpatient Health Plans (PIHP) Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan Specialty Behavioral Health services. The PIHP is responsible to ensure that the service is available in sufficient capacity to meet the need in the region.

Comment: In the Individual Plan of Service (IPOS) section, is this indicating that if the intensive crisis stabilization team continues to meet with the youth/family after the initial crisis?

Response: Many comments were received regarding the crisis team's responsibilities regarding the IPOS. The purpose of intensive crisis stabilization services is to resolve the presenting crisis. These are not ongoing services. Any changes to the IPOS would be the responsibility of the current treatment team, including the child and family.

Comment: We do not have the resources or the number of children to implement this program in a rural area.

Response: Many comments were received regarding implementing this service with limited staff and in rural areas. This is a current PIHP Medicaid EPSDT State Plan Specialty Behavioral Health service and should be provided to people eligible for those services. The PIHP is responsible to ensure that the service is available in sufficient capacity to meet the need in the region. There is no additional funding associated with this service. Rural response time is 2 hours to accommodate rural areas.

Comment: Would you consider directly addressing, or underscoring that Substance Use Disorder (SUD) might be present, and that the decision for level of intervention does not have to be immediately confined to MI vs. SUD paths only?

Response: The population that may receive this service is defined in the proposed language. SUD is included.

Comment: Is the policy to cover any location?

Response: Many comments were received regarding location of services. This service is intended to be provided in the home and community where the crisis is occurring. Federal Medicaid regulations prohibit the use of Medicaid for this service in detention facilities, residential care and during inpatient hospitalization. Prior to a hospital admission, a team could respond in the emergency room or school with the permission of parents and staff at the location. Please see Medicaid Manual, Behavioral Health and Intellectual/Developmental Disabilities Chapter, Section 2.3 – Location of Services for further clarification. If utilizing non-Medicaid local funding, different arrangements can be made locally.

Comment: For follow-up after the crisis, would the team be expected to consult with school personnel or others that would have contact with the child/youth within 24 hours (36 hours?) of the crisis?

Response: That would not be the responsibility of the intensive crisis stabilization team. Appropriate referrals should be made as medically necessary and as agreed upon by the family. Contact with any other entity must be with parent/guardian's permission via a signed release of information.

Comment: What code is to be used to bill for these services?

Response: Many comments were received regarding which code to use for this service. Intensive crisis stabilization services are and have been Medicaid State Plan services and already have an encounter code, S9484. Instructions for how to use the code and what it covers are included in the

PIHP/CMHSP ENCOUNTER REPORTING HCPCS and REVENUE CODES document located at http://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf.

Comment: Does the psychiatrist have to be on-call 24 hours and do they have to be a child psychiatrist because this may be a challenge to our agency as we have one child psychiatrist on staff.

Response: Many comments were received regarding the requirement for access to an on-call psychiatrist. Yes, team members must have access to an on-call psychiatrist by telephone if needed. A psychiatrist needs to be available for consultation when the team is working due to the intensity of this service. The psychiatrist does not have to exclusively treat children.

Comment: Are staff required to be assigned to this program full-time?

Response: Staff are not required to be assigned full-time to this program.

Comment: Within the Population section, the indication is written as services or co-occurring SED and SUD services for children with SED and/or I/DD, including autism, etc....This implies that the youth would have a diagnosis already. Later, the policy draft speaks to eligibility for a youth not receiving services.

Response: If not open to PIHP services, a screen must be completed to determine eligibility, much like screening that occurs when individuals call the 24-hour crisis line.

Comment: What are the time frames for follow up on a crisis plan, IPOS after mobile crisis contact by the therapist or case manager.

Response: This should occur the next time the therapist or case manager meets with the family.

Comment: The Population section defines the ages (children or youth, ages 0-21, with SED and/or I/DD, including autism, or co-occurring SED and SUD), why?

Response: Under EPSDT, children and youth up to age 21 who meet medical necessity criteria are eligible for this service.

Comment: What is the unmet statewide need to justify this program? What are the outcomes that will make meaningful impact above and beyond current services sufficient to justify the cost?

Response: Many comments were received regarding the reason for the change in this service and expected outcomes. This is not an addition of a service. Intensive crisis stabilization services are and have been existing Medicaid State Plan services which means they are and have been required to be provided by the PIHPs. The changes proposed to this service are meant to customize the service for children and families and make it more meaningful and effective. The fact that there is a shortage of psychiatric hospital beds for children in Michigan and that the current array of PIHP services available to children is not stopping this influx of requests for hospitalization requires an increase in options for crisis response for children and families. Existing programs in other states and in Michigan that utilize a mobile crisis response approach for children experience lower rates of psychiatric hospitalization for children. With the changes proposed to intensive crisis Stabilization Services for children, it is anticipated that these outcomes can be replicated.

Comment: A commenter asked about staff safety after-hours and in the community?

Response: Many comments were received regarding staff safety. PIHPs already provide services in the home and community. MDHHS expects each agency to have policies and procedures in place to ensure staff safety when providing any and all PIHP services.

Comment: What if there are two concurrent requests that don't allow for the time frame to be met? Are multiple teams required?

Response: The two concurrent requests should be triaged based on imminent need. Two teams may be needed based on volume. Location of staff should be taken into consideration when staffing a shift.

Comment: Does this policy apply to SED services in general and/or Mobile Crisis Unit services?

Response: This language proposes to change the existing intensive crisis stabilization services for children ages 0 to 21 that currently exists in the Medicaid Manual. PIHPs are required to provide services in accordance with requirements as outlined in the Medicaid Provider Manual.

Comment: The S9484 code is for an hour. Is there any way to shorten that time frame?

Response: MDHHS is exploring options to shorten the billable unit of time for the encounter code S9484, if possible.

H2011 implemented

Comment: The services must include all populations although the model for children should be individualized based on needs/effective interventions which could vary significantly across populations.

Response: Many comments were received regarding the requirements for qualified staff. There is no exemption for having staff that is qualified to serve the mandated populations that PIHPs must serve. None of the qualified staff requirements will be changed.

Comment: The policy states that the PIHP must seek and receive approval for crisis stabilization yet the model described is more prescriptive of the mobile intensive model. This needs to be clearer if you are only endorsing that model.

Response: MDHHS is not requiring a specific model. The service is defined by the language in the Medicaid Provider Manual and those are the standards that must be met.

Comment: Can you define "paraprofessional?" Could this be a youth peer, parent support partner? Access to on-call psychiatry is concerning with the shortage of child psychiatrist as I am assuming the consultation would only cover a child psychiatrist. This would need to be clarified as well.

Response: "Paraprofessional" and "psychiatrist" are defined in the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes1 document.

Comment: On page 4 of the proposed policy, there is a sentence that stated treatment resources and any other resource the child or youth and parent/caregiver may require. I would change that to "may need."

Response: That change was made.

Comment: The requirement of two staff at all time. We endorse two staff the majority of the time, however, would like some flexibility in this area for times that may not warrant two staff.

Response: Many comments were received regarding having two staff respond to crises. Two staff are required.

Comment: If the Homebased team offers these services, would that affect their outcome indicators? (i.e., 4-hour minimum requirements)

Response: Home-based staff should respond per home-based requirements to crises arising in families open to home-based services. Staff is either providing home-based services or intensive crisis stabilization services, both cannot be provided simultaneously. Intensive crisis stabilization services do not count toward home-based face-to-face requirements.

Comment: Whose request were the timelines of 1 hour for urban and 2 hours for rural?

Response: The 1 or 2 hours response time is from the time the family calls to request assistance.

Comment: Under the Purpose of Intensive Crisis Services section, the "shorten the length of an inpatient stay" language is removed. How does this change affect a program's ability to conduct discharge planning, especially in situations where a child or youth may require planning for such services in advance in order to make a discharge plan successful?

Response: Intensive crisis stabilization services are meant to respond to a crisis as it is occurring.

Comment: Under "Approval," a three-year recertification requirement has been added. Is there an exception process for situations where recertification is not completed due to technical or paperwork errors?

Response: No.

Comment: Defining a Crisis Situation - Overall, we support the criteria outlined to define when a crisis situation is occurring. The one criteria we feel is somewhat vague is the first bullet: "The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance."

Response: This policy is intentional in its requirement that the parent/caregiver defines the crisis.

Comment: What is the approval process for intensive crisis stabilization services for children?

Response: Many comments were received regarding approval of programs. The approval process is the same process as for other MDHHS approved programs, i.e., home-based and wraparound. Additional information about program approval will be provided by MDHHS after Medicaid language is official.

Comment: Can MDHHS clearly define "appropriate supervision" and what training the crisis team members must have, as the proposal only says they must be trained in "crisis intervention and de-escalation".

Response: Each agency should follow their own policies and procedures for the training of intensive crisis stabilization team members. MDHHS will not further prescribe "appropriate supervision" or the content of the training curriculum beyond requiring crisis intervention and de-escalation skills to be a part of it.

Comment: Leaders in the field are moving away from calling this practice a "crisis" stabilization practice and moving towards the concept of mobile response and stabilization. Thus, the language in this policy should be changed to reflect the service as being responsive to the youth and family to assist in stabilization.

Response: The proposed Medicaid Provider Manual language speaks directly to the Medicaid State Plan service called intensive crisis stabilization services. Providers can name their programs anything they chose.

Comment: For population, it is important to note that when the team is responding to a transition age youth or young adult, the interventions should be youth driven, family guided (the opposite of when responding to a youth). Is there a time frame that is going to be proposed for Mobile Stabilization and Support?

Response: All services should be family-driven, youth guided. The purpose of intensive crisis stabilization services is to resolve the presenting crisis. These are not ongoing services. If ongoing services are medically necessary, appropriate referrals should be made.

Comment: Under "Location of Services," we suggest that some type of base threshold of expectations be set so that a certain amount of services are expected to occur within the community.

Response: MDHHS believes the standards are clear as written in regard to this being a mobile service that goes to where the youth and family are to resolve the crisis situation.

Comment: The proposed policy states "These services are for children or youth, ages 0-21, with SED and/or I/DD, including autism, or co-occurring SED and SUD and their parents/caregivers who are currently residing in the catchment area of the approved program and are in need of intensive crisis stabilization services in the home or community as defined in this section." Immediate implementation across all populations aged 0-21 will require a broad clinical base of youth expertise. It is important that

clinicians work within their scope of practice, especially when a youth is experiencing crisis.

Response: This is an EPSDT Medicaid State Plan service. The 0 to 21 age range is a federal requirement for EPSDT services. Appropriately trained staff are expected.

Comment: When does MDHHS expect services to be operational?

Response: MDHHS recognizes that there will be a ramping up time for this service upon approval of the amended language.

Comment: What community-based supports, resources and services should families be referred to?

Response: Any identified community-based supports, resources and services that are clinically appropriate and to which the family agrees to be referred.

Comment: Would COFR youth be included in the population to be served?

Response: All youth currently residing in the catchment area that are eligible for the service would be included.

Comment: What services are included in intensive crisis stabilization services?

Response: The services listed are required to be provided as clinically appropriate as part of intensive crisis stabilization services.

I trust your concerns have been addressed. If you wish to comment further, send your comments to Kim Batsche-McKenzie at:

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Sincerely,

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