Final Transcript

STATE OF ILLINOIS: Training on Revision of Part 132

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SPEAKERS

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PRESENTATION

Moderator: Welcome to the Provider Training on Revision of Part 132. At this time, all participants are in a listen-only mode. Later, we will conduct a question and answer session. Instructions will be given at that time. As a reminder, this conference is being recorded.

I would now like to turn the conference over to our host, Ms. Cathy Cumpston. Please go ahead, ma'am.

C. Cumpston: Thank you, Greg. Welcome, everyone. I know that this is probably not everyone's favorite thing to do on a Friday afternoon, but we're glad you're here and we hope that this will be worthwhile for you. This is Cathy Cumpston with the Division of Mental Health. I am the Medicaid Officer here, and I have with me, Kristi Herman from DCFS who does sort of the same thing I do, only at DCFS.

We hope that you have in your possession today a PowerPoint. It was sent out with the announcement of the training. So, whoever received the announcement at your organization also received a copy of the PowerPoint. You don't actually have to have it. We will go through

everything on it, but it would be helpful to you at least later to be able to refer back to it.

We are today going to review the changes that are being proposed to Rule 132. The rule amendments were published at the end of December 2011 as a proposed rule by JCAR. It did go through a public comment period. We have responded to the comments that were received during that public comment period. Unfortunately, those of you who submitted comments have not received responses yet because the DHS system is rather time consuming and the responses that we proposed and the changes to rule based on the comments have to go through a legal review process and it's still doing that. We are hopeful that that review process will end soon and that then anyone who submitted a comment will get a response back.

Then the rule changes that we proposed would be able to go forward and we could submit the rule to JCAR for a second filing. So, we are continuing to be hopeful that that gets done before too long. We also want you to know that when that happens and the rule is adopted, you will all be notified immediately and we will publish on the web pages a copy of that rule so that you know what the final version is. Unfortunately, we cannot send out separate from that process anything to all of you or we would certainly be glad to do that.

Today, we are not going to deal with all of the details of the changes that we have made to the rule because many of them were minor wording changes and we're not going to go through those line-by-line with you. What we would like to do today is hit the major points and highlight what is changing that we really think is important to all of you. As the operator said at the beginning, we will have a question and answer period at the end of the presentation, and we will spend as much time as we can responding to your questions. We would like for the questions to be restricted to changes in the rule and things that are presented today rather than general rule interpretation questions.

We do have an e-mail address where you can always send questions like that, and we have an interagency group, that meets every Tuesday morning to address any questions that we receive and whoever submitted the question gets a response from us. Then once a quarter, we update the Q&As on the webpage to make sure that anything new gets added.

In addition to you all getting a copy of the rule when it is finally adopted as amended, the guidelines, instructions and checklists, which is the

survey tool that is used, will also be published so that you can see anything that is in it that is helpful to you. There's also a service definition and reimbursement guide that needs probably very little change based on the rule changes, but that will also be revised and also then will be available on the web page.

So, let's just jump right in to page four of the PowerPoint and talk about something that happened a year ago. In May of 2011, some amendments to this rule were adopted that changed the definition of medical necessity primarily as it relates to services for children and adolescents. We broadened the definition to include children and adolescents referred for mental health services as the result of an EPSDT screen or as we refer to it in Illinois, a Healthy Kids Mental Health Screen. So, if somebody has a physician that does an EPSDT screen on them and thinks that they need mental health services, then they are now, since last May, able to get those services based on that screen and while there is a mental health assessment going on.

The Healthy Kids Mental Health screen can be used much as an admission note is. You can initiate services immediately based on that screen and the recommendation that mental health services are needed. It is good for a period of 60 days after a physician signs it, and then, anytime during that 60 days if a client and parent come in with that screen, then the mental health provider may use that for 30 days while they complete the mental health assessment.

Going back to page three that I skipped, we did make some changes to policy in the rule. I'm not going to go through each of them. You should be able to review the rule amendments and see where those policies have been changed, and we've given you the numbers. 132.65, 132.85, 132.90 and 132.95 are where there are policy changes that are required. Client record audits and performing those, confidentiality of client records and we will talk more about some of these later, policy on reasonable accommodations and policy on utilization review.

So, there are some changes here that we wanted you to note, and we also wanted to share with you that we will be giving you a 30-day grace period after the adoption. So, remember, any grace period that we talk about today, is after the adoption of the amendments. It is not from today. From today, you may have another 90 days, who knows, but after the amendments are adopted, then you have 30 days to make changes to your policy statements that are required by these sections of rule.

Just to let you know, we have Lee Ann Reinert from DMH joining us. Lee Ann is here as our clinical expert from DMH so that if we run into any questions, we will have her available to us. Thanks.

We made some changes to definitions:

Mental Health Professionals: We added a certified family partnership professional as an MHP and we also clarified that we expect that an MHP has a high school diploma or a GED along with experience. However, we did provide a grandfather clause for any MHPs you now have working for you or that you have working for you when the rule amendment is adopted that don't have these things, then you can keep them working for you.

Rehabilitative Services Associate: We changed the definition of an RSA by also adding the need for a high school diploma or GED and a grandfather clause for those RSAs working for you at the time of the amendment changes.

We added definitions of intervention and activity to differentiate between the two. There are some services that we define as interventions and some that we define as activities. As we get along farther in this presentation, you will see that there are then differing documentation requirements based upon whether something is an intervention or an activity.

We added, at the request of several people, a definition of a mental health setting and a definition of a psychotropic medication.

We added a new section to Rule 132, 132.27. It's a new section, but there's very little in it that is new. We moved most of the section from 132.145. So, we were trying to clarify and clean up rule requirements so that it at least to us made more sense.

Each time we do this, we hope that our amendments make the rule, make more sense and sometimes we're successful and sometimes we're not, but that's why we added this new section and moved some pieces from someplace else. We also clarified in this section that accessibility standards that are required apply to certified providers whether they're contracted with the state or if they're a subcontractor. Accessibility standards apply to everyone.

In Section 132, 30 and in 132.50, we provided the ability for the certifying state agency to either revoke or to not renew a certification for providers who consistently perform poorly. There are a couple of ways that that happens. The SA provider has a certification review and scores 74% or less on a certification review. This is not a post-payment review. This is a certification review.

Then, the next full certification review, three years later, the provider again scores 74% or less, then that is a reason for not renewing the certification at that point. Another possibility for revoking a certification is if a provider has been suspended from submitting bills because of a poor performance on a post-payment review and has not been able to make sufficient corrections for over a year to bring that back up and be able to bill again, then, the certifying state agency can revoke the certification.

We made a fairly substantial change to post-payment review. We have currently a process that produces an initial notice of unsubstantiated billing and then after a period of time, we do a final notice of unsubstantiated billing. We've been doing that for a very long time now. We are changing that.

We want to note, however, that although we are changing this, documentation requirements haven't changed. Providers are still given and will be given advanced notice of post-payment reviews. Providers will continue to have the right to appeal post-payment review findings.

We're going to make certain that during the post-payment review process, the reviewers actively engage the provider so that if the reviewers are missing something, if there's a note missing, if there is a treatment plan missing, if anything is not where it should be, rather than just make a note of that, we are expecting the reviewers to engage the provider for assistance in trying to locate documents. Then, at the end of the review, the reviewers will present the findings to the provider and give them a preliminary report of their findings. There will no longer be an initial notice of unsubstantiated billing.

There will no longer be a 30-day opportunity for submitting missing documentation. We expect that that will be done during the review process. We will, after about 30 days, issue a notice of unsubstantiated billing.

Also, in this section, we have included the right for the certifying state agency, for the public payer, to extrapolate findings of the post-payment review. I want you all to rest assured that as of right now, neither DCFS nor DMH have any plans to be extrapolating their findings. That allowance is in rule, and it coincides with the way the Feds do their post-payment reviews or their audits. When they conduct one, they do extrapolate their findings. So, it is bringing us into alignment with the way the Feds do Medicaid audits.

If at some point in the future, anybody does decide to extrapolate, we will make sure that the process used to select records is statistically valid and can stand up in court as a proper means of selecting records. In 132.65, we made what we believe is probably a minor change. We wanted it to be clear that compliance with Rule 132 is the responsibility of the provider. It is not the responsibility of the state to make sure that any of you are in compliance.

It's our responsibility to determine if you are in compliance and then take proper action if you are not, but it is always the provider's responsibility to stay in compliance. So, we have added a requirement here about an active system for your determining compliance. We believe that based upon our reviews and based upon the high level of compliance with most providers that most of you are probably already doing something similar to this where you are routinely reviewing your records, routinely reviewing what you're doing and the training of your staff and how your staff documents things to make sure that they are doing it in accordance with the rule requirements to keep you in compliance.

We made some minor adjustments to personnel requirements in 132.70. We clarified that background checks are required prior to people working in direct care. One of the things that is not in rule that we do want to make sure that everyone understands is that DCFS providers who are required to do a LEEDS check, don't also have to do another check. The LEEDS compliance will be sufficient to meet the requirements in this particular section of the rule. Information about the health care worker background check and the act are noted in the PowerPoint so that if you would like to get copies of what is actually said about them or what the act required, you may go there and download and print out that information.

It is also a requirement for all providers, DMH and DCFS providers that there be a check of the health care registry. It is on this registry that instances of abuse or egregious neglect are recorded for many areas. I

don't know that DCFS abuse/neglect gets reported there, but there are a lot of other areas for which abuse/neglect gets reported to this registry.

The law says that anyone that has been found to have abused or egregiously neglected someone may not work in this field in any capacity. So, they cannot work as a secretary, executive director, chief financial officer. They cannot work in this field if they have abused or egregiously neglected someone.

In section 132.85, record keeping, we hope we have made some changes that are going to be helpful to you. We reviewed this section and we thought that there were things here that were probably reviewed by someone else.

We cannot tell you who does review them, but they did seem to be something that applied far more to financial audits, contracting processes and not to the provision of mental health services. So, we removed those things. We wanted to do what we could to reduce redundancies and to eliminate things from this rule that we thought were duplicative monitoring processes that we just didn't need to have here.

We made a change to client rights. We require now that client rights be explained to the clients on an annual basis. If you have people who you serve who have been in your program for more than a year and you have not routinely been re-explaining their rights to them, you must, once these amendments take effect, you must explain their rights to them and then do so annually after that as long as they're in your program. We will give you 60 days after the adoption of the amendment to explain rights to people who have not had that explained to them in the last year.

We had a question come up about the addition that we have made to the rights statements about accessibility and accommodation of disability, and no, we are not going to require that everyone you serve have their rights re-explained to them to include the addition to the rights statement in the 60 days following adoption. We will allow that the new rights statement be incorporated into the annual explanation of rights as that comes up.

We did add language under client rights about restriction of rights and some very specific requirements if someone's rights are restricted. There must be a plan that is put into place for how someone's rights are restored. That plan must be signed by the client or the client's parent or guardian and by the Q and the L. Then, the client affected by the restrictions and

his or her parent or guardian gets a copy of that plan. So, you cannot restrict someone's rights without a plan to give them their rights back and without their participating in development of that plan and understanding that plan.

Service documentation, we did not add documentation. We still have the requirement that there has to be a note with a date, with a service description, with the beginning time, with the end time or duration signed by the staff person with their credentials that provided the service and dated. So, that's all still there.

We are not going to accept summary notes, summary notes where something is done over a period of all day long or a week or a month and then you just summarize what happened. We have been moving away from that for some time. We currently expect that wherever there is some sort of summary note allowed that each episode of the service have a specific documentation about what happened during that period of time. So, we're moving farther away and saying now, you just have to take those pieces and make a note for each of them.

Then, here's where we talk about how we have changed the documentation requirements to actually reflect what the service is. So, for instance, on page 14 of the PowerPoint, under mental health assessment and ITP development, review and modification, the old requirement was that there had to be a description of the intervention and the client's response to that intervention in terms of goals and objectives. Well, obviously in a mental health assessment development or ITP development, there aren't goals and objectives for which the client will respond. So, we have changed the documentation requirement there so that it must include a description of the time spent with the client or collateral gathering information or developing, reviewing or modifying the ITP.

Another example, psychotropic medication administration, that is an activity and the documentation must include a description of it, which would be administered such and such medication to so and so. Therapy and counseling, that's going to look more like what you're used to because the documentation there must include a description of the intervention, the client's or family's or guardian's response to the intervention and progress toward goals and objectives in the ITP. So, that is the documentation requirement that once applied to everything, even where it really didn't make sense. So, we have tried to simplify or to clarify what the documentation requirements are.

In mode of service delivery, we have expanded the ability for you to use video conferencing. We wanted to recognize the broader use of telemedicine in mental health and so have added that services may be provided via video conferencing. Basically, what this does is to allow psychotropic medication monitoring and training to be done by video conference.

I would now like to turn this over to Kristi Herman and she will take us through most of the rest of it.

K. Herman: Thank you very much, Cathy. We're going to shift from service documentation back to the mental health assessment. We'll go through some of the changes to the ITP and then we'll talk more about services. We put this together in the order of the rules so it jumps back and forth a bit. So, I apologize for that.

We're going to start on slide 16 talking about some of the changes to the mental health assessment. The vast majority of the changes that are going to be implemented were made to consolidate or even to remove requirement components of the MHA. We went through and we determined that there were many components and many items that we could either do without or that we could consolidate. So, I want to go through a couple of those items on slide 16 that we just want to point out.

The extent, nature and severity of the presenting problem will be consolidated to reasons for seeking treatment including symptoms. We will be looking for what symptoms are bringing the client to treatment, but again, hitting the exact extent, nature and severity of those will not be required. In addition, we've eliminated all of the specific items that were attached to the mental status evaluation, and we're really going to rely on the Q and the L to identify the items that are most salient to the client's mental status and to include those in the mental health assessment. We're no longer going to dictate what items have to be in that mental status evaluation. So, if there is a type of mental status evaluation that you have been using that you feel is effective for your clients, that's going to be acceptable.

In addition, we're not going to require a list of psychotropic meds that the client has taken or is currently taking. We just want to know if in fact the client has or is taking medication.

So, let's move on to slide 17. Again, as one of the examples of where we took some of the stand alone items in the MHA and consolidated them under a new section. That's strengths and resources, and there are several items that are listed in strengths and resources as examples of items that can be addressed to really indicate what strengths and resources a client has, but you're not required to hit each of those individual items. Anytime it says in the rule, e.g. that means that those are examples of what can be addressed so you don't have to include everything in that list. We'll also accept a client report on their general health so you don't have to have specific findings of their last physical exam.

I do want to spend some time talking about the last bullet. In the revisions to the rule, we have said that you don't have to include the specific Part 132 services that are going to be provided. So, having the Part 132 services listed on the MHA report is not required per se. However, and this is a really important note, if there is going to be any kind of gap in time between the completion of the MHA and the completion of the ITP, you still need to have those specific Part 132 services on the MHA if you're going to provide those services before the ITP is completed in order for those to be medically necessary and properly authorized for billing. So, if there's any time delay, you finish the MHA and four days later, you finish the ITP, if you want to do any services in between that time, you still have to have those Part 132 services listed on the MHA report. However, again, if you do them on the same day, you do not need to put those on the MHA.

I want to make a quick reference to medical necessity since we were talking about services being medically necessary. In the current rule, we did indicate some additional information around the specific items that are needed to be documented to determine medical necessity. In the rule revision, what we've indicated is that those items have to be addressed on the mental health assessment and probably the best place to put those is in the summary analysis section or the MHA report. That really ties together the whole picture of why this client has a medical necessity for Part 132 services. So, I did want to mention that, make sure to call your attention to it.

Let's move onto slide 18, talking about treatment plan development, review and modification, really just a few points about the treatment plan. Not much was revised in this section. One thing that we did do was to make it consistent with the Confidentiality Act. The Confidentiality Act

states that a copy of the signed ITP must be given to the client. There are no circumstances under which you may not give the client a copy.

Current rule does indicate that if it's contraindicated that if you document that, it's okay to not give them a copy of their ITP, but that will no longer be the case. Everybody, regardless, every client will have to be given a copy of their ITP. So, if you currently have a client where you did document that there was a contraindication, you will have 60 days after the adoption of the rule amendments to make sure that you then go back, give them a copy of the ITP and document that in the record. So, again, if there was any client that was not given a copy of their ITP, you will need to go back, give them a copy of their ITP and document that you did so.

Let's move on to 19. We're going to start talking about the specific services and the changes that we made there. One of the bigger revisions that we made was to community support, but it was not to substantially change the definition. In the definition, we did make a few wording changes but they weren't substantive changes.

The major change that we made was to consolidate community support individual and community support group into one service, which is going to be community support. The individual and group are the modalities that you can use, but again, they both fall under the service definition of community support. Then, this makes it consistent with other services like therapy counseling, which has different modalities but is the same service definition.

So, the requirements remain the same about how you document your groups, how you document your community support individual interventions. For DHS providers, the utilization management requirements for community support group will also still apply. So, you do need to make sure on your treatment plan that you're still indicating community support individual and community support group and indicating the amount, frequency and duration for each of those individual services.

Let's move on to slide 20, and we're going to talk about case management - client-centered consultation. We did make a fairly substantive change to the service definition in client-centered consultation. We wanted to clarify what constitutes professional communication and also who can be involved in that professional communication.

So, the professional communication can occur among provider staff or between provider staff and staff of other agencies who are involved in service provision to the client. The professional communication, we also specified, and I will just actually read you the definition of what the examples are. So, professional communication includes offering or obtaining a professional opinion regarding the client's current functioning level, improving the client's functioning level, discussing the client's progress and treatment, adjusting the client's current treatment or addressing the client's need for additional or alternative mental health services.

So, you have to be sure when you're engaging in a consultation with another professional that these types of services that I just mentioned are provided and are documented in order for it to qualify as client-centered consultation. One of the things you'll notice in there is that family members have been removed as people who can be involved in the professional communication. The family members, when you are consulting with them, it will not be billed under client-centered consultation.

However, I want to point out, and I want to be very clear about this, family members can still be engaged when you're doing community support services and when you're doing family therapy/counseling services. So, some people have the perception that because they cannot do client-centered consultation with family members, there's no other service available. What I just want to reiterate is that again, family members, when you are talking to them, most of those interactions are going to fall very well under community support in developing actual resources for the client and also in offering support to the client's natural support system to help them deal with the client's individual mental health issues.

I want to tell you that there's one exception to this and that has to do with professional foster parents. Again, these are foster parents who are employed by the agency as staff who have foster children in their home. If you are consulting with them as staff of the agency around the treatment of the child because they are a professional staff member, they can be included in client-centered consultation.

Let's move on to slide 21. We'll talk very quickly about the changes to Assertive Community Treatment or ACT and then also to Community Support Team or CST. For ACT you must have a certified recovery support specialist on the team and for Community Support Team, you may

have either a certified recovery support specialist or a certified family partnership professional, and you will have 12 months from the adoption of the rule amendments to make this change to your team. So, again, your grace period there is going to be 12 months from the adoption of the rule amendments.

Slide 22 will talk really briefly about psychosocial rehabilitation. The only change that was made that was substantive was to remove the minimum amount of time of 25 hours a week that the service must be made available. Other than that, no changes were made.

So, I am going to turn it back over to Cathy who's going to take us through the rest of the presentation.

C. Cumpston

Before we begin our question and answer session, I just want to remind you all that we will let you know when the amendments to 132 are adopted. We will post the rule as amended. We will post the guidelines, instructions and checklists, and we will also post the updated service definition and reimbursement guide. So, those will all be available to you as quickly as we can get them online as soon as the rule amendments are adopted. We're just going to stay optimistic that that will happen before too much longer.

I also wanted to remind you of the e-mail address to which you can send any questions, any general rule interpretation questions that you have at anytime that you have them. That is dhs.mh@illinois.gov. As I said earlier, we review those on a weekly basis. We respond to whoever sent the question and then on a quarterly basis, we update the Qs & As that are posted online.

We've also, on the PowerPoint presentation, given you some phone numbers and some names and e-mail addresses of people that can be of assistance to you. We've given you the three different phone numbers for the DHS bureau of Accreditation Licensure and Certification. They are great resources for helping with certification questions for the DHS certified providers.

The Infant Parent Institute phone number because they are also a great resource for certification questions for DCFS certified providers, and then, the Illinois Mental Health Collaborate for Access and Choice, we gave you their phone number, and they are great resources for post-payment review questions. Once again, thank you very much for participating, and

we will now turn this back over to Greg to tell us how to do questions and answers.

Moderator Thank you, Ms. Cumpston. First, we turn to the line of Viviana Ploper from C4. Please go ahead. Your line is open.

V. Ploper Can you hear me?

C. Cumpston Yes, we can.

V. Ploper Hi, Cathy. This is Viviana.

C. Cumpston Good afternoon.

V. Ploper Good afternoon. I had two questions, one in regards to the removal of consulting with family members around consultations, ...

C. Cumpston What is your question?

V. Ploper So, what if we're consulting with somebody, a family member, but they're not involved in family therapy. It's not about skills, but it might be some history that we suddenly know there's a family member that has information about a client and we want to consult. How would we bill that service?

C. Cumpston That would fit very well under mental health assessment as you're gathering more historical information that would be relevant to the assessment piece. It fits very well under there.

V. Ploper It's under assessment?

C. Cumpston Yes, under mental health assessment.

V. Ploper At any time, we can do assessment even if we are doing the therapy?

C. Cumpston Yes, absolutely. Mental health assessment is not a one-time event. It's something that can go on throughout the life of treatment.

V. Ploper My other question has to do with the issue of the CRSS, the Certified Recovery Support Specialist. When I hear about the changes in the rules, I'm thinking about how hard it is to get somebody that now I know they get certified with ... and how hard it is to get an ... candidate. So, what

happens—like we have two options and two CST teams here at C4. So, what happens if we are not able to get somebody certified or we can't hire somebody certified? Are we shutting down our program, our CST?

C. Cumpston — Well, first of all, you do not have to hire someone new. Right now, you are required to have a person in recovery on your team. That person who you currently have on your team in recovery can become certified. So, you don't have to hire somebody new.

V. Ploper — I understand that.

C. Cumpston — Then, if they are not able to get certified within the 12 months following the adoption of the rule changes, then you would not have a duly constituted team. Lee Ann Reinert would like to also comment on that.

L. Reinert — Hi. What I would like to add to that is if you believe it's going to be a challenge to get the person certified, please remember that each of our regions have recovery specialists that are employed by the region and should be utilized as a resource by our agencies. They are very aware of the process. They're very skilled. They have a lot of resources and can do a lot to assist you in helping your staff to become credentialed with the CRSS.

V. Ploper — I understand that. If we are in the process of having another team and once let's assume the rule has passed and I know you know how challenging it is to get somebody to do this and also then having to certify them. So, we're concerned about the effect that this might have in our systems and whether we're prepared to have to close down and act. In the past, we said well if we don't have an RCM become CS team instead of ACT, but I'm just asking you to think about the consequences of that. Not that we don't think that somebody needs to be certified, but I think it's a challenge.

C. Cumpston — Thank you very much.

V. Ploper — I think you guys need to have a plan.

C. Cumpston — We do.

V. Ploper — Another question is—is CST in the same boat with this exactly mandating for both? They both need to be certified?

C. Cumpston	Yes.
V. Ploper	What does it mean to be grandfathered in? Do they have to take the test or they become certified because I—
C. Cumpston	There's no grandfathering in in this area.
V. Ploper	Okay. So, they don't get grandfathered in?
C. Cumpston	No. That has been the people that do not have a GED or high school diploma.
V. Ploper	So, they need to be just—I read someplace that it said one was certified—or it said qualified to be certified.
C. Cumpston	No, it does not.
V. Ploper	So, it's certified.
C. Cumpston	The PowerPoint presentation gives you a location of where you can get a copy of the rule and you should read it. Okay. Thank you.
V. Ploper	Thanks.
Moderator	Next we turn to the line of John Schulze with McLean County Human Services. Please go ahead.
W	We've got a question about the 60% of all community support services must be delivered in natural settings.
C. Cumpston	Could I ask you to please send that question to the DHS MH Q&A e-mail address because we would like to focus today on changes and that is not something that has changed?
W	Okay, thank you.
Moderator	Next, we turn to the line of Jodi Figueroa with Crosspoint Human Services. Please go ahead.
M	Hi, I'm here with Jodi. I have a question about community support individual and community support group. They're being combined, and I guess I'm wondering is there going to be some corresponding change with

medical necessity regarding those two because in medical necessity, it is specified that a person would recover either in an individual setting versus a group and vice versa. So, I guess I'm wondering does that also change.

C. Cumpston — There is no change in the requirements for the services in 132 to be medically necessary. So, if a service is provided with a group modality, that group modality must be medically necessary as the same as if something is provided individually, and that does not change in these amendments.

M — Okay. Thank you.

Moderator — Next, we turn to the line of Karen Rousey with The Baby Fold. Please go ahead.

K. Rousey — Hi, I have two questions. One is in regards to these requirements for client rights to be explained annually and the ITPs to be given copies to each client. Is there a guideline for those that serve children under the age of 12, and does that apply then to their guardian versus the client? That's my first question.

K. Herman — This is specific to the client, and there's no age limitation on it. So, even if you're dealing with your younger kids, your staff still do have to document that they explained it and that they believed that the client understood it. The rule is very specific to that staff statement indicating that it was explained to the client.

C. Cumpston — In a way that they would understand.

K. Rousey — So, the notice does not go to the guardian then?

K. Herman — If that is a practice that you have, I would encourage you to continue it, but per rule, it is really to notify the client.

K. Rousey — Okay. The other question is in regards to the background checks, and I think I heard you say that DCSF background checks will qualify as replacements for the other ones listed. Is that correct?

K. Herman — Right. That's correct. You don't have to do a redundant background check process because you already have to do that through the LEEDS, right?

K. Rousey — Yes, and there's no timeline on this in terms of delivering services while those are being checked, correct?

K. Herman — Say some more about that.

K. Rousey — Well, there are many times great delays in getting the DCFS clearances on background checks and somebody may be working and providing services for several months prior to the actual clearance. They can't be alone with children or with a client, but they can provide services in settings where they're not alone.

C. Cumpston — Could you submit that to us in writing at the DHS MH e-mail address? We think that that makes sense and is reasonable, but we would just like to verify rather than just guess for you. I need to get some clarification on that one.

K. Rousey — Could you also just speak to the Bachelor's degrees that you think will now qualify from MHPs.

K. Herman — Those are listed in the rule revisions. Cathy's actually looking those up right now.

C. Cumpston — Mental health professional, and we added these specific degrees because we had gotten so many questions over the years about could you help us to know what degrees really are relevant. So, we added these. It says Bachelor's degree in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy or related human service field. So, we still put in or related human service field, and then a Bachelor's degree in any other field with two years of supervised clinical experience in a mental health setting. So, we're trying to help providers really defend maintaining a mental health environment and being able to not have to accept any Bachelor's degree that came along. So, we were really trying to provide some guidance as to what we were expecting to be eligible to provide these services.

K. Rousey — That's helpful and I'll look in the rule. Thank you.

Moderator — We turn to the line of Fausudeen Lawal with Bobby E. Wright. Please go ahead.

F. Lawal	My first question has to do with the community support. We want to get some clarification on it. We do understand that the community support individual and the group, we would still have to use the same codes that we've been using—that we're currently using and then for the utilization management, we still have to—it's still following the same guidelines for the community support group. Is that correct?
C. Cumpston	That is correct.
F. Lawal	The other question is there is no rate track change at all, right?
C. Cumpston	No, there is not.
F. Lawal	The third question still with community support group, community support as a whole—we don't have to bundle those services, do we? I don't know if you all understand what I'm talking about with bundle. Do we have to combine those services when reporting them to HFS for billing purposes?
C. Cumpston	You would bill just like you would bill them now.
F. Lawal	Okay, thank you.
Moderator	Next, we turn to the line of Charlie Burt with ChildServ. Please go ahead.
C. Burt	Hi, thank you for taking the question. I had a question about the community support and community client-centered consultation. I know you're limiting talking to the family, but what if you're at a meeting with family as well as other professionals.
K. Herman	Let's say you're at a team meeting or something along those lines and the family is present, it is okay to bill that time for your professional communications with the team as a whole. So, just because the family is there, that doesn't automatically mean it cannot be billed.
C. Burt	Is that preferable to bill the client center case management versus community support where you might be supporting the client at that same meeting?
K. Herman	It really depends on what you're doing. If you are doing your professional communication with the team, then that would be your client-centered consultation. If that then changes, and you end up doing more support

functions to the family related to the client's mental illness, then that would be community support. It really does depend on what kind of interactions you're having during that meeting time.

C. Burt — Thank you. I appreciate it.

Moderator — We have a question from the line of Marci Kresin with Heartland Health and Outreach. Please go ahead.

M. Kresin — Hi, everybody. Quick question on the recovery support specialists—if we bring on a recovery support specialist after the rule has been adopted, does that person have to have the certification or do they also get a 12-month grace period?

C. Cumpston — We haven't really talked about that. I would expect that anyone hired after the amendments are adopted would have to meet the standards that are in place at that time. To allow us time to consider this specifically, could you put that in writing and send that to us at the DHS MH email address?

M. Kresin — Sure. For example, you get two years if you bring on someone who's not quite qualified—like to get their CADC, they give you give you time.

C. Cumpston — I would like for you to put that in writing so that we're not giving you a response today that we regret later.

M. Kresin — Sure. Not a problem. Thank you.

Moderator — Next, we turn to the line of Kevin Jesse with Mental Health Adult Probation of Cooke County. Please go ahead.

K. Jesse — Hi. Just following up on page seven of the PowerPoint with regards to scoring 74% or less during two consecutive recertifications. Is that with BALC you're referring to?

C. Cumpston — Yes.

K. Jesse — Secondly, with explaining client rights, we have to—would you recommend having a form to document that?

C. Cumpston — You must document it. How you document it is up to you.

K. Jesse — Must document. Okay, thank you.

Moderator — Next, we turn to the line of Julie Rodriguez with Association House. Please go ahead.

J. Rodriguez — Yes, my question is regarding the mental health assessment. It seems that some of the requirements that you previously had were minimized or reduced a little bit. I would assume it would be okay if we kept it as it was.

K. Herman — If you like the format that you currently have and you don't want to change it, that is fine. I would just go through and make sure that you have addressed all the items, particularly strengths and resources, and the only reason I mention that one is because in the current iteration of the MHA, that kind of tends to be buried in different sections. So, I would just make sure that you have that very clearly identified.

J. Rodriguez — Perfect. For the ITP for the community support which is now individual and group combined, we would of course always list them as separate services. You did mention that you'd still want to include that they needed individual and group even though it's the same code at this point going forward. Again, we list them on the ITP separately. Would that be okay as well?

K. Herman — Continue to do that, yes.

J. Rodriguez — Finally got it together, we don't want to make anymore changes. Thank you.

Moderator — Next, we turn to the line of Brek Lienhart with Circle Family Healthcare Network. Please go ahead.

B. Lienhart — My question is—is there a specific requirement for documenting the explanation of the client's rights to them? Is that billable under community support mental health or what?

C. Cumpston — It's not billable.

B. Lienhart — It's not a billable service?

C. Cumpston — No, but we're going to bill it under what?

B. Lienhart — I don't know. I was wondering if it was allowed to be billed.

C. Cumpston — We're all sitting here thinking of what service might that really be, and we're not coming up with a 132 service that would cover that. That is just something that you do prior to providing services to assure informed consents.

B. Lienhart — For the annual MHA update, just a renewal of that announcement to them.

C. Cumpston — It's not billable.

B. Lienhart — Okay, thank you.

Moderator — Next, we turn to the line of Carol Colburn with CRCC. Please go ahead.

C. Colburn — Hello. I have a question. Do the modifications that you've been discussing in the PowerPoint presentation match requirements of the collaborative?

C. Cumpston — The collaborative is an agent for the DHS Division of Mental Health. As such, they work for us and they implement the program according to our requirements, and so, yes, therefore when the amendments are adopted, they will definitely have the same requirements.

C. Colburn — Thank you.

Moderator — Next, we turn to the line of Tony Miller with Massac Mental Health. Please go ahead.

T. Miller — In the requirement for the MHP where the provision is for high school or GED along with experience, must that experience be in our own agency or may it be in any social service agency?

C. Cumpston — It may be in any place.

T. Miller — It may be in any social service agency?

C. Cumpston — Yes.

T. Miller — Okay, thank you.

Moderator Next, we turn to the line of Jan Biscan with Metro Family Services. Please go ahead.

J. Biscan I had a couple of questions, first about documentation and psychotropic med administration. Our nurse currently has a log for each client that's in their chart that indicates the date, the times that she saw the client and what she provided for them in terms of the kind of medication and the dosage and then she initials her entry. Is that sufficient, or does she have to write some sort of narrative?

C. Cumpston That would probably be sufficient if she actually had an entry that each time she signed with her credentials after her signature and dated. She cannot just initial things. She has to sign for it to be required documentation.

J. Biscan So, not just initial?

C. Cumpston Right.

J. Biscan I had a question also about the mental health assessment. In order to establish that the golden thread is there, the supervisors in our agency tend to look at the mental health assessment and what services have been prescribed to meet the client's needs. Then, when the treatment plan comes across our desk, we compare that to the mental health assessment to make sure that nothing is being prescribed that wasn't assessed as a need. So, having those names of services on the assessment somewhere is at this point pretty important for us, but they do appear multiple places. Do I hear you say that it would be okay not to have them in multiple places on the assessment? How do you determine when you compare an assessment to a treatment plan that the services on the treatment plan have been deemed medically necessary?

C. Cumpston First of all, when you say multiple places on the mental health assessment, that was puzzling to us.

J. Biscan Well, we do write it in the narrative piece where we document a conversation with the client about the services we're recommending for them and why. Then, we also document the names of the services under a last page that we have on the treatment plan and kind of prioritize those services as we've been instructed to do by consultants.

C. Cumpston — We are not requiring that you change what you do here. You could continue to do that. There is not now a requirement that the services be in multiple places on your mental health assessment. Right now, they only have to be in the mental health assessment report, and that then has to be documented by the LPHA as being medically necessary. So, I don't think that—

J. Biscan — I'm thinking maybe we could cut back on the number of places that they put it, but—

C. Cumpston — I think you probably could.

K. Herman — If you're doing your MHA and your ITP on the same day—are you doing it on the same day or is there a time gap between the MHA and the ITP?

J. Biscan — There's typically a few days at least time gap, but the staff know that they may not provide any services in that time gap.

C. Cumpston — If the services are prescribed on the mental health assessment and they then subsequently show up on the treatment plan as the same services within the required time frame for completing the treatment plan, you may provide those services between the completion of the mental health assessment and the completion of the ITP.

J. Biscan — But typically, our staff do the ITP very quickly after the assessment is finalized.

C. Cumpston — The real reason that we made this change to the rule was that we had heard from numerous providers that they do the mental health assessment and the ITP on the same day and that it was redundant to require that the services be prescribed on both. So, as long as you're doing them several days apart, yes, you really do need to have them on both, but once on both would be great. If you're doing them on the same day, then just having them on the treatment plan is sufficient.

J. Biscan — Okay. Well, thank you very much.

Moderator — We have a followup from the line of Marci Kresin with Heartland Health and Outreach. Please go ahead.

M. Kresin	Thank you. A question regarding the mental health assessment—all the changes for the mental health assessment if adopted would also flow through for the annual mental health assessment update?
C. Cumpston	Yes, it would.
M. Kresin	Was that listed somewhere?
K. Herman	No, actually now that you mention that, unfortunately, we didn't put that in the PowerPoint, but it is in the rule revisions.
M. Kresin	Okay, great. Thank you.
Moderator	We have a question from the line of Cathy Moehring with SIRSS. Please go ahead.
C. Moehring	I have a question about not having the interventions listed on the mental health assessment. Current practice is for when we have a review done that they've been looking to see that what is listed on the mental health assessment is carried over onto the treatment plan. So, my first question is will they continue to look for that if it's not on the mental health assessment?
K. Herman	If there's a time gap between the two, and those services are provided in between that time, then yes, that will continue to be looked for.
C. Moehring	I want to make sure that you understand not that the services end up on the treatment plan, but what they've been reviewing is that let's say I said on the mental health assessment that I thought that the person needed community support individual, but then I changed my mind and after discussion with the client, we didn't actually put that intervention on the treatment plan, they have looked for some explanation for why that did not occur, and we had to document the reason for the change from assessment to treatment plan. So, if we continue to put interventions on the assessment, are they going to continue to look for that?
K. Herman	Just one more clarifying question. Did you provide that service in the meantime, or did you just put it on the MHA but then decided not to put it on the ITP?
C. Moehring	Did not provide it. Just put it on the assessment and then did not—some changes occurred. We decided that was not medically necessary or

appropriate intervention, but we have to document the fact that we said it in the assessment and now it's not in the treatment plan or vice versa. If we decided to put something on the treatment plan that was not on the assessment, we had to make some sort of documentation about the addition and why it was needed. That part I can see, but the other way around, I'm not sure.

C. Cumpston — Would you please submit that question to us in writing?

C. Moehring — I will.

C. Cumpston — Thank you very much.

C. Moehring — Thank you.

Moderator — Next, we turn to the line of Alice Gibson with the Abraham Lincoln Center. Please go ahead.

A. Gibson — My questions are related to the MHA. I just need some clarification. As far as the psychotropic medications, with the adoption of the new rule, we no longer have to list the past psychotropic medication or what they're currently taking? We just have to make a note that they're taking medication?

K. Herman — Yes. This is basically looking for a report that the client's giving you about if they're currently taking medication. If they know what the medication is and you want to put it in there, that's fine. But if they don't, and they say, yes, I know I'm taking two medications, but I don't know which ones, then that's okay. It's client report really that we're looking for.

L. Reinert — What we're really trying to do there is reduce your liability as an agency with any type of medication errors or errors in your documentation where if you're simply relying on a self report, we know that before any psychiatrist prescribes medication, they're going to have to do their own psychiatric evaluation. They're not just simply going to look to your mental health assessment and someone who may not be a medical professional having listed medications on a document, that they're going to need to do that for themselves and their own liability. So, what we don't want to be a party to is asking an agency to have nonmedical staff documenting actually something that's a medical issue and then perhaps having a contradiction in their own record where they have something

documented by a nonmedical staff and then something else documented by medical staff. So, the medical information should be documented by that medical professional, but certainly you cannot do a mental health assessment without asking a person about whether or not they're taking medication, whether they have in the past.

C. Cumpston — I would also just like to remind you that if you are providing psychotropic medication services, that that section still requires a listing—if they're being prescribed by your physician or somebody that's on contract with you, that there's still requirement for the medication specifically to be listed in that area.

A. Gibson — In the record.

C. Cumpston — Yes. That has not changed. It's just not part of the mental health assessment.

A. Gibson — My next clarification is medical necessity should be now documented—well, we already document it I guess throughout the entire mental health assessment, but now specifically in the summary analysis.

K. Herman — That is really just a suggestion of where it would make the most sense to capture all of the medical necessity pieces. The emergency rule that was adopted has some very specific components of medical necessity that have to be documented. So, if you rely on it just being captured in the mental health assessment without having those specific items indicated, you run the risk of missing a piece or two.

A. Gibson — Thank you. That was it.

Moderator — There are no further questions in queue. Please continue.

C. Cumpston — So, once again, thank you all very much for your participation.

We will look forward to some of the questions that we asked to be submitted in writing so that we can discuss them further and get them posted on the Q&A website. Seeing no further questions, that will then conclude our presentation for the day. I'll turn it back over to you, Greg.

Moderator — Thank you very much. Ladies and gentlemen, that does conclude the conference for today. Thank you for your participation and for using AT&T Executive TeleConference Service.