IMPACT Plus
August 2003 Technical Assistance Workshops
SubProvider Questions & Answers

Freedom of Choice

(1) Does freedom of choice only apply to IMPACT Plus providers? What about when parents are forced to seek services at CMHC's? (this is not to speak poorly on CMHC's—it is just that many families do not view this as a choice).

A Medicaid recipient has freedom of choice among qualified Medicaid providers; however, Impact Plus is not designed to be an alternative to Medicaid's Community Mental Health Center Program. In order to access Impact Plus, an individual must have Medicaid coverage as well as meet the additional qualifying criteria as set forth under 907 KAR 3:030E. A Medicaid recipient that does not meet the eligibility criteria for Impact Plus may elect to receive mental health services from qualified Medicaid providers such as a community mental health center, psychiatrist, or hospital.

(2) If true "freedom of choice" exists, how can some agencies continue to require weekly/monthly therapy with one of their own therapists if/when a family wishes to only use that agency's psychiatrist and wishes to use a therapist from another agency? In these cases "freedom of choice" is given only lip service.

All mental health providers should have a relationship with a psychiatrist in order to bridge information concerning daily behaviors, potential side effects, and therapeutic interventions when a child's symptomatology may benefit from medication.
Therapists serving Medicaid eligible children may consider working with psychiatrists who also accept Medicaid.

(3) Can you speak to the role of "freedom of choice" in the wraparound process? Clients in our region have been told their services may be denied if they choose a different provider midstream. Are there any regulatory implications or red flags for HRC with this type of decision from a client?

There are no "red flags" for HRC or regulatory implications if a recipient changes providers as long as the recipient continues to meet eligibility criteria and the services continue to be medically necessary.

Sample Application/ Care Plans

(1) The care plan on the website needs to be expanded. The template only allows for three objectives. You can't add boxes for more objectives.

We will look into adding more boxes. However, it is often preferable to limit both objectives and goals to a reasonable number that can be more easily accomplished by the client.

(2) Can you provide us with a copy of a care plan that is "acceptable"? It would give goals, objectives, and other information in a format to use with other care plans to submit.

(3) I think it would be very beneficial to show service coordinators a completed written example of an excellent eligibility packet as well as a thorough service plan. This would also be helpful for BHP's as they assist service coordinators in the development of Medicaid approved "clinical language" in service plans. Maybe this could happen in a future training?

Each plan is reviewed from the perspective of how it proposes to meet the needs of the child. It should not be based on a cookie cutter approach, but on the individualized strengths and needs of the child. The plan is not just a tool to be utilized for utilization review/utilization management purposes, but should also be used as the written "roadmap" for treatment, clearly reflecting the focus of the child's treatment via the goals and objectives. Just as no two children in the program are exactly alike, no two service plans should be the exactly the same.

See #2 below regarding the eligibility application/packet. The plan is not just a tool to be utilized for utilization review/utilization management purposes, but should also be used as the written "roadmap" for treatment. The plan should not be driven by a "cookie cutter" approach, but should clearly reflect the focus of the child's treatment via the goals and objectives.

Just as no two children in the program are exactly alike, no two service plans should be the exactly the same. In regards to the comment about "Medicaid approved clinical language", there is no such thing. A service plan is reviewed from the perspective of medical necessity according to the needs of the child.

(4) Can you put a completed application on the web site that has all the sections filled out, using a specific diagnosis like O.D.D. or Major Depression?

(5) In the future, could you provide an example eligibility packet, because I really struggle with how to show the six-month history? I end up writing three to four pages and find myself repeating the same thing over and over.

The application is to be individualized based on the needs of a child. There are no standardized answers based on a particular diagnosis. While the program

requires that a child have an Axis I diagnosis, this is just one of the eligibility criterion.

In an effort to assist the provider community, instructions and guidelines for how to complete the application were mailed to providers on September 9, 2003. These instructions are also posted on this web site.

HRC Issues *Please Note: HRC has changed ownership. The company's new name is National Health Services or NHS.*

(1) It appears that HRC is approving/denying services based on documentation preferences, not the actual needs of the client. Can complaints be filed against specific HRC employees? To who(m) would these complaints be sent?

The documentation must clearly reflect the actual needs of the client in order for medical necessity to be determined. An appeal or request for reconsideration must be directed through the appropriate channels; however if a provider has a specific concern related to utilization review, please contact Carla Mahan at the Department for Mental Health and Mental Retardation Services. Ms. Mahan may be reached at 502-564-4797. Her mailing address is 100 Fair Oaks Lane 4W-C, Frankfort, KY 40621.

(2) What are the credentials of those who review the applications prior to them being given to the psychiatrist for final approval?

A psychiatric registered nurse or a behavioral health professional performs the first level review.

(3) Why is it that only a BHP can write or assist with an eligibility assessment but then an RN can approve or deny services? I don't understand how an RN can override a BHP's assessment.

National Health Services is licensed as a peer review agent. As such, Medicaid has contracted with NHS to perform utilization review/utilization management on its behalf. A denial of a service comes from a psychiatrist, not a registered nurse. Beginning September 15, 2003, a psychiatrist will be the only staff qualified to issue a denial of eligibility.

(4) We received a phone call from an HRC doctor stating that if we made certain specific changes such as adding a goal for one of the diagnoses, then the services would be approved. We sent in the appeal with those exact changes, and the denial was upheld.

We are unable to research this particular incident as no specific information was provided; however, as a general rule, we would suggest that if a NHS

physician contacts a provider and requests additional or more specific information, to document the contact including the name of the physician. Please keep in mind that the second review will be comprehensive and may reveal additional issues not identified in the first review.

(5) If a BHP has to project the next six months behavior for a child to be eligible, how then can an HRC doctor determine that a child is too severe and can't be helped by IMPACT Plus?

Just as the behavioral health professional uses clinical judgement to assess a client's needs and resulting services to address the identified needs, a utilization review physician/psychiatrist also uses clinical judgement to determine if the documented need can adequately be met by the proposed plan of care. If the severity of the identified needs cannot, by clinical judgement, be met by the proposed plan of care, then a denial will be issued. If the behavioral health professional disagrees with the physician's clinical judgement and believes the client's need can be met by the proposed plan of care, reconsideration can be accessed with additional documentation provided to support the behavioral health professional's clinical assessment and clinical judgement.

(6) Do our questions/concerns matter in regard to how this process could change to be more user-friendly? i.e. improved relations with HRC physicians. It would help for the physicians and reviewers to be more objective or forgiving of errors that can be corrected.

The Departments for Medicaid Services and Mental Health/Mental Retardation Services recognize the importance of provider input in program design and implementation. Most providers would probably agree that the process has significantly improved since NHS originally took over the utilization review function. NHS receives approximately 300 or more requests each week related to Impact Plus. NHS is required by contract to issue decisions on the majority of these requests within 72 hours. If there is an issue that a NHS physician believes can be easily addressed through clarification over the phone, this is usually attempted; however, due to the volume of requests that NHS processes, this is a courtesy, not a requirement.

Hearings

(1) We did a face to face appeal on November 1, 2002 and still have not gotten a decision. Any suggestions?

The specifics of this particular concern cannot be researched at this time, because no specific information was provided. If a hearing is held, but a decision is not rendered within thirty to sixty days, the provider or the recipient's legal guardian may contact Scott Swinney with the Department for

Medicaid Services. Mr. Swinney may be reached at 502-564-5198. His mailing address is 275 East Main Street, 6E-E, Frankfort, Kentucky 40621.

(2) What can we do when hearings are backed up? Can we drop and reapply?

Anytime that a Medicaid recipient receives an adverse determination, the recipient is entitled to pursue the fair hearing process, at the discretion of the recipient or recipient's legal guardian. Over the last few months, the number of requests for hearings has greatly increased. This has resulted in a delay, and at times, a lengthy delay in getting hearings scheduled. At any time the recipient or recipient's guardian may elect to withdraw their request for a hearing; however, this is strictly at the discretion of the recipient or recipient's guardian. If the recipient or guardian elects to withdraw the hearing request, they may reapply for Impact Plus eligibility or services.

(3) What is the process for providers to gain info from HRC on cases that are way past deadline?

Medicaid requires that NHS issue a decision for Impact Plus eligibility or a request for services within 72hours for most cases. If NHS has contacted the provider and is waiting on additional information, the "clock stops" until the requested information is received. That said, there are times when decisions aren't issued within the deadline. If a provider has not received a decision within six working days:

1) **Contact the case management provider to make sure that a request was submitted and to see if NHS has requested additional information.**
2) **If the request was submitted and no additional information was requested, you may make an inquiry with Rose Connelly, Medicaid Psych Supervisor at NHS at 502-426-4888, extension 6420.**

(4) We had a client who was initially approved for IMPACT Plus. The initial service plan was denied. We resubmitted and the denial was upheld. We were told that the next step was a hearing. Question: Could the team meet again and redevelop a completely new service plan, due to increased knowledge gained in today's training, and resubmit instead of going through the hearing process?

The right of reconsideration or a fair hearing is the right of a recipient, not the provider. If the recipient or recipient's guardian elects not to appeal, the provider may reapply on behalf of the recipient. However, the new request must start after the denial period has past (services denied through 10/31, new request can not start until 11/01).

(5) What recourse does an agency have when HRC does not give any time to transition a client and they do not meet their time frame in responding to an appeal? The agency then has to assume the cost of providing services without a guarantee or payment,

because the client cannot go 2-3 weeks waiting for the appeal decision. Waiting for a fair hearing can take even longer.

When clients no longer meet eligibility criteria or medical necessity criteria for services, the provider should assist them in gaining access to other community resources. Since IMPACT Plus is designed to stabilize children and move them to lower levels of care, discharge and transition planning should be considered from the beginning of services.

For excessive time-frames of decisions, please see response #3.

Reimbursement for Application

(1) Will there be reimbursement for assessment on eligibility?

No

(2) If there is going to be so much detailed information needed for the application and the need for more contacts, etc. to obtain the information needed to complete Needs Assessment and outcomes, then would there be any possibility of different reimbursement or additional initial units of TCM to complete the application process?

An Impact Plus service may only be authorized after eligibility has been determined.

Autism

(1) What about children with Autism or other PDD? How can you predict and give a target date? (in request for services)

For children who were determined eligible for Impact Plus prior to the May 21, 2002 regulatory change, a plan for discharge within six months is not required. However, documentation must be provided within the collaborative care plan and progress report that demonstrates that services provided and the goals and objectives are adequately meeting the client's needs. Progress or lack of regression must also be documented.

(2) If autistic children are dropped from IMPACT Plus and they don't get the waiver how will they have access to services?

At this time, the Department is awaiting a decision from the Centers for Medicare and Medicaid Services (CMS) regarding the PDD waiver application.

First Steps, school-based services, and the SCL waiver are some other possible programs, which may serve children with autism.

(3) The waiver is only going to cover a little over 100 children with autism. Will there be IMPACT Plus services for children who don't have access to the waiver?

At this time, the Department is awaiting a decision from CMS regarding the PDD waiver application. No decisions have been made regarding what, if any impact, the decision will have on the Impact Plus program. If approved, the waiver will provide services for up to 140 children.

New Providers

(1) Any word on when or if IMPACT Plus will be opened to new providers?
(2) When will you be opening for acceptance of new providers?

IMPACT Plus is an optional program provided by the state of Kentucky. Due to the projected Medicaid deficit new providers will most likely not be considered during the current fiscal year and the anticipated timeframe for accepting new providers is currently unknown.

Job Descriptions

(1) Why is it so hard to get TCS IMPACT Plus approved? i.e. supervisor's credentials, background checks, transcript, etc.

There are regulatory requirements for IMPACT Plus providers, including TCS workers. For all provider positions and services, all requirements must be met. The process for reviewing credentials, including a weekly meeting to issue approvals, is timely and consistent provided that clear information is submitted by the employing subprovider.

(2) What is (are) the criteria to be eligible for professional and paraprofessional TCS?

Please see page 16 and 17 of 907 KAR 3:030E (Section 6(6)), approved July 1, 2003. The regulation is listed on this website for your convenience.

(3) Explain why it is acceptable to allow a BHP under clinical supervision to provide therapy, do ongoing assessments, provide clinical documentation and service provision over an extended period of time with clients and their families, but not allow them to initially assess what issues need to be addressed for the child?

Initial assessments must consider the full range of possibilities for understanding a given child or adolescent's functioning including biological,

environmental, family, and individual factors. Furthermore, priorities for intervention must be carefully considered including risk management, realistic goals, and likelihood of success. Finally, the initial assessment is important in determining eligibility. For these reasons, IMPACT Plus requires that an independently functioning clinician conduct the assessment. Once the focus of intervention is set, a BHP under supervision may work directly with the client, provided that a BHP is available for ongoing supervision.

(4) How long until an intensive training occurs specifically for BHP's?

Training specifically for BHP's will soon be available. Please look for a training that will be offered during the spring "Choices and Changes" conference (formerly referred to as the Seasonal Conference) titled "Using Outcomes to Support Strengths-Based Treatment planning, Discharge Planning, and Supervision".
We will continue to develop training specifically for BHPs and we welcome more suggestions on specific content that is typically not found through the annual Mental Health Institute and Choices and Changes conferences. Both of these conferences traditionally offer training that is valuable for a behavioral health professional to attend.

Eligibility

(1) We have had children denied eligibility due to being too severe to show improvement in six months (per training today). But, the regulation states they must improve OR have further regression prevented, yet HRC is not recognizing the latter. Why?

If the information being presented clearly makes the case that services provided are facilitating improvement, or are specifically preventing regression, (and all other criteria is met) then most likely further services will be authorized. The entire section partially cited above must also be considered "requires a coordinated an intensive plan of medically-necessary community-based behavioral health services that can reasonably be expected to improve the recipient's condition or prevent further regression <u>so that the recipient may be discharged to a less intensive behavioral health service or program in an anticipated six (6) month time frame (907 KAR 3:030 Section 4(b)c)</u>" Therefore, if preventing regression becomes an ongoing use of services without an indication of when discharge will occur, NHS will appropriately issue a denial.

(2) The new eligibility packet does not at any point ask for "specific dates" of behaviors. I have had several children denied for services due to lack of "specific dates." How will this new tool help reviewers who are looking for specific dates?

The eligibility application requires a description of persistent behaviors as related to the diagnosis that have occurred during the last six months.

Providing specific examples with dates is a good way for a provider to best describe the behavior issues over the last six months. Specific examples with corresponding dates can also help document persistency of issues as related to the diagnosis. Even though specific space is not designated for a date, please include some indication about the timeframes of behaviors being presented.

(3) It is very difficult to demonstrate a six month timeline of behaviors within the home environment, when often, the caregiver is very low functioning, is a poor historian, and there are no other providers involved (some children do slip through the cracks). Any suggestions on how to pull this information from the parent/caregiver to meet the criteria?

In this case it would probably be beneficial to ask the parent's permission to meet with the child's teacher, counselor, and any other involved school personnel. There also may be extended family members that can provide valuable information. Conversations with the child, when developmentally appropriate, can also assist in identifying historical information. Please seek additional tools from supervisors who may be experienced with techniques such as routines based assessment as it may be helpful to ask a parent to walk you through a typical (or most recent) day. However, even when parents have limited ability to communicate the full extent of their child's problem, they can most likely offer valuable information relevant to the applicants.

(4) Some CMHC's are refusing to release information on cases, making collection of six month history impossible. What should we do?

If the legal parent has signed a release of information requesting records be forwarded to another provider, then a mental health agency (or any healthcare office) cannot, by law, deny that request. When a request is not fulfilled in a reasonable timeframe, consider advocating on behalf of the family while moving up the supervisory chain.

(5) Who developed eligibility criteria? Denial for lack of persistent behaviors and lack of demonstration that they can have improvement in six months seems contradictory. How can a child be denied for both, when the latter seems to say that HRC sees documentation of the former? Will criteria be reviewed at any time to determine if the client is still meeting requirements of the program?

Eligibility applications documenting severity in the client's home, school, and community are also used to justify how the proposed coordinated plan of care is anticipated to address the identified needs. For severity to be determined, all behaviors identified must be persistent in all areas of a client's life. If denials occur based on lack of documentation showing persistency, the reconsideration process can be accessed and additional documentation provided to show persistent issues. If the coordinated plan of care and the anticipated services do not document how improvement will occur, then the services identified are not

appropriate to meet the identified needs of the client. Again, the reconsideration process can be accessed. Eligibility can be denied for multiple reasons and NHS will give the provider documentation of why a denial occurred. With this information, the provider can then formulate a reconsideration response that directly addresses the specified reasons for denial.

An eligibility review occurs with each continued service review. If a client does not meet ongoing eligibility, then a denial will be issued.

(6) Who came up with the notion that within an approximate six month time frame, a child will be able to meet a new provider, build a relationship with that provider, and begin to deal with multiple issues enough to improve and be exited within such a brief time frame?

Evidence-based/best practice literature (Standards for Services to Strengthen and Preserve Families with Children & Surgeon General's Report) states that intensive services are utilized to develop immediate, short-term goals. These goals are to be time-limited, related to the primary risk factors, immediate, and achievable. Most literature states that this level of intensive services should last approximately 6 months.

The six-month time frame is not an absolute timeframe and if the regulatory criterion continues to be met and demonstrated to NHS continuing services can be approved. Again, if intensive services continue past the initial 6 months, a time-limit is to be provided and followed.

(7) How can it say that parents have a "choice" when HRC does approvals/denials based on BHP information?

This question does not specify what types of approvals/denials are referenced. During the eligibility process, any behavioral health professional that has previously served a recipient, may serve the recipient in the future, or who supervises a targeted case manager can sign-off on the assessment requirements within the application. Because the parent is required to sign the application and release the information, the parent has a choice to sign the application or to not sign the application. Once eligibility is established, the parent then has freedom of choice to choose providers. One of these choices is the behavioral health professional that will participate in the team and in the provision of individual services.

(8) What are your suggestions to tell parents that their child is "too severe"?

If NHS determines that the coordinated plan of care identified within the eligibility application can not adequately meet the client's needs, the client can be identified as "too severe". With this information, the provider can explain to parents that their child's needs may be too severe to adequately be served within

the IMPACT Plus program or the proposed plan does not sufficiently meet the needs of the child. Two things can occur. The provider can work with the parent to determine a different plan of care that may better address the child's issues and complete the reconsideration process with this new information. Or, the provider can help the parent find a more appropriate level of care to address their child's needs.

(9) What are the other options other than hospitalization, which I thought IMPACT Plus was trying to prevent?

If a client is denied eligibility because the client's needs cannot adequately be met in the IMPACT Plus program, hospitalization is not the next step in all situations. Perhaps the anticipated plan of care requires more intensity with the client accessing the higher end services within IMPACT Plus, (e.g. partial hospitalization, day treatment, crisis stabilization, therapeutic group residential, therapeutic foster care). If all potential services within IMPACT Plus have been assessed as not appropriate to meet the client's needs, then other provider resources may need to be accessed. Hospitalization as well as Psychiatric Residential Treatment Facilities may be appropriate resources depending upon the needs of the client.

(10) How do you "maintain" a "too severe" in their community without IMPACT Plus when current lower intensity services are unsuccessful? **see answers to #8 and #9.**

(11) Will children be deemed ineligible who meet all other criteria, but cannot access an evaluation from a BHP?

The regulation 907 KAR 3:030E states within the eligibility criteria that a behavioral health professional must provide assessment of a client's needs. If a behavioral health professional is not a part of the eligibility process, then the criterion is not met and the client is deemed ineligible.

(12) The rationale listed for BHP's under clinical supervision being able to perform assessments for crisis stabilization was that a BHP may not be available in a pinch. In rural KY, BHP's are sometimes completely unavailable and would make this program discriminatory toward those individuals. And what is the point because an RN can override all of the assessment work of the BHP.

Only a physician is able to deny eligibility or continuing services in the IMPACT Plus Program. RN's and other behavioral health professionals provide an initial review. If a denial is recommended from the initial review, the case is forwarded to a psychiatrist for final review.

(13) Is service coordination not a needed goal/service? Is our job not to teach the parents how to advocate for child/children; to role model? Why are clients found not

eligible when they only have service coordination and no other IMPACT Plus services?

Part of the eligibility criteria is that an intensive, coordinated plan of care be identified to meet the client's identified needs. If targeted case management is the only identified service, then an intensive, coordinated plan of care has not been established as required for eligibility. Just because a client does not meet the level of need for IMPACT Plus services does not mean the family could not benefit from lower levels of care and less intensive services.

(14) A statement was made that you must document that there is "no other way this child can be served other than IMPACT Plus." This being the case, why are children approved for IMPACT Plus for counseling, when this service is already available and accessible through regular Medicaid?

In order for a child to be determined eligible for IMPACT Plus, severity must be documented meeting all criteria within KAR 907:030E. To meet eligibility, a coordinated and intensive plan of services is to be documented, showing how these services will address the identified need and promote progress. If a child has been determined eligible for IMPACT Plus, services through regular Medicaid have been determined unable to meet the child's need, making it necessary for IMPACT Plus to be accessed.

(15) Can you speak to the rationale of making denials of medical necessity based on underutilization of a service?

See number 14 above. Additionally, if the coordinated plan identifies a level of intensity and duration for a service to meet the severe needs of the client, it is expected the plan will be followed or revised thereby addressing any underutilization of services.

(16) How can "underutilization of service" be a reason for denial of future services? I thought that was the purpose for team meetings: to review current services and make adjustments as appropriate. Example: services were requested weekly in May and June, but the client missed one week in May because of surgery, and then one week in June when they went on vacation. Services were denied for July and August because they did not utilize weekly in May and June. This in penalizing client's months after missing a service. How can this be addressed?

If a client is able to miss services and maintain without regression, it is then determined that the client does not need the intensive level of services. Of course, there are times that a client will miss appointments due to illness, weather, or vacation. In these times, it is necessary to document how the client still requires the intense level of service even though the client missed the service and did not regress. This can also trigger for the treatment team that a client may be ready to step down into less intensive services and begin the discharge process,

documenting the plan to lower intensity, identifying the date of discharge, and making appropriate referrals for ongoing service needs.

(17) When discussing the need for a "coordinated and intensive plan of medically necessary" services: we have been receiving denials based on a lack of need for this plan when we are utilizing CMHC services as well as IMPACT Plus. For example, IMPACT Plus Case Manager and TCS, but CMHC doctor and therapist. Is this appropriate?

A CMHC is able to provide targeted case management, therapeutic child support, individual therapy and medication management. If the child requires these services and the need can be met at a CMHC, then IMPACT Plus services may not be necessary or appropriate. If the child needs these services and the need or intensity cannot be met at a CMHC, then documentation is to describe why the need cannot be met.

(18) Will client/family "right to choose" be a consideration in reasoning for not accessing a less intensive service or program?

(19) What if the family does not want their child medicated and prefers psychotherapy, but has had a bad experience or conflict with the only available less intensive programs in their area?

(20) What documentation is appropriate to provide on the eligibility packet or ongoing reviews to support that a less intensive service is NOT available?

No. The "right to choose" is frequently misinterpreted. Families have a right to choose among providers in a network once they are eligible for services within the network. Preference for other providers does not "override" eligibility requirements and it cannot be used as a justification for accessing a lower level or higher level of care due to personal preferences. IMPACT Plus is not an alternative or replacement program for less intensive programs or Community Mental Health Centers.

If however, the less intensive services or programs have been tried and deemed unsuccessful, that information may be presented for consideration.

(21) If a client comes to us for help and they have not been in the local mental health community, we refer them and start the application process. Why is the client denied eligibility when we send in our request for services only asking for TCM?

Severity has to be determined and one of the key indicators of severity is that other less intensive services have been accessed and have not worked. If a client has not received services within a CMHC or other service provider (private practice, school counseling, etc.) then these services need to be accessed first. Targeted Case Management is a service provided by CMHCs and can be accessed within that level of care. IMPACT Plus subproviders should help identify the targeted population to be served by the IMPACT Plus network prior

to submitting such information to NHS. It may be beneficial for agencies to revisit the clinical intake process for their specific agency to help identify when a child needs to be referred to CMHC vs. IMPACT Plus.

(22) If the child has a regular Impact TCM, do you want this person listed under Section IV IMPACT Plus case manager?

If the IMPACT TCM is assuming the role of the IMPACT Plus Targeted Case Manager, then this person should be listed under Section IV as the case manager.

(23) What if the parents refused lesser services, i.e. medication? Will this cause them to be denied?

Specific questions will need to be addressed to provide argument for this situation. Some questions may include: why does the family refuse medication or other services; if the parents did not refuse, would the service be beneficial; are the client's issues severe enough to justify skipping the lesser services for IMPACT Plus. IMPACT Plus is not an alternative for lower levels of care. Eligibility requirements must be met, severity must be evident, and a client must require an intensive, coordinated plan of care that can not be accessed in another setting to be in IMPACT Plus.

(24) Application, on page 6, section 2: in regard to access of less intense level of services: A client lives in a rural, secluded area of the region. The guardian has a newly acquired illness which restricts her ability to drive and access other services. Client's services will likely be terminated soon due to being in the program for approximately two years, despite his continued need for services. Would this be a qualifying factor to continue services?

To answer this issue, more client specific information is needed. What is the reason that the client has not progressed for two years? If continued services are approved, how helpful will these services be if the previous services have been unable to provide the client with progress for approximately two years? Is the only reason that the client requires IMPACT Plus is because of the guardian's inability to transport? What is the discharge plan as IMPACT Plus services will eventually end, etc.?

(25) When a goal is met do we tell the HRC on the care plan or just eliminate it from the plan?

Any changes to the goals and objectives on the care plan are to be documented on the progress report. When a goal is met, the progress report is to document the reasons why the goal has been met and any new information that now requires treatment and services.

(26) What if a child misses appointments with a BHP due to a 50 mile drive distance, yet there is an available BHP in the community but IMPACT Plus or HRC only approved them on a "special case" or circumstance, when actually the BHP could more consistently provide services because they are closer and more accessible? What do you do to correct this?

To answer this question, the specific information regarding why the BHP is only considered on a "special case" must be reviewed. If a BHP is available in the client's region and the parent chooses that provider, then that provider should be approved. However, there could be extenuating circumstances that may prevent the BHP from being an ongoing service provider.

(27) Regarding transition of children from more intensive to less intensive services, we are having difficulty on the less intensive side when children are approaching discharge. For example: If we look at lowering intensity one to two months prior to anticipated discharge, HRC is often stating that these services can be provided by CMHC's and IMPACT Plus services are subsequently denied.

When looking to lower intensity, clear documentation outlining the difficulty of access must be provided so that NHS is able to ascertain the reasons. If lowering of intensity is part of the discharge/transition plan and has been clearly documented with a specific discharge date, NHS should approve. However, if lower intensity services are provided without clear reasons or for a longer period of time than necessary, NHS can deny based on the ability to receive these services in other settings.

Maintaining Eligibility

(1) If a child has a lapse in service due to illness, hospitalization, etc., will he/she keep eligibility for 60 days after the ending date on the request for services? If not, how long will he/she keep eligibility?

The eligibility period is based on the last team meeting. Approximately 60 days after the last team, eligibility will remain intact. If a team meeting does not occur within that 60 day time period, eligibility will lapse. The reasoning is that a client in the IMPACT Plus Program has too many issues and concerns to go more than 60 days between the team meetings.
The eligibility period may also lapse while a client is hospitalized or in a psychiatric residential treatment facility. This will be based on how long the client is in the facility and the treatment issues that placed the client in the facility. Because treatment issues will change as a result of institutional placement, eligibility may need to be re-established.

(2) We have been told to only count on three months for placement in a residential treatment facility? Is this true?

Yes, according to 907 KAR 3:030E, both residential and foster care services must "be provided in accordance with a collaborative service plan that can reasonably be expected to improve the recipient's condition so that the recipient may be discharged to a home-based services program of IMPACT Plus services in an anticipated three (3) month time frame".

Other Questions

(1) In the discussion, you have emphasized the concept of "collaboration." How have you collaborated with providers about the design and implementation of these changes?

Collaboration occurs in many different ways. Collaboration occurs within each program review as SubProviders are able to communicate their specific concerns. Collaboration occurs with each phone call and issue discussed regarding client issues and provider issues. Collaboration occurs with each IMPACT Plus forum and meeting that occur periodically throughout the year in addition to the annual peer group meeting during the Choices and Changes Conference (one sub-provider attended last year). Additionally, specific SubProviders have been invited to participate in work groups (like therapeutic group residential subproviders) and committee meetings as appropriate. Also, SubProviders are encouraged to invite IMPACT Plus central office staff for meetings or forums if providers have specific issues that warrant discussion and can not wait for one of the other aforementioned opportunities.

It is also important to note that the Department for Mental Health and Mental Retardation Services contractually employs subproviders to perform services. While the Department collaborates on behalf of children and families, the Department is also responsible for monitoring quality, tracking expenditures, and determining regulatory compliance, and recommending recoupments to Medicaid.

(2) What do TCM's do when the family fails to keep appointments with the BHP repeatedly, the missed appointments have been addressed numerous times, but the parent continues to fail to keep the appointment for various reasons. The parents then are stressed or upset because the child is acting out and at risk for losing IMPACT Plus?

Client self determination is a difficult concept for us in the human service field. If a parent or guardian is unable to keep appointments, despite frequent conversations regarding the implications of these missed appointments, then the parent is deciding by their behavior that services are not important. Then, it is

up to the provider to terminate the relationship officially. This is especially difficult when parents control the situation and their children really need the service. Utilize supervision to ensure that all avenues to involve the family have been accessed. And, when terminating the relationship, please remember to make appropriate referrals to other service providers and document the termination process that occurs.

(3) Would it be possible for HRC reviewers and IMPACT Plus staff to meet a sample of actual clients and parents each year?

Currently, as a component of some program reviews, parents are called to complete telephonic surveys regarding services. Interviews with clients (primarily in residential, partial hospitalization, and day treatment programs) have also occurred. Furthermore, staff have periodically assisted consumer groups and/or participated in planning discussions with the Youth Council connected to the Kentucky Partnerships for Family and Children and the Autism Spectrum Disorder Consortium. Legislative Research Commission staff also interviewed families as they researched program effectiveness and developed recommendations for improvement (the full report can be found on this website). Furthermore, NHS staff will soon be participating in on-site residential reviews.

(4) How do we deal with agencies that have case management and therapy "feeding" their therapist's group with clients versus letting the family choose.

Freedom of choice is a federal right that all clients and families have when receiving a Medicaid funded service. If a provider is not providing a family with freedom of choice, this needs to be communicated with central office so that appropriate steps can be taken to remedy the situation or discontinue the subprovider contract.

(5) Why was the emphasis on family functioning removed? How was it determined that this is unimportant to reviewers? MFT concepts saturate this program. How do you pick and choose these concepts of comprehensive importance?

Family issues are very important and each provider is welcome to target family functioning as an outcome within their specific program. Family functioning and the GARF are included in the collaborative service plan. The GARF score can still be given (and expanded upon) within the eligibility application but it is no longer a requirement. The GAF score continues to be a requirement because it is a standard method of practice recognized and utilized in all levels of care.

(6) "Our regulation does not recognize the QMHP designation." Is this legal?

QMHP is a designation found in KRS 202A.011. It refers to professionals who can initiate an involuntary psychiatric hospital commitment. The IMPACT Plus regulation does not address involuntary commitments.

(7) What room exists within this program for specializations; within the intensive in-home parameters? An example might be BHP's who have been trained and supervised to provide EMDR and MST (multi-systemic treatment), etc. Further, such an approach might be subcontracted through identified IMPACT Plus providers and/or Comprehensive Care. This can be very goal-oriented, time-limited, and measurable.

If a behavioral health professional is qualified to provide a specific treatment intervention such as EMDR or MST, the collaborative service plan must document the specifics of the service and the qualifications of the person providing the service. These specific interventions can be utilized within the individual therapy service as long as the professional is practicing within their designated scope of practice and the interventions are not investigational or experimental in nature.

(8) How does the new regulation affect clients who came in under old regulations?

All clients that entered the IMPACT Plus program prior to May 21, 2002 fall under the "old regulation". This means that continued service reviews are based on old regulation criteria. IMPACT Plus is dedicated to continue the service provision to these clients as long as the service requested is necessary and appropriate.