

Questions and Answers from the January 7, 2015

Provider Training Session

1. How do Fairfax case managers learn about out of state residential providers?

All providers with whom Fairfax has an open contract are listed in our local CSA Provider Directory. The internal directory is a primary source for obtaining information about resources. Regarding of-of-state providers, our practice standards reflect our goal of serving children in their home and community or as close to it, as possible. State CSA law requires that VA Medicaid-enrolled providers are used when available and appropriate to meet the youth's needs. When an appropriate provider who is currently under an open contract cannot be identified to meet specialized needs for youth, case managers have many ways of researching specialized service providers to include the internet, past history of use, directories, colleagues, referrals by other providers, etc. Child-specific contracts may be established on a case by case basis when documentation shows that there are no appropriate and available Medicaid-enrolled providers and in-state providers. Only under these conditions will the CPMT consider an out-of-state provider.

2. Do private day schools need to bill Medicaid for services listed in the IEP?

The Agreement for the Purchase of Services (APOS) states:

27. ANCILLARY SERVICES:

- A. Providers are encouraged to use Virginia Medicaid certified providers for medical, dental, and psychotherapeutic services. A list of Providers who have enrolled with Virginia Medicaid is available at: <http://www.dmas.virginia.gov> then click on the link for Provider Search.
- B. To request information regarding enrollment as a provider in the Virginia Medicaid Program contact the Department of Medical Assistance Provider Enrollment/Certification Unit at:
First Health Services - PEU PO Box 26803 Richmond, VA 23261-6803

Phone: 1-888-829-5373 (in state toll-free), or 1-804-270-5105

Fax: 1-804-270-7027
- C. The website for Provider enrollment is: <http://www.dmas.virginia.gov> then click on the link for Provider Enrollment.

Although not stated, it is requested that Providers of Medicaid eligible services that are ancillary to an IEP, bill Medicaid for children with Medicaid. This is a state mandate regarding the use of Medicaid for eligible services prior to accessing CSA funding.

3. Slide 39 – What would you suggest on how to include trauma-informed practice in ISP if it differs from our current approach?

Providers are encouraged to attend training in trauma-informed practice and treatment. The state is offering a variety of free training across the state at the present time. A provider might reflect trauma-informed practice by including trauma screening and assessment into their work and reflecting that in reports. Awareness of symptoms of trauma should be factored into diagnoses and interventions. If the provider is not offering specific trauma-related services, it is still recommended that all providers have an awareness level of the issues faced by individuals affected by traumatic experiences.

4. How would you include cultural/linguistic competence information and where?

The treatment plan should report and document efforts to provide services in an effective manner that is sensitive to the culture, race, ethnicity, language and other differences of an individual. Such services may include, but are not limited to, use of bilingual and bicultural staff, provision of services in culturally appropriate alternative settings, and use of bicultural Paraprofessionals as intermediaries with professional staff. During last year's CSA Symposium at NVCC, Barbara Huff provided the below tip on how to increase cultural competence and diversity .

TIPS on Cultural Competence and Diversity

- *Ensure the board and staff reflect the diversity of membership and of the community.*
- *Spend time getting to know and understand the cultural values of diverse groups in your community.*
- *Use an inclusive definition of diversity that covers age, gender, economic status, sexual orientation, geography, language, race, ethnicity, religion and disability.*

5. I did not see educational related services, e.g. counseling, in the state standard list distributed at the meeting. Are we supposed to include them under another state service or are we allowed to add it as a service?

These services will be included in the final version of the Standardized Service Names. The Standardize Service Names section of the Provider application will have space for Providers to propose "Other" services not already included.

6. What recommendation would you make on how to facilitate the signing of a treatment plan by case managers?

We would like our case managers to have ongoing contact with private providers and encourage them to have an initial meeting, even if by telephone. Part of the discussion should be clarifying expectations from each other and perhaps the signature on the treatment plan could be part of that conversation. County and school staff utilize secure email and faxes to facilitate document transmission.

7. Do we hold-off treatment until a case manager signs?

No. If the provider has received a purchase order for services, proceeding with the services in a timely fashion is recommended. We would like documentation of attempt to acquire the case manager signature. Adjustments to the treatment plan can be made at a later date, as needed, if the case manager and members of the team-based planning group recommend changes, in collaboration with the family/youth.

DBHDS Licensing regulations states, “ The ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document his attempt to obtain the necessary signature and the reason why he was unable to obtain it.”

8. What if the case manager’s signature is not obtained?

Documentation that the treatment plan was sent, on what date, to whom, etc. is recommended. Revisiting the request for a signature in follow up team meetings or other contacts is also recommended. The provider then has documentation that the case manager was given an opportunity to review the treatment plan as part of the collaborative service planning process.

9. Are you able to distinguish individual therapy from group therapy? Our costs sheets are not equipped to do so.

Yes. Our system and rate sheets will have individual and group therapy separated.

Out Patient Services:

Out Patient Services: Therapy – Individual

Out Patient Services: Therapy –Family

Out Patient Services: Appearance

10. On the in-progress matrix of newly standardized definitions of services, I do not see descriptions such as speech/language and occupational therapy.

These services will be included in the final spread sheet as both individual and group options.

Special Ed Related - Occupational Therapy (OT) Group

Special Ed Related - Occupational Therapy (OT) Individual

Special Ed Related - Speech/Language Services Group

Special Ed Related - Speech/Language Services Individual

11. How do you evaluate Providers for compliance with your tenants?

The FAPT requires submission of current treatment plans or progress reports by providers for review of ongoing services and for requests to extend services. The case manager’s individual service plan describes the family, the team and the work to be undertaken to meet the family and child’s needs to achieve the family’s long-term vision. This is an evolving and changing document.

Progress and updates are included as components of the care plan. At the end of services, case managers and parents are afforded the opportunity to complete an evaluation of services. A number of information sources are considered in determining whether providers are utilizing system of care practice standards including feedback and observations from the youth, family, and case manager as well as review of treatment reports. See page 6 insert: Making the Paradigm Shift in Service Planning and Delivery.

12. Are you benchmarks mentioned in the training measurable?

Yes, benchmarks of system of care utilization are measurable. For instance, the requirement of youth and family participation is measured by randomly selecting cases each month after FAPT review for signature on the MAP and attendance at the FAPT meeting. Wraparound Fidelity monitoring is currently conducted for youth and families who received Intensive Care Coordination Services. Outcome measures are reported quarterly to the CSA Management team to monitor adherence to the provision of High Fidelity Wraparound services, the effectiveness of the services and impressions of youth, families and team members involved with the youth and family receiving ICC services.

13. Who is the contact for ensuring the information and acquisition of community supports when a child (in group homes located outside of Fairfax County) is transitioning back to Fairfax?

Team-based planning members share responsibility for preparing the youth and family to discharge from CSA funded services to community and natural support services. The FAPT ensures that discharge planning begins when services start by requiring that a transition plan is included with each request for initial and extended services. While the CSA case manager is responsible for submitting the FAPT paperwork, input from the team is included in the plan. Both formal and information supports are documented that explore family resources as well as community supports in the transition plan.

14. Can we contract with you to provide intensive care coordination?

The Fairfax-Falls Church CPMT currently contracts with two providers for intensive care coordination: the Fairfax-Falls Church Community Services Board and United Methodist Family Services. CSB became an ICC provider because of the initial state policy restricting ICC provision to CSBs. The provision of ICC was included within a competitively awarded contract between the county and UMFS to operate the Leland House crisis stabilization program. The county's current need for ICC is met by these two providers. If, in the future, additional ICC providers are needed they will be selected through either the current open contracting process, or a competitive process.

15. When making contact with folks regarding SIR verbal notification is leaving a voicemail sufficient or do we need to speak with someone? What if there is no one answering the call?

For children in foster care, serious incident reports should be handled as follows:

During normal business hours, residential and foster care providers including both DFS and TFC should notify the case manager by phone. If the case manager is unavailable, the provider should

leave a voice mail message and follow the emergency instructions on the outgoing message. The provider will be instructed to contact the duty worker assigned to the case manager's unit at 703-324-7639 to notify him/her about the serious incident.

If a serious incident occurs after hours, the provider should leave a message for the case manager on his or her voice mail about the serious incident and call the after-hours number that was provided at intake/placement to report the incident to the after-hours duty worker.

16. We are interested in connecting with our utilization review to make sure we are conducting our own UR in accordance with your standards.

Providers may contact the UR Manager for Fairfax for additional information about the internal UR process used in CSA. Our UR may differ from a provider's UR in that we are focused on overall service utilization and levels of care across CSA as part of our program administration.

17. When you conduct UR, what are you looking for and to what end?

The URs conducted by staff within the CSA program are currently advisory to the FAPT. The reports reflect a review of the documentation requesting services that is generated in the team-based planning process along with relevant provider reports. UR Analysts utilize the CANS, provider reports, background information, and contact with relevant individuals usually by phone, to obtain information about youth and family strengths, needs, risk behaviors, and prior/current interventions to evaluate CSA eligibility, level of care, and appropriateness of the requested services. UR reports to the FAPT provide them with a recommendation for service authorizations. The intent of UR is to offer system-level oversight for youth and their families to receive appropriate, effective services in a manner that is fiscally accountable and in compliance with state and local policies that allow access to CSA funds.

18. If we have a contract through 2016, do we need to complete the application and submit it by March 31?

No. If your contract period is through December 31, 2016, you do not need to apply at this time.

19. Rates are normally delivered by May and we are required to post to the CSA website by July 1, so if we submit rates with the application, it would necessarily be applicable beyond July 1. So would we resubmit them as an amendment?

We understand that providers are often unable to propose rates for the next fiscal year until May, June and even July. We ask that you proposed what you anticipate your FY16 rates will be and they can be adjusted after award of APOS's via updated rate sheets.

20. Is there a provision for indirect service portion for related services in a special education day school, i.e., speech therapist is required to attend IEP meetings? Is there a provision to invoice for this indirect service?

There has not been language in past APOS's stating the ability for providers of services ancillary to the IEP to bill for appearances at IEP meetings. This will be proposed to be included in the FY2016 APOS and Addenda for Special Education Services.

Making the Paradigm Shift in Service Planning and Delivery

Based on: Osher, T. & Osher, D. The Paradigm Shift to True Collaboration with Families. Journal of Child and Family Studies, Vol. 11, No. 1, March 2002 pp. 47–60

	Provider Driven	Family Driven
Source of Solutions	Professionals and agencies	Child, family, and their support team
Relationship	Child and family viewed as a dependent client expected to carry out instructions	Partner/collaborator in decision making, service provision, and accountability
Orientation	Isolating and “fixing” a problem viewed as residing in the child or family	Ecological approach enabling the child and family to make informed decisions about services
Assessment	Deficit oriented	Strengths based
Planning	Agency resource based	Individualized for each child and family
Access to Services	Limited by agencies menus, funding streams, and staffing schedules	Comprehensive and provided when and where the child and family require
Expectations	Low to modest	High
Outcomes	Based on agency function and symptom relief	Based on quality of life and the goals determined by child and family