Ask is (call pending). (Is event pending). Good morning everyone. It is 11:02. We have 23 people on the line. Thank you and welcome to our group. I wanted to go over this morning that we have a new function to our public meeting, the closed captioning, if anyone needs that, they can click on the link that's in the chat. It is also displayed on the screen and it is easiest to have two windows open, one with the closed captioning and one with the PowerPoint that you're going to see. If you have any questions about the service, feel free to email here and we'll review the medical Tess any. There are several people who took the survey and provided us comments. Did work earlier this week with the work group and we found it helpful, we only have an hour, we could start if there are any questions that people submitted, sort of start with those so that we can answer those if we can or if you have feedback, then we can roll in the comments if we have time.

I want to make sure everyone knows that this is not the last time they will be seeing this criteria, and this is just draft form. We're looking to post our manual for public comments sometime in April. We were hoping April 1st. I think it will be a little bit later than that. We have some work to do on it.

You will also have another opportunity to provide public comment during that time. This is not the last time you will see this.

We would like to get comments back from you all as our stakeholders.

I will try to go over to Stephanie.

Jeff, our coleads today for this work group, welcome, everybody.

>> Stephanie: Thank you.

I want to say thank you to everybody who took the time to open the email, look at the survey, provide comments and feedback. It is important that we hear from you so that we know what's important and what we should focus on and what questions that you have and comments that you have. Just want to start with that.

So I guess I'll start with the service definition section with the questions and comments that came in for that. You will have to bear with me, I just saw that this morning. I will scroll through and read them for you. Hold on.

No worries, that's what we did in the last group. We didn't go --

>> Okay. Okay. All right.

This is more so a comment about a good service definition description, it looks like it was just a comment saying it was a good service definition for that one. Looks like most people said that the service definition looked appropriate. There were no questions.

>> We're off to a great start! All right! Let's wrap it up!

>> We're done!.

Jeff, did you want me to do the next one, do you want to do the next one? Do you have the excel spreadsheet up? If not, I can do it?

>> Do I have it up? I do have it up.

>> We can answer these questions. If you want to just go through them, we can answer this. It is pretty much the same question multiple times. The.

>> Next question was please provide comments on critical features and service component section. Just read these off and then we'll comment on them?

>> Like I said, they're kind of the same, if you want to summarize, it has to do with the -- with the service components that are not -- you know, not covered as Medicaid service.

Specifically the house, the vocational services that are with fidelity but not covered specifically under Medicaid.

Yeah. Yeah. They want to know why required services are not covered. The answer is, correct me if I'm wrong, CMS only allow us to cover a certain services. I believe that's the reason that it is like that.

Generally speaking, our providers read between the lines because we can't necessarily put it in writing. That's a reason why we did the per diem and a reason why, you know, you really only -- you know, you only have to do at a minimum of 15 minutes face-to-face in order to build that per diem. Noting that that per diem will, you know, really pay for the other service components, you know, that potentially we can't say we cover.

Really, that's -- you know, that's the reason why we did the per diem, it is because we know there are services that need to be provided in order to meet fidelity and the per diem, that's how the services are covered.

>> Also just to know, you know, there's a lot of discussion going on around future ability through 1115 waver through the high-needs support waver to be able to provide coverage explicitly for housing support, we don't have that approval and that waver. There could be additional funding stream available through the waver outright for the services. We just don't have that available to us at this time.

We do understand, you know, the concern of providers about the additional funds, you know, through general fund, you know, through DBHS to sustain and support the full staffing model of ACT given that there are portions of act and full fidelity that are not paid for in this full per diem. We have had a lot of individual discussions around that, we do hear that concern.

>> Another -- I think we probably have some work to do in terms of potentially clarifying this session in our -- this section in our manual. I think it really is sometimes semantics rather than the terminology we use.

You know, care coordination, case management, they are things that Medicaid does pay for. I think many of those items that you're seeing on the list, how they are vocational, they are technically words, services that CMS doesn't cover, they fall under that care coordination and the case management realm, it is a covered service.

I think sometimes it is just sort of terminology and what we call something. Because you know that this is the 11 states program, we want to call it what it is, of course. Know that I think the services are sort of covered under other umbrellas.

There was one I guess sort of off of that, a time related question, the crisis intervention, the stabilization of the component, does this mean that the services cannot be billed if they're receiving .

Which one are you on? Are you on --

>> Service component! Yeah. Yeah. There's a lot of questions here.

I know in the exclusion sections I believe, we put in that you could not have intervention of crisis and at the same time, a comment I saw, they mentioned in they're doing an ECO, a Texas DO, they would need to be able to access crisis intervention during the same time, which makes sense.

I think we talked about this in one of our meetings about TDOs.

>> I do remember -- I don't think I was in that conversation, but I remember somebody bringing that up, bringing that back to me.

That's something we need to feel out, that subtlety. You know, we're in a tricky spot too. We're -- these manuals will all get revised in disease necessarily when we bring in the other services and need to recharacterize crisis and other services. It is a little tricky. Just want to put that out there.

In the spirit of that, we have to appreciate that the teams should be the ones providing first response to the member, you know, if they're having a need, since ACT is available 4/7. You know -- 24/7. It sounds like in the certain escalated scenario, where they need a TDO evaluation we need to come up with a way to represent that need and how it should be met.

We will problem solve on that.

>> Also, Jeff, would you say the first comment here, where it says health literacy needs to be defined, I believe we were working on that internally.

We are.

This is a new term.

You know, what we have learned a lot, those of us that are new to the amendment process about the semantics of language that CMS likes, what they -- you know, what is not -- what's not kosher with them, for example, psycho education, it is a word that's not preferred. You can really think of health literacy counseling as a sin mum to psycho education, it is a different way of saying it. Any time you're talking about mental health and wellness, symptoms, teaching about, the nature of the disease, treatment, you know, about medications, when you're teaching about those, helping to support understanding of participating.

Laura put the definition up in the chat! We know that's a new word that we'll define in manual. I'm just reading through it.

>> The definitions, unfortunately, they were not attached when we sent out, they were actually attached as a -- they were not attached to ACT, it was -- it was on us that we did not provide that information. There is a definition session in manual that will go up for public comment.

>> We got them from the service components, we're good to go with the questions on there? Yeah. Next section, provider requirements and staff requirements. Let's see. Under team composition, roles, it colorly states some components are not necessarily covered by fidelity or Medicaid, same thing, justification.

We have addressed that already.

To comment, saying that the qualifications look good. The therapeutic support and interventions and individual group family therapy muts be provided by a licensed mental health professional, would that be included? Yes. That's -- that's they're all included throughout. It is included in the definition there.

Once again, the same question if -- I guess we need to clarify that in the medical necessary criteria since that came up twice. Looks like that section, it is all the questions. We can move on to the service authorization section.

>> Service authorization section.

>> It is pretty long, Jeff, if you want to tag team, we can tag team on this.

>> I will give it my best speed reading effort.

We'll start with authorization component states assessments are to be completed every 90 days, what's the justification to doing them more frequently? Updated assessment is required every 90 days, what's the rational for that requirement, along the same lines, that comment also regarding every 90 days, adding to the workload of the -- is this in addition to the six-month review, will this replace the quarterly review? Let's stop there and address the 90-day six month quarterly review question.

>> I guess they're asking about right now they have to update the treatment plan every 90 day, the medical necessary criteria says updated assessment. Maybe it should be just treatment plan. It says assessment entry plan.

You're on mute, Alissa. You can talk.

>> Sorry. I think we need to flag this section so I can look at it and better understand which requirement is coming from where and what it should be pointing to. I hear the concern about workload and we want to look where the there can be deficiencies. I would like to look at it more closely and talk to you all about it. Unless Laura has better insight than me.

This has come up in a couple of meetings we have had with the team and I just -- I think this is a section that we could look at in terms of clinically requiring the update of an assessment every 90 days. I think part of the rational for this was that, you know, generally updated annually, the treatment plan is updated every 90 days and the rational for the update every 90 day, it is that the service authorization could potentially be as long as a year and the MCOs and others, they may be looking for updated clinical information in between that year and we really want a close watch on how the numbers are doing because the service authorization potentially are going to be -- there will much longer period of time in between the reauthorization. We're open to feedback.

>> Laura, were you able to ask questions? Should we put it in the chat?

How would you request or suggest that we not mix the authorizing process with regulation. I understand that you want the teams to have sufficient information or to have more frequent assessments and preparation for authorization. I would ask that we consider separating the authorization process from the regulations, and so requiring teams to conduct assessments more frequently I think puts undue burden on the team. Of course we're constantly assessing, revising the treatment plan, documenting that everybody 990 days and the quarterly review which I think is

sufficient enough to provide documentation to the MCOs should they request a more frequent authorization. I will ask that we keep them separate.
  >> Thank you for the feedback. I understand.
  >> Thank you.

  >> That's very helpful.
  >> Jeff, I think we can probably move on, we'll take that one back for consideration.
  Anything else that you saw? I think they were all the same questions.
  >> They look all targeting. One person said that he was confused on this session, clouding the documentation information. I have to look to see -- maybe just specifically about the assessment and treatment plan. That's probably what it is.
  >> Another question coming up, everybody else, if you can be an LMPHES or if they complete ate assessments, yes, same as it is now. It will continue.
  Is that it? I think that's it, Jeff, for that section.
  >> Provide comments regarding admission criteria, diagnosis, system, functional impairment section.
  >> Yeah.
  >> I can do that one. I can do that. It could be a question coming through. Somebody just reiterating that it requires a lot of repetiveness and additional work to review quarterly and assessments every 990 days. Thank you.
  >> Does the allowance for psychiatric illness outside of SME with the position letter include the diagnosis listed in the exclusion criteria? There should be additional requirements than a physician's letter, ACT is not suitable for everyone and physician may be requesting ACT services for inappropriate reasons. Good question. This came up in one of our meetings about the position letter.
  I'm not sure -- I don't have an answer to that, I don't know if you have an answer to that, or if we need to take it back. I know there was a lot of discussion about the admission criteria.
  >> If the question is what a physician's letter, would it override the diagnostic admission criteria for something that's listed as an exclusion. I would hope the answer is no. Just because the physician, they may not understand the community treatment, I think that this person needs to have treatment.

  This is where they can support determination of necessity, looking that the letter, there is some very rare instance, it is an unusual presentation. You know, I'm trying to think clinically, some kind of an odd combination of things that they may grew that it would meet criteria. Ultimately, we would hope to leave that in the hands of the MCO and with the training we'll provide for them and ACT and hoping they can get the criteria and taking that positions letter and context but understanding -- we could use a note to include that strategically in the training to the MCOs to be sensitive to this issue and to look carefully if the position is looking to override. It is not someone trying to slip through inappropriately.
  >> There is a -- there is a frontline of defense, even before the NCOs have to make that determination. Part of fidelity, the team itself, it is the gate keeper of who is admitted or not, based on the knowledge of criteria and vision and the model. I think this question gets at what we see across the board, you know, people -- people being kind of pulled aside by an exec saying, hey, you know, client X has gone through every service that we have and they call, you know, es every day, they're outside making a lot of noise you need to work with them. That's not a criteria in and of itself. The criteria, they're there to ensure that this model is designed to not work with the SMI population, the subset of the SMI population, the real specific criteria. Hopefully through again the ongoing training, we tart to learn more about identifying those things so it doesn't necessarily have to wait for that testing.
  >> Thank you.
  >> Is that Brian Campbell?
  >> I do see the head there.
  Okay. That was all of the questions for that section.

I could move on to the criteria, my dog is is being very loud behind me, he's yawning.

>> The individual psychotic orders could be effectively treated, the process, safely maintained at a less intensive level of care. The assessment is safely maintaining the recovery process and MCO assessments often differ for client and support requirement if the compensations apply during a recovery process. We have the same interpretation of regulation.

>> That's a great question. One thought that came to my mind when listening to the question, I think that this will come into play when we have training with the MCOs to talk to them about what this looks like for this particular service. Do you agree? Substance use disorder, intellectual disability, it is a primary reason for the impairment of the personality disorder for IDBB and they often do not do well in this level of service even with another SMI diagnosis.

>> We have this in the exclusion section where if somebody's diagnosis is solely developmental disability and intellectual disability, that they're excluded from the service. This is what the question is asking. They should be excluded.

>> I think -- how is it worded? Is it exclusively?

>> It is in the exclusion section. It says the individuals functional impairment is -- yeah. It is -- it is confusing. If the exclusion Croix tier Y the individuals' functional impairment is locally as a result of personality disorder, EDD, NIDE, impairment solely as a result of the traumatic brain injury or autism spectrum disorder excluded from the service.

This is from the area colonial, I think if they can confirm if I'm interpreting this right, you're just -- the issue, it is changing solely through primarily allowing greater latitude for you to screen out.

>> That's what I think --

>> I think somebody said yes.

Yeah. You're correct.

Instead of fully, primarily. That's the suggestion.

That's something that you can take back, it does reference the code. You have to make sure it is correct based on what the code says.

It would be helpful if there is a statement that even if the individual has an appropriate diagnosis, but has a cooccuring personality disorder and developmental disability as defined in the code, the impairment is solely as a result of TBI, autism spectrum disorder. Okay. I think this is -- I think this is a request for adding CDI, autism, spectrum disorder on the list of primary SDEs, personality, developmental disabilities.

>> I think that's what it says --

>> This is Jerry, can you hear me? I'm not quite sure what I wrote in there, but what I was going for, if we have the clarification that even if someone has the primary diagnosis, they have this cooccuring diagnosis for borderline personality disorder, autism spectrum disorder, TPI, et cetera, they may not be appropriate -- TBI.

>> There's a lot of -- there's definitely issues with certain individuals when you put them on the team, even if they have a schizophrenia diagnosis if they have a corecuring diagnosis and it is good to put that in the language that they may not be able to be accepted, they may be, but they may not be as well.

I think what we have in there, the inexclusion criteria, explicitly, the primary issue is this, they're not eligible, what I'm hearing, preeing back, what I'm hear, maybe the desire to have additional language that would specify if these were secondary or cooccuring, that that would be left to the clinical judgment of the team to determine the appropriateness.

>> Yes, I think that several of the pack teams we talk often have issues with getting certain referrals and they may say this person has a schizophrenia diagnosis and you need to work on the psychosis and at the same time they have a very significant borderline personality disorder, TBI, ID diagnosis, so the referral sources are pushing that they still have the schizophrenia diagnosis and that we can work on that. You can't solely

work on that and ignore the rest at the same time.
 >> Sure.
 >> Sure.
 Yeah.
 >> That makes sense for us to take back and talk about, to put that -- to make sure that's a little more color. In terms of the appropriateness. Jeff, what do you think.
 I hear Jerry's point.   .

 Thank you for that feedback. We'll put it on the list to take back.

 >> Thank you. Thank you for speaking up too. Sometimes it is helpful to get more of the back and forth to understand.
 >> Yeah.
 >> We'll get there real quick, I'm sorry to take up so much time.
 I always say that in our team leader meeting, my friends, they ask me questions that are really team questions, you know, we may be able to answer that, we should really ask them, that's their authority.
 I'm glad to hear that they're asking. This is your time, man. Put these folks on the hot seat.
 >> I'm afraid to ask.
 That's Jeff's favorite thing. Sorry, Stephanie, sorry.

 I'll chime in on that regarding the transportation --
 >> (Jeff, we can't hear you. I couldn't hear you.

 >> He's.
 You want us to take it? It is about transportation, right?
 >> Yeah.
 >> So this is the one where unfortunately you -- we did look at this, it was right within the time we were sending out a draft, we have the policy team, there was actually nothing in the CMS policy that would prohibit transporting the client, particularly as assertive engage., being in a car, providing intervention in a car and so we're going to amend that language. There isn't any politics CMS prohibition -- any explicit prohibition that will be fixed. That's the concern. We did a lot of digging there. There was a lot of digging.
 A lot of good stuff happens in the car.
 >> Yes. It does! The clinicians agree.
 >> Yes. Yes.
 >> 100%.
 Is that it, Jeff?
 >> Can you hear me? We can. Yes.
 >> Yeah.
 >> Then yes, that's it for that column.
 >> The next section is the continued care criteria diagnosis symptoms, functional impairment section, am I in the right place? Yes. Yes. The first question, state criteria, ISP, they're updated every 0 days, as clinically appropriate, currently we review ISPs acrider every 90 days and more frequently if clinically appropriate, what's the justification for requiring updates every 30 days.

>> I'm not sure of the justification, it may be something that we have to take back again in relation to the other question about service authorizations and assessments and ISPs, kind of seems like the same -- unless Alissa, Laura have any feedback.

The next plan has to have with the treatment plan, ISP, 30 days, take that back, next question, same thing.
Next question, same thing.
Next question, same thing. The next question, the same thing.
We hear you. We definitely hear you on this one. We got you. We'll take this one back. That's it for this section.
As a general ask, anything that alleviates the burden of additional documentation and paperwork for enacting, it will be helpful. As we know, the work is very challenging already, so then adding any additional paperwork or documentation burden is going to be a struggle.
>> We hear you.
Yeah.

>> Thank you.

Next section is regarding comments on the discharge criteria section. First comment related to the discharge criteria stating that the team can monitor the transition, at the lower level of service for 30 days. Is that going to be billable.
I'm not sure. I'm going to let somebody else answer that one. I'm not 100% sure. It is a good question. I know we have Brian Campbell on the call as well. Wemy have to take it back to think about whether it is billable and how it is billable. My think something that they're monitoring and they are -- if there is any -- it is a 15-minute minimum, if there was any kind of contact with the member that met the service -- that was an active service component during that period. Just wondering about overlaps, whatever they're transitioning to.
I'm sorry, I missed part of the questions. This is Brian, everybody hear me?
>> We are.
Stephanie, do you want to repeat it?
>> Yeah. Sure. It says -- they're asking if the period of 0 days, discharge, if they're able to bill for that period of -- when they're following or monitoring that member.
>> Yeah. I would think that's still -- it is a discharge planning process, there is probably still an activation active in that time period, I would think that unless you're engaging in a covered component, service component, that time will be billable.

>> Thank you, Brian, that's -- I think it is also important to help the MCOs understand, you have an authorize ration for say case management, also while trying to build for ACT service, I think that's a critical piece to help understand that we would still be able to be paid for that as well.
That's great.
>> There may be overlap geese you could build in the claim system. I don't know how sophisticated it needs to be. The authorizations, they could just allow that.
Yeah. It should be part of -- you are following the person, part of the treatment plan, you should be reimbursed for that activity.
>> This is candy from Valley. I know we're moving to the next section. It says that you can't bill for individual group therapy or medication management at the same time and so our folks will be stepping down to those services. Definitely need some more language.
>> Right. I was actually just thinking that.
Yeah. That's what I was thinking about. Yeah.
I'm looking at the service limitations right now. Yeah.
>> You may have to fix that on the authorization side, you know, when -- yeah. That's going to require some thinking, figuring out how that will work.

We need to make the system part of it match the clinical need to monitor and followthrough while they're being picked up in the -- you know, that next service.

We'll talk with them about it.

>> That's good feedback.

Thank you.

>> That is literally the theme of that whole -- all of the comments in that section.

>> Okay. Good.

>> You know, we want to put out there too, just as a little flag, you know, we're not going to get it all perfect, we accept that now, we have radical acceptance, we're not getting it all perfect, what are the benefits of this being a rolling implementation with that second phase coming, we'll have another opportunity in six months and if we do see things that are really not jiving in the first few months when it gets started, we'll continue to meet with you all as a learning collaborative group, once the implementation begin, and we'll be getting feedback. If things don't work out as they're intended, we can always add training, clarification, different language to headache sure that this is a continue process improvement to make sure it meets the fidelity of the service and members are able to get the quality and type of service that's aligned with the practice.

>> I think we can count on some funky system things happening is what I'm saying.

>> Moving on to the service limitation section, the first question, it had to do with transportation, we already answered that about being able to provide services in a car.

Looks like a comment that had come through.

>> I saw that.

Other states, there is a 30-day overlap where you can ensure a smooth transition in the client for step down for other service, that's the plan, that's what we would like to have, to figure out logistically, how that will work on the operation side.

Here is the question I was mentioning earlier, if the ACT team utilizes the emergency department for ECO, TDO, they have to have overlapping and billing for ITT and crisis intervention, I think we said we would take that back to discuss more.

>> Let's see. Next question, it is about the services that can't be built concurrently, if there is an overlap for a short-term, how will multiple service requests be handled, short-term authorizations provided. Basically what we have already talked about, we have to take that back and figure out how the service cans work concurrently.

Let's see. All right.

Time spent doing, attending, participating in recreational activities often uses a way to engage with the client as mentioned, the discharge section, it guides the act model underscores the individuals participating in the service are expected to struggle with engagement given the severity of their mental illness, you say recreational activities often helps with this, please consider all activities to help with engagement, to be billable to Medicaid,.

>> It mentions the transportation piece.

>> Basically they're asking for recreational activities to be a covered service, to be able to be built. I'm not sure if there is any -- you know, maybe there is some --

>> We could say there's -- you know, clinical and documentation consideration here. I'm going to give as a psychologist my own translation of this.

For example, I used to work on a TBI unit and I did a ton of basically nursery has been. What the neuro psyche rehab looked like with these kids and teenagers, it was oftentimes game play.

We were trying to reteach them skills, tracking certain visual information, turn taking, you know, if they have afacia, helping them to say words,

they pick up an uno card, they have to match the word with a color. You know, the game was a plate we were delivering the cookies of intervention on, if you know what I mean.

It wasn't that any documentation I said played Uno forensic rehab today, I said practice -- for psyche rehab today, I didn't even mention Uno, that was just the platter that the skill came on. I hear what you're saying, sometimes we have used activities that exercise that mental muscle, the social, emotional muscle for someone, and it is not that medicate is pay -- Medicaid is paying for, for example, basketball, something, but if you're working -- if you are throwing a ball back and forthwith someone, shooting hoops with them, using that to practice turn taking, communication, socialization skills that are central to someone who for example has psychosis and has a hard time with relational skills or eye contact, whatever it is, you may be doing some type of recreational activity that would demand that skill. You may be documenting and describing the skill that was practiced, that's valid, that's: Equally have lid, all of us in the field have done this for year, it is really about understanding -- having the folks on the team understand the skill that's being rehearsed and focusing on documentation of the skill rather than the activity that allows for that practice. Of course, that's a slippery slope, there are probably some rec activities, if I take someone to the movie, sit had silence for two hours, that's probably not necessarily practicing a skill, right. There is others that legitimately are.

Going to buy lunch together, they're practicing the routine of -- you know, of skills related to ordering, eat, doing things socially.

>> The intervention is not the recreational activity, it is what the skills -- you have to -- yes. It is the skill that you're teaching during that recreational activity. TMS is not going to pay for you to watch somebody play basketball, whatever it is. Now. If you're playing basketball during a session, great. You are obviously doing something else during that session to teach or coach a skill.

That would be taken from the treatment plan. You already know this. I'm preaching to the choir.

>> What's the difference between CBT and fun? The answer is doing ratings. If you take a fun activity, you have entered your mood before and after, suddenly you're doing behavior therapy. It is really about -- I think it is about intentionality. It is about what is the intention, being very clear on what the intention is, being able to document, you know, what is the intention, whatever the activity is, what the outcome is.

I want to put that frame around it, what we say -- when we say recreation is not reimbursable, it is not reimbursable saying you're straight doing recreation, it is I'm demonstrating the skill or the outcome of the activity. The skill and outcome of the activity. Does that make sense to everyone.

I'm sure it does, we thought we would give the example.

We have had comments come in, I thank you for that explanation.

Totally. That goes for any service.

>> I have to remember this with the clip Cal trial part, you have the platter, how we give some different examples of ways that clinicians have been doing that for as long as we have existed, doing this work.

It is just that we have all been -- the way we talk about it.

Thank you.

Next question, can the per diem be built with SUDIOP, same day, within the same woke while ACT offers such treatment, there is a value and our consumers able to attend that group or other intensive abuse system like MAT services while receiving ACT.

>> Alissa, do you have a response for this one? That would be a fidelity issue. Jeff, do you have any -- any council on that topic.

I will repeat the question.

The overlapping -- the crisis question, it is also a fidelity question as well. In terms of using outside crisis intervention when that's not covered under the per diem.

>> Stephanie, which -- where is that on the list? In the column?

>> Let's see. That's row 10.

Column AB.

Okay.

>> Row 10. Okay.

It was -- it was basically asking if IOP could be built at the same time, same day, same week.

Can you put it in the chat? If that's the question, I mean -- if that's what's clinically indicated, the team has done everything that they can do, the individual desires that, it is part of the treatment plan, I don't see why not.

Jeff, that brings a -- thank you for bringing that question forward.

It also is the same for psychosocial rehab which I know is -- I'm in the akin to fidel, we may have some folks that may clinically need some additional support for a short period of time and they go to a psychosocial program.

Fair point. .

Not to digress, I would say they need assistance with, you know, socialization, intrigues community integration. I would diswage you from referring people to PSR, that's a personal thing.

The point about the team being the sole provider of services, it has a limitation. It is they should be the sole provide of services with -- in which they're skilled and qualified to provide. Right.

All people need dental care and routine physical exams. We don't assume the team to do that. Just as the team is most likely not equipped to serve in an MAT fashion or provide IOP services because it is a different service. That's where we say that it is okay to sort of work with -- outside of the bubble of ACT. Right. If it is something that you can't get from the team, you need it, I think it would be clinically irresponsible to deny someone access to a service that they needed. That's my two cents.

>> This is candy from valley of the I was going to second what Jeff was saying. The cooccuring specialist is not required to have-LMHP, so SUIOP services should be managed by the connection. We don't have that ability. You know.

Just saying.

The skill set.

Same with the prescreen, we don't necessarily -- not everybody on the team is qualified to be a prescreener, they're not all master levels, that's something that's required to be a prescreener.

>> All right. Thank you for the feedback. It sounds like that's something that we may have to consider or take back for more discussion. It looks like -- was somebody going to say something?

>> That was -- that's all the questions for that section. We can move on to guidance, Jeff.

>> I just want to time check that what we're looking at, 5 minutes, we want to keep going or --

>> Okay.

>> Okay. Pull up the spreadsheet.

>> We're on guidance. The first question in the billing code information, it has context may only account for 25% of the team's billed time, this means more clarity. Please clarify. Up he, did that come from --

>> Yes. I wonder if there is something within the team act that we can use, we can go become and use to clarify the definition of collateral, what the contacts would be.

Do you think that would be helpful.

>> This is an issue we're running into with kind of aligning our licensing regs and fidelity too, it is just seeing where maybe that doesn't necessarily belong in the billing guidance, it is a fidelity thing, trying to keep things as clearly in their column as possible, that throw as huge wrench into everything or not, it could be something that we could discuss, or how to address it otherwise.

>> It is also tricky on our side, putting that kind of limitation in there when there is not going to be -- the only police where that's going to be differentiated, it is in clinical documentation.

It is into the they're going to bill differently if doing a collateral for contact.

Right. Right.

>> So it comes down to our ability to track and really monitor that so the usefulness of having it there, in the absence of a way to proactively track it for the team, you know, for you all too, you know, one thing if I was an administrator, a provider, I could run a report to see how much we were doing of collaterals, whether we were tipping over an audit point, how do you measure that? You go in every clinical note, try to measure if it is 25%, is this to ensure that you stay within a certain amount of direct contact with the member themselves. This is a tricky one. I do think we should take it back, talk about it in the context of the team ACT and the fidelity. Where that should be represented and for what purpose, like you were saying, Jeff.

>> Roger that.

We have time to maybe -- we did already answer what is health literacy counseling, why do you have to be a license type or in the medical field to provide it.

>> I can try to find the response.

I don't know, any history on psycho educated interventions and the scope of who can do that.

>> It has something to do with the word counseling, being able to provide counseling and being a licensed individual.

>> Psycho education, the way we have done it over time, it is implemented by the QMHP and the collaboration of the LMHP according to the treatment plan, so the health literacy component that's similar to that, so it could be a structured group setting where maybe we're leading the group over, it is the anxiety tendencies or something. The coping strategies. You know, just reinforcing something that's in the treatment plan that's designed already. That the person should be aware of, just learning more symptom awareness, something like that potentially, it is not near counseling and bordering in the licensed realm. That would be something that they would be able to do.

I don't think it would cause concerns with our friends at DHP.

>> Is this something in terms of -- the fact that -- the folks, they're not necessarily delegating to unlicensed folks that they're providing it within the team-based approach.

>> Yeah. It is not a delegation. It is provided within the team-businessed approach. Yeah. Peer woulds have a role in some of that too. It depends on what the activity is and dynamics to assess that could be delivering that.

Yes. I'm just thinking with the comment about scope for health literacy counseling, where we may have to go back and make clarity on who all could provide it within which context or within which scope or what exactly the activity is. We'll go back, look hat that internally.

>> Yeah.

>> I think that would be a helpful clarification.

>> I will point out to, that our definition, under skills restoration, it is kind of where we put the QMHPs, there is language in there about system management, there is the QMHP, it will do this service and it falls under the skills restoration. It is not that it is not allowed, it is just falling under the different category.

In the scopes of the different team members, we understand there being questions about -- I'm being mindful of time. We're three minutes over noon.

I don't know if you want to -- some of the -- please know that it will actually be considered, all of the feedback we received today as well as the feedback in the survey you filled out and we have an additional opportunity when we post for additional comments as well, it is probably not perfect when it is listed but we have another phase coming, and we'll be tweaking certainly as we go. Appreciate the feedback as we implement and things are not working, or they're working great, we really have -- this is not going to be the last time that we have the conversations. We will

be coming to you for feedback for probably quite some time so that we can tweak it, get it to the place where it needs to be assessed. We appreciate you very much. We will be in touch and you can always email or email box, our mailbox which is here, you can email me directly, either is fine.

We appreciate you guys very much. This is -- this has been recorded, and it will be set up on the public website in the next week or so.

Let's see if there is anything else you want to say.

>> No, just thank you to everybody. Appreciate all of the feedback and cooperation. We'll be in touch soon.