Coordinated Specialty Care (CSC)

Policy Change Summary

Section 1: Definitions

- **Removed definitions:** "Affiliated," "Early Serious Mental Illness (Transitional Age Youth)," and "LMHP-Type."
- **Added new definitions** not present in Draft 1:
  - "Natural Supports" — newly defined to mean informal, unpaid assistance from individuals in a person's life (family, friends, faith community, etc.), identified by the individual and engaged only with consent. Requires at least one caregiver/LAR for youth.
  - "One-to-One" — newly defined: one qualified provider to one individual at a time, with the provider's full attention directed exclusively to that individual. May be in-person or via telemedicine and does not include group delivery.
  - "Encounter" definition finalized: face-to-face interaction with at least 15 minutes of at least one required service component.

Section 2: Service Definition and Critical Features

- **Critical Features list updated** to include "Individual, Group, and Family Psychotherapy" — group psychotherapy formally added.

Section 3: Required Service Components

Introduction: Group staff-to-individual ratio (1:10) added to Section 3 introduction, applying across all service components that allow group delivery.

3.1 CANS Lifetime Assessment

- **LMHP co-signature timeframe changed**: Draft 1 said "within one business day"; Draft 2 changed to "within seven business days."
- Requirement that a significant change in the individual's circumstances triggers a reassessment removed.

3.2 Treatment Planning

- **ISP signature requirement formalized with specific timeframes:** signatures required within 30 days of admission and 15 days of an ISP review. Draft 1 had no defined timeframe.
- **ISP signatory list simplified:** Draft 2 requires only the individual/legal representative and LMHP Team Leader. Draft 1 also required "CSC team members working with the individual," which was removed.
- **ISP Review requirement added:** explicit MCO care coordination added ("coordinate care with the individual's MCO").

3.3 Psychiatric Services

- **New requirement added:** provider policies and protocols must align with the CSC model regarding antipsychotic dosing protocols, guidelines, and access to clozapine when first-line antipsychotic does not work.
- **Prescriber participation requirements expanded:** involvement in team meetings; seeing individuals with other team clinicians; accessibility for consultation during the work week; sharing health records with the team.

- Specific contact frequency requirement removed ("at least twice a month for the first six months").

3.4 Psychotherapy

- Group ratio limits (1:6 for youth; 1:6 for adults) removed. Group psychotherapy is still allowed but subject to the general 1:10 limit in the Section 3 introduction.

3.5 Family Engagement and Support / 3.5.1 Health Literacy Counseling

- LPN added to the list of qualified providers for Health Literacy Counseling.

3.6 Rehabilitation Skill-Building

- **New language added clarifying employment/instructional supports:** CSC may include these supports if activities are focused on management of symptoms of mental illness and recovery; team members may work with individuals at a worksite or instructional setting to implement appropriate interventions.
- **Removed blanket statement** that "supported employment and education support are not Medicaid covered services" — replaced with more nuanced coverage language; non-covered job-specific training activities moved to Section 6 exclusions.
- **New documentation requirement added:** all consultation shall be documented in the individual's medical record.

3.7 Care Coordination

- RN and LPN added to the list of qualified providers.

3.8 Crisis Support

- **New crisis philosophy language added:** CSC providers shall prioritize internal crisis resources; individuals shall be educated on how to access 988 directly; capacity to self-initiate crisis contacts is a core treatment goal.
- **Availability requirement revised:** 24/7 availability retained with clarification that the CSC team is directly available minimum 8 hours/day, 5 days/week; after-hours coverage may be handled via triage/coordination policies across other service areas of the same provider.
- **New documentation requirement for external crisis referrals:** if a CSC provider initiates a referral to any external crisis resource, the provider must document: (a) prior interventions attempted; (b) clinical rationale; (c) time, location, and interventions provided; (d) continuity of care actions. Must also transmit the current ISP and crisis plan to the receiving provider at the time of referral.
- **Crisis plan requirements formalized with new mandatory elements and timelines:**
  - Must be completed and signed within 30 days of admission.
  - Must identify the CSC provider as the primary crisis contact.
  - Must include: warning signs, preventative/recovery strategies, crisis resources/professional contacts, current medications, and a step-by-step crisis sequence.

Section 4: Provider Qualification Requirements

4.1 Staffing Requirements

- List of roles was updated to reflect draft DBHDS regulations (12VAC35-105-1429)
- "Co-occurring Substance Use Disorder Specialist" was removed as a named role and revised as a training requirement in 4.1.1
- "Psychiatrist/Licensed Psychiatric Medical Professional" renamed to "Psychiatric Provider."

4.1.1 Required Team Members

- **Team meeting attendance threshold changed:** Draft 1 required attendance at "majority (over 50%) of team meetings"; Draft 2 requires attendance at "at least 3 out of 4 weekly team meetings per calendar month."
- **Co-occurring disorder specialist reduced from a named team role to a training requirement:** at least one CSC team member shall have training in working with individuals with substance use disorders.
- **LMHP Team Leader new sub-requirement added:** shall have the ability to provide consultation to CSC team members when needed.

4.2 Caseload Requirements

- **Major revision:** flat "30 individuals" caseload limit replaced with a 1:20 staffing ratio model.
- **Detailed FTE calculation methodology added** — specifies how to count therapists, peer specialists, co-occurring specialists, family specialists, care coordinators, SEES, community outreach staff, and team leader (at 0.5 FTE if direct services are 50% of role).
- **New prescriber-specific caseload ratio added:** 0.2 FTE prescriber time per 40 individuals served.
- **Student interns** explicitly excluded from FTE calculation.

4.3 Staff Training Requirements

- **Training frequency changed** from "initial and ongoing" to "initial and annual."
- **Training program options expanded** to include "another similar nationally recognized program specific to CSC training" in addition to Navigate and On TrackNY.
- The supplemental list of optional broader training topics (19 items including benefits counseling, CBT for psychosis, NAMI trainings, etc.) removed entirely.

4.4 Supervision and Team Meeting Requirements

- **Team meeting documentation requirements significantly expanded — 10 required elements now specified:** date/time/location; names and disciplines of attendees; names of absent members; facilitator name; active client roster review; treatment plan updates; team decision-making/action items; high-risk/priority case discussion; transition/discharge planning; HIPAA-compliant storage.
- **Specific supervision frequency requirements removed** ("bi-weekly" and "no staff without supervision in a calendar month"). Draft 2 requires all team members to receive and participate in clinical supervision, with all supervision documented in the staff's employment file.
- Monthly consultation requirement for the psychiatric provider and LMHP Team Leader from an agency administrator/prescriber removed.
- RPRSS supervision requirement added as a standalone requirement within the supervision section.

4.5 DBHDS Licensing Requirements

- **License type now specified:** "Mental Health Center-Based Coordinated Specialty Care (CSC) Service (License #03-022)" — Draft 1 said "To Be Determined."

4.6 DMAS Provider Enrollment

- **Provider specialty now specified:** "provider specialty 928 (Coordinated Specialty Care)" — Draft 1 said "To Be Determined."

4.8 Fidelity Monitoring

- **Fidelity scale updated:** Draft 1 referenced a 33-item scale with a score below 116 considered poor; Draft 2 specifies a 35-item scale with a score below 123 considered poor.
- Poor fidelity now explicitly impacts eligibility for reimbursement for services, not only the EBP Finder listing.

Section 5: Medical Necessity Criteria

5.1 Admission Criteria — CANS Lifetime

- The two-domain CANS scoring minimum (at least two domains scoring ≥3) removed — only Level of Need 4 or greater is now required.

5.1 Admission Criteria — Age Requirements

- Upper age limit finalized at 15–30 at initial admission (down from 15–35 in Draft 1).
- **New provision:** service authorization requests for individuals 31 or older may be submitted after a lapse in CSC services if less than three years have passed since initial admission — allows for re-enrollment.

5.1 Admission Criteria — Diagnostic Criteria

- **Sub-criterion removed:** "Current episode represents first or second psychotic episode requiring clinical intervention."

5.2 Continued Stay Criteria

- **Age exception added:** "The individual continues to meet admission criteria except for the age requirement, as long as the individual was between the ages of 15–30 at admission" — individuals may age out without losing continued stay eligibility.
  Care coordination documentation requirement strengthened: "should" changed to "shall."

Section 6: Exclusions and Service Limitations

- **Concurrent service exclusion list revised:**
  - Added: Community Psychiatric Support and Treatment — Community (Adult or Youth); Targeted Case Management.
  - Removed: Addiction and Recovery Treatment Services (ARTS) Levels ASAM 2.1–3.7; Mental Health Partial Hospitalization Program; Mental Health Intensive Outpatient; Therapeutic Group Home (TGH) services.
- **Group size limitation standardized:** Draft 1 had separate ratios (1:6 youth, 1:10 adults); Draft 2 establishes a uniform 1:10 ratio for all groups.
- **New provision:** Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policies apply to all youth under the age of 21.

Section 7: Service Authorization

7.1 General Requirements

- **New requirement:** all service authorizations initially start at the standard 6-month timeframe with corresponding units per Section 7.2.
- **New provision:** if an individual is not making progress for 18 calendar months, the authorization timeframe may decrease to 3 calendar months.

- **New provision:** if a provider is requesting and providing services within permissible amounts and individuals are recovering, the MCO may waive the service authorization requirement.
- Natural supports added to the list of parties the LMHP collaborates with in preparing authorization requests.

7.2 Service Authorization Period and Unit Allocation

- Authorization period consolidated to a single standard 6-month period — Draft 1 had a tiered table broken out by Level of Need (4–6) with largely identical rows.
- H2041 unit allocation reduced from 36 to 30 units per authorization period, with a new cap of 5 units per calendar month. Unused units do not roll over.
- **New minimum service requirement:** individuals shall receive no fewer than 24 consecutive months of service; authorizations issued in 6-month increments within that period.

Section 9: Billing Requirements

- **H2040 threshold changed:** Draft 1 required 7+ encounters/month to bill PMPM; Draft 2 requires 6+ encounters/month.
- **H2041 threshold adjusted:** Draft 1 billed H2041 for 6 or fewer encounters; Draft 2 bills H2041 for 5 or fewer encounters.
- **New in-person service provision requirements:** at least 4 in-person encounters/month required for H2040 billing; at least half of encounters in-person for H2041 billing.
- **New one-to-one service provision requirements:** at least 4 one-to-one encounters/month for H2040; at least half of encounters one-to-one for H2041.
- H0031 billing limited to once per 365 days per member; routine CANS updates shall be billed via H2040 or H2041, not H0031.