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May 30, 2013 Joint Committee on Finance Paper #322

Comprehensive Community Services (DHS -- Medical Assistance and Related Programs)

[LFB 2013-15 Budget Summary: Page 215, #4]

CURRENT LAW

Comprehensive community services (CCS) are community-based psychosocial rehabilitation services. Under federal law, CCS is an optional medical assistance (MA) benefit that falls under the definition of other diagnostic, screening, preventive, and rehabilitative services recommended by a physician or other licensed practitioner "for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

To be eligible for CCS under Wisconsin's MA program, an individual must be determined, as a result of a DHS-approved functional screen, to require more than outpatient counseling but less than the services provided by a community support program (CSP). They must also have a diagnosis of a mental disorder or a substance-use disorder, and a functional impairment that interferes with or limits one or more major life activities and results in needs for services that are ongoing, comprehensive, and either high-intensity or low-intensity. To be determined as having a functional impairment for these purposes, the individual must meet the definition of a "Group 1" or "Group 2" person. Individuals in Group 1 include children and adults in need of ongoing, high-intensity, comprehensive services who have diagnoses of a major mental disorder or substance-use disorder and substantial needs for psychiatric, substance abuse, or addiction treatment. Individuals in Group 2 include children and adults in need of ongoing, low-intensity comprehensive services who have a diagnosed mental or substance-use disorder. Individuals in Group 2 generally function in a fairly independent and stable manner but may occasionally experience acute psychiatric crises.

DHS administrative rules require that an assessment be completed within thirty days of an individual's application for CCS. The assessment must address a broad range of "domains of

functioning" including but not limited to such considerations as community living skills, housing issues, employment, education, mental health, physical health, substance use, medications, and crisis prevention and management.

The resulting assessment report is used to develop an individualized service plan that describes the services to be provided to the person, identifies the individuals who will provide those services, and lists the measurable goals and the type and frequency of data collection that will be used to measure progress toward desired outcomes. The service plan must be reviewed and updated as needed or at least every six months. Before any MA-reimbursable services are provided under the CCS benefit, a mental health professional must review and attest to the applicant's need for psychosocial rehabilitation services and medical and supportive activities to address the desired recovery goals. In addition, if the applicant has or may have a substance-use disorder, a substance abuse professional must also sign the authorization for services.

The CCS benefit under Wisconsin's MA program is provided through counties that have chosen to provide the services and are certified CCS providers. Under current law, these counties pay the non-federal share (approximately 40%) of MA-allowable CCS costs. The counties also submit CCS cost reports to DHS, which uses those reports as the basis for establishing the MA reimbursement rate. DHS then pays the county the federal share (approximately 60%) of the MA rate.

According to DHS, twenty-six counties provided CCS to 1,507 individuals under the MA program in 2011-12. The total amount of federal MA matching funds generated by these county-provided services was $8.8 million, indicating total MA-reimbursable CCS expenditures of approximately $14.7 million ($5.9 million in county contributions and $8.8 million in federal MA matching funds) in 2011-12.

GOVERNOR

Provide $16,701,900 ($10,202,000 GPR and $6,499,900 FED) in 2014-15 to fund a projected increase in MA benefit costs that would result from expanding state support for CCS, beginning July 2014.

Statutory Change. Provide that in counties that elect to deliver CCS through the MA program on a regional basis according to criteria established by DHS, DHS would be required to reimburse service providers for the amount of the allowable charges for those services under the MA program that is provided by the federal government and for the amount of the allowable charges that is not provided by the federal government. This provision would take effect July 1, 2014 and first apply to CCS provided under the MA program on that date. This change would not apply to counties that provide CCS under the MA program but do not provide those services on a regional basis according to DHS-established criteria. Those counties would continue to use their own funds to support the non-federal share of CCS benefit costs.

DISCUSSION POINTS

1. Chapter 51 of the statutes assigns to county boards of supervisors primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within the county and for ensuring that those individuals in need of such emergency services found within the county receive immediate emergency services. This responsibility is limited to the programs, services and resources the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds. State law also requires a county board of supervisors (or boards of supervisors, in the case of multi-county arrangements) to establish a county department of community programs or department of human services to, among other things, administer a community mental health, developmental disabilities, alcohol and drug abuse program.

2. Several examples illustrate a county's responsibilities in these areas. Under state law pertaining to emergency detentions, a law enforcement officer can take an individual into custody if the officer has cause to believe the individual is mentally ill, drug dependent, or developmentally disabled, and evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm. The officer can transport the individual to any of several approved facilities (including an approved hospital, center for the developmentally disabled, or an approved private treatment facility) if the county in which the person was taken into custody approves the need for detention.

3. Similarly, if a mentally ill or drug dependent county resident is the subject of an involuntary civil commitment under Chapter 51 (following an emergency detention or otherwise), the court can commit that individual to the care and custody of the county for treatment either in an inpatient setting or an outpatient basis. In such instances, the county is required to arrange for the individual's treatment in the least restrictive manner consistent with the individual's requirements in accordance with a court order designating the maximum level of inpatient facility, if any, that may be used for treatment.

4. For county residents subject to emergency detention or an involuntary civil commitment under Chapter 51, the costs borne by the county depend partly on whether the individual is an MA recipient. While the MA standard plan generally covers medically necessary inpatient hospital services, that coverage, as it relates to mental health conditions, is subject to several limitations. First, the MA program does not cover any portion of inpatient hospital services provided to individuals ages 22 through 64 if those services are provided in an institution for mental disease (IMD). This "IMD exception" applies to psychiatric hospitals in the state that are classified as IMDs, including the state mental health institutes.

5. Second, under a provision enacted as part of the 2009-11 state budget, counties are responsible for the non-federal share of inpatient service costs provided to non-forensic, MA-eligible county residents at the Mendota and Winnebago mental health institutes if the individuals are younger than age 22 or older than age 64 (this is in addition to the aforementioned "IMD exception" for individuals between the ages of 22 and 64). Given the current daily inpatient rates at Mendota and Winnebago ($999 per day, plus an additional $200 per day for the first three days of

an emergency detention), involuntary commitments and emergency detentions under Chapter 51 can impose significant financial burdens on counties, even if the individual is enrolled in MA.

6. People with mental illness can also receive inpatient and/or emergency room treatment at general acute care hospitals. If the individual is an MA recipient, the state provides the non-federal share of the MA-allowable service costs. For this reason, counties have an incentive to have their MA-eligible residents receive necessary inpatient mental health services in a non-IMD setting. Arranging inpatient treatment in general hospitals for these individuals can be challenging, however, due to a limited number of suitable hospital beds in the county.

7. Enrollees in the MA standard plan are also eligible for other types of state-matched mental health services through the MA program, such as outpatient psychotherapy. DHS indicates, however, that access to these MA-covered mental health services can be limited in some areas of the state due to the low number of MA-certified providers and/or the perceived inadequacy of the program's reimbursement rates.

8. Costs related to mental illness and substance abuse also impact administrators and taxpayers at all levels of government in myriad other settings, from county jails to juvenile detention facilities to classrooms.

9. To further support counties with their Chapter 51 responsibilities, the state's MA program has developed a number of MA community mental health benefits for which counties receive federal reimbursement if they provide the non-federal share of the MA-allowable service costs. These community mental health services include the following:

Crisis Intervention Services: Crisis services are emergency services for individuals experiencing a psychiatric emergency.

Community Support Services (CSP): CSP is integrated community treatment for those with the most severe and persistent mental illness with functional limitations who need intensive, comprehensive, ongoing treatment and support.

Comprehensive Community Services (CCS): CCS is for individuals less functionally impaired by their mental illness than those requiring CSP who need help arranging a comprehensive range of services to support a fuller recovery.

Targeted Case Management: Targeted case management services are for individuals less functionally impaired than those receiving CSP or CCS who need help arranging support services.

Mental Health Outpatient Services: These services are intended for individuals who are capable of functioning well enough to maintain their daily lives and functioning with regular or intermittent support from mental health professionals.

Community Recovery Services (CRS): These services provide support to mental health consumers in one or more of three areas: (a) community residential services; (b) evidence-based supported employment services; and/or (c) peer support services.

10. Although counties are not required to provide all the community-based services outlined above, most find it in their interest to provide at least some of the services as a means of satisfying their obligations under Chapter 51 while providing treatment to their citizens in settings less costly and less restrictive than traditional inpatient settings. Counties also provide these services in the expectation that coordinated community-based treatment will help avert the need for future mental health crisis interventions.

11. To provide context to the Governor's CCS proposal, DHS has provided several examples of individuals who receive CCS under the MA program. The first is that of a middle-aged man diagnosed with bipolar disorder who also had substance abuse problems and few family or social supports. Prior to enrolling in CCS, this individual had had a number of emergency room crisis contacts, several of which resulted in emergency detention hospitalizations. This individual's outpatient therapist referred him to the CCS program, where his team consisted of the therapist, a service facilitator, a psychiatrist with support from a psychiatric nurse, a community-based rehabilitative worker, and substance abuse counselor. The team met frequently to help this individual with all aspects of his life, ranging from substance abuse problems to budget counseling. DHS indicates that after a little more than a year, this individual graduated from the CCS program and is living independently.

12. The second is that of a twelve-year old boy who was referred to CCS by the local school district due to behavioral difficulties (absenteeism, avoiding school work, physical conflicts with peers) and mental health symptoms (anxiety, anger, and suicidal ideation). He had also had a recent hospitalization due to depression and suicidal ideation. Prior to these events, he had been receiving outpatient services for ADHD. He had been sexually abused at age seven. Through the CCS program, the boy and his parents began collaborating with school staff to align home and school behavioral interventions. Treatment services included cognitive behavioral therapy to improve coping skills, mood regulation and self-advocacy, therapeutic mentoring with an emphasis on social skills development, and psychiatric medications. DHS indicates the boy is currently attending school full time with no absenteeism in the past year, and has not been re-hospitalized. He is projected to transition to outpatient services in the next six months.

13. These examples illustrate the wide array of services counties provide to individuals under the CCS benefit. This partly stems from the fact that neither state nor federal law prescribes the exact set of services that can be provided under CCS. Instead, these psychosocial rehabilitative services are geared toward the individual participant's circumstances as identified through their CCS assessment, functional screen, and interaction with team members. This flexibility is evident in the Attachment to this paper, which describes the array of services and activities counties provide to CCS enrollees.

14. In fiscal year 2011-12, twenty-six counties chose to provide the CCS benefit through the MA program. These counties are listed in Table 1, which also provides the following CCS-related information for 2011-12: (a) the number of county residents who received CCS; (b) the number of county residents who received CCS, stated as a percentage of the county's total MA enrollment; (c) the total amount of federal MA matching funds claimed by the county for CCS costs; and (d) the average amount of federal MA matching funds claimed per CCS enrollee.

TABLE 1

CCS Enrollment and Federal MA Matching Funds by County, 2011-12

County	Individuals Receiving CCS SFY 2012	Individuals Receiving CCS as % of County's Total MA Enrollment	Total CCS Federal Claims SFY 2012	Avg. Federal Matching Funds Per CCS Recipient
Adams	32	0.71%	$182,364	$5,699
Brown	89	0.21	809,329	9,094
Calumet	38	0.75	100,106	2,634
Columbia	11	0.13	47,731	4,339
Dodge	28	0.22	70,453	2,516
Fond du Lac	17	0.11	93,113	5,477
Green	31	0.51	100,372	3,238
Green Lake	5	0.15	25,727	5,145
Jefferson	72	0.57	359,989	5,000
Kenosha	57	0.17	133,420	2,341
Kewaunee	10	0.32	11,895	1,189
La Crosse	135	0.66	1,046,674	7,753
Manitowoc	17	0.13	107,131	6,302
Marathon	219	0.88	924,723	4,222
Oneida	26	0.35	169,918	6,535
Outagamie	142	0.61	1,181,298	8,319
Portage	42	0.37	184,107	4,384
Richland	70	1.80	376,431	5,378
Sauk	52	0.48	436,134	8,387
Sheboygan	33	0.18	115,317	3,494
Walworth	18	0.10	153,327	8,518
Washington	52	0.38	377,021	7,250
Waukesha	98	0.31	748,119	7,634
Waushara	33	0.74	193,403	5,861
Winnebago	94	0.37	464,595	4,942
Wood	86	0.51	390,409	4,540
Total	1,507		$8,803,106	

15. As Table 1 indicates, there is wide variation among the counties that currently offer CCS with respect to the amount of federal matching funds claimed per CCS enrollee. This is partly due to the latitude CCS programs have when developing individualized service plans for their enrollees. Other factors include the availability of mental health resources within the county, and the cost of those services. Unlike some other provider reimbursement rates under the MA program, the allowable CCS rates (which form the basis of the federal match paid to CCS-certified counties) are based on the CCS cost reports counties submit, which the Department audits to determine the reasonableness of the claimed costs. Public finances are also a factor counties undoubtedly consider when determining the level of services (if any) to provide to their residents under the CCS benefit.

16. Under the Governor's proposal, the MA program would reimburse a county for both the non-federal share and the federal share of MA-allowable CCS costs if the county agrees to provide the benefit on a regional basis according to criteria established by DHS. This change would go into effect July 1, 2014, and first apply to services provided on that date. The change would not apply to counties that do not provide CCS on a DHS-approved regional basis. To the extent those counties elect to provide CCS as an MA benefit, they would continue to use their own funds to support the non-federal share of the MA-allowable costs.

17. DHS estimates that the Governor's proposal will cost $16,701,900 ($10,202,000 GPR and $6,499,900 FED) in 2014-15. The Department developed that estimate as follows. First, with respect to enrollment, DHS assumed that all of the twenty-six counties that currently provide CCS will switch to the DHS-certified regional model over a six-month period beginning July 1, 2014. Second, DHS assumed the remaining Wisconsin counties will establish certified CCS programs under the DHS regional model over a twelve-month period beginning July 1, 2014, and that individuals in those counties will participate in CCS at the same average rate as MA participants in the current CCS counties (approximately 0.37% of total MA enrollees). Based on January 2012 statewide MA enrollment data, those assumptions generated a statewide CCS enrollment projection of 4,011 individuals by June 2015. DHS then added 10% to that projection to adjust for the possibility that CCS participation rates will increase if counties are no longer responsible for the non-federal share of the allowable service costs.

18. As for the projected costs per person, DHS used the average per enrollee all-funds costs in the twenty-six counties that currently provide CCS ($9,666), and added 10% to adjust for a possible increase in service costs under a state-matched regional model. These assumptions generated estimated benefit costs of $10,632 (all funds) per CCS enrollee in 2014-15. The Department's phased-in enrollment projections and cost assumptions are summarized in Table 2, which shows the total funding provided in AB 40 for the Governor's CCS proposal.

TABLE 2

CCS Enrollment and Per Person Cost Projections used in AB 40

	Counties Currently Offering CCS	Counties Not Currently Offering CCS	Projected Total CCS Enrollment	Projected Monthly AF Costs*	Projected Monthly GPR Costs*
July 2014	251	242	493	$0	$0
August 2014	502	484	986	437,008	174,803
September 2014	754	726	1,480	874,018	349,607
October 2014	1,005	968	1,973	1,311,029	524,412
November 2014	1,256	1,210	2,466	1,748,040	699,216
December 2014	1,507	1,452	2,959	2,185,050	874,020
January 2015	1,507	1,694	3,202	2,622,061	1,048,824
February 2015	1,507	1,937	3,444	2,836,535	1,134,614
March 2015	1,507	2,179	3,686	3,051,009	1,220,404
April 2015	1,507	2,421	3,928	3,265,483	1,306,193
May 2015	1,507	2,663	4,170	3,479,957	1,391,983
June 2015	1,507	2,905	4,412	3,694,431	1,477,772
				$25,504,620	$10,201,848

*AB 40 assumes no additional CCS costs in July 2014, due to a one-month lag in claims.

19. DHS has not developed the criteria that will be required under the regional CCS model beginning July 2014. Department staff has indicated, however, that part of the expected benefits of regionalization would occur through improved economies of scale (particularly for smaller counties) in program administration and service delivery. Any such cost savings realized through regionalization would benefit the state in a GPR-supported program. There is also an expectation that regionalization will lead to some degree of standardization not just with respect to service delivery but also to administrative aspects of the program such as cost reporting.

20. Another primary goal of the regionalization requirement is to encourage more counties to provide CCS as an MA benefit. The example given by DHS is that of a rural county with a low number of certified mental health professionals or other resource limitations. Today, such a county may not offer CCS, or may limit the range of services provided under its program. Under a regional model, DHS anticipates that counties such as this could access mental health resources in neighboring areas.

21. This office also spoke with CCS managers in several counties. These individuals indicated that another impediment to smaller counties offering CCS as an MA benefit currently is the cost and resources needed to become an MA-certified CCS provider. These employees suggested that regionalization might allow such counties to reduce or avoid those certification costs if, for example, they were part of a region where a previously-certified county agrees to provide CCS to all of the region's residents.

22. The goal of encouraging more counties to offer CCS is also the main impetus behind

the Governor's proposal to have the state fund the non-federal share of MA-allowable CCS costs starting in July 2014. According to the Department, significantly increasing state support for flexible community mental health services that help support individuals in the community will help avoid having to provide these services in more expensive, restrictive institutional settings by better aligning financial incentives regarding community versus institutional care. In sum, DHS maintains that providing CCS as a state-matched MA benefit will provide counties additional resources and incentives to provide coordinated, community-based care to individuals, thereby helping them to avoid crisis situations and to take steps to recovery.

23. Regarding the assumptions DHS used to develop the funding provided in AB 40 for this proposal, they are based on actual CCS participation rates and actual CCS costs in the twenty-six current that currently provide CCS. In addition, the Department added 10% to both the current enrollment and expenditure averages to adjust for the chance that counties may provide more services to more people if the state pays the non-federal share of the costs. Given the difficulties in trying to estimate how many counties might provide CCS on a regional basis starting in July 2014, and when exactly their entry into the program might occur, and what level of services they might offer, the Committee might find the Department's cost projection reasonable. In that case, members may wish to adopt the Governor's proposal without modification. (Alternative 1)

24. There may, however, be several reasons to believe the Department's cost projections underestimate the proposal's costs. First, the twenty-six counties that currently provide CCS under the MA program would have a financial incentive to transition to a DHS-certified regional model as quickly as possible, beginning July 1, 2014, in order to receive the state-funded MA match and reduce county expenditures. Adjusting the Department's projections to assume those twenty-six counties join a DHS-approved regional CCS model immediately, rather than over six months, and holding all other assumptions constant, would increase the proposal's projected costs in 2014-15 by $1,335,000 GPR. (Alternative 2)

25. Second, the shift to a GPR-supported regional model may encourage counties to enroll more people in CCS than suggested by current participation rates, and/or to provide more services to those participants. In that regard, the county employees this office spoke with in preparation of this paper indicated that they hoped to serve more county residents in their CCS programs if the state began providing the non-federal share of the costs.

26. Third, future GPR costs under a regional CCS are likely to be impacted by the participation of Milwaukee County and Dane County. Neither of those counties currently provides CCS under the MA program. Combined, those counties account for nearly one-third of total statewide MA enrollment. It is difficult to determine at this time whether those counties would have CCS participation rates above the current average. It would appear likely, however, that per person service costs in those counties would be higher than most other counties, on average, due to access to a wider array of mental health resources and higher provider reimbursement rates.

27. Fourth, DHS has recently indicated that non-elderly childless adults with incomes less than 100% of the FPL who would become eligible for MA under other provisions in the bill would be entitled to benefits under the standard plan, including CCS. CCS is not a covered benefit under the current Core Plan. It does not appear that the additional GPR costs that might arise from

providing the CCS benefits to those enrollees are factored into the Department's projections.

28. Fifth, most counties in the state currently operate a CSP program. CSP provides integrated community treatment for those with the most severe and persistent mental illness with functional limitations who need intensive, comprehensive, ongoing treatment and support. In the hierarchy of community-based mental health programs provided by counties under the MA program, CSP typically serves individuals with more intense needs than those enrolled in CCS. Counties currently fund the non-federal share of MA-allowable costs under their CSP programs. It is reasonable to expect some migration of some individuals from county-supported CSP programs to state-supported CCS programs beginning July 2014 as a result of the Governor's proposal.

29. In addition, Committee members should be aware of the fact that the GPR funding in the bill for this item is based on the assumption that CCS enrollment will gradually increase through 2014-15 under the Governor's regionalization proposal. The totally phased-in enrollment total of 4,412 individuals does not occur until June 2015 under this assumption. If one annualizes the projected CCS costs using the Department's June 2015 enrollment projection, and projected per person costs (based on average 2011-12 enrollee costs, increased by 10%), the annualized projected GPR costs are approximately $19.2 million. Using those same assumptions, the projected biennial cost of the proposal, when fully phased-in, is approximately $38.4 million GPR.

30. In view of these potential out-year costs, this office has spoken with the Department with respect to two possible modifications to the proposal. Under the first, the state and the county would split the non-federal share of MA-allowable CCS costs under a regional model. The Department responded by expressing concern that there may be legal impediments under federal MA law with such an arrangement in cases where one county was providing CCS services to residents of a different county in a CCS region. The Department also indicated that such a cost-sharing arrangement would discourage some counties from offering CCS, and would therefore undermine the administration's goal of having these services available to county residents statewide.

31. The second possible modification discussed with DHS would create a maintenance of effort requirement for counties that would require them, as a condition of offering CCS on a regional basis (and having the state pay the non-federal share of CCS costs), to maintain their current level of support for mental health services. The reasoning behind such a requirement would be to prevent counties from simply substituting state funds for their own funds and thereby undermine the bill's goal of increasing the overall level of support for these services statewide. The Department responded by expressing concerns as to the administrative burdens that might be associated with monitoring and enforcing such a maintenance of effort requirement. The Department also expressed concerns that such a requirement may penalize counties that currently provide CCS at their own expense.

32. In light of the concerns raised by the Department, this paper does not offer either of these suggestions as formal alternatives to the Governor's proposal. Given the current lack of details regarding the criteria the Department may incorporate into its regional CCS model, however, the Committee may wish to require DHS to submit a report to the Committee no later than March 1, 2014 which addresses the following issues: (a) a description of the criteria DHS will apply in its CCS regionalization model; (b) a description of how the regions will be established and the degree

of county participation in that process; and (c) an updated list of the counties which, by that date, have indicated they will offer CCS on regional basis according to DHS-established criteria. (Alternative 3)

33. Finally, the Committee could reject the Governor's proposal out of concerns regarding the magnitude of the state's financial commitment in 2014-15 and beyond. (Alternative 4)

ALTERNATIVES

1. Adopt the Governor's recommendations.

2. Increase funding in the bill by $1,335,000 GPR in 2014-15 to reflect a revised assumption regarding the rate at which counties that currently offer CCS under the MA program will decide to offer the benefit on a regional basis according to criteria established by DHS starting July 2014.

ALT 2	**Change to Bill** Funding
GPR	$1,335,000

3. Require DHS to submit a report to the Committee no later than March 1, 2014 that addresses the following issues relating to the Governor's CCS proposal: (a) a description of the criteria DHS will apply in its CCS regionalization model; (b) a description of how the regions will be established and the degree of county participation in that process; and (c) an updated list of the counties which, by that date, have indicated they will offer CCS on regional basis according to DHS-established criteria.

4. Delete the Governor's recommendations.

ALT 4	**Change to Bill** Funding
GPR	- $10,202,000
FED	- 6,499,900
Total	- $16,701,900

Prepared by: Eric Peck
Attachment

ATTACHMENT

CCS Service Array
(Updated April 1, 2013)

*Assessment Domains 36.16 (4). Identify all domains applicable to each service described in the array: (a) life satisfaction, (b) basic needs, (c) social network, family involvement, (d) community living skills, (e) housing issues, (f) employment, (g) education, (h) finances and benefits, (i) mental health, (j) physical health, (k) substance use, (l) trauma/life stressors, (m) medications, (n) crisis prevention management, (o) legal status, (p) other identified domains.

Assessment Domains*	Service Title	Description and Examples of Activities
all domains	1. Assessment	Initial assessment, functional screen and assessment summary; completion of annual review of strengths, attributes and needs. Includes: • Activities involved in the process used to identify the strengths, needs and desired outcomes of a consumer, and • Activities involved in evaluating progress toward desired outcomes.
all domains	2. Recovery Planning	Services are determined through the development of an individualized recovery/service plan designed to provide for the highest level of independent functioning and quality of life possible and desired by the consumer.
all domains	3. Service Facilitation	All coordination, follow-up and monitoring activities that ensure the consumer receives assessment services, service planning, service delivery and supportive activities in an appropriate and timely manner. Includes: • Assisting the consumer in self-advocacy. • Helping the consumer obtain necessary medical, dental, legal and financial services and living accommodations. Progress will be tracked toward goals and consumer satisfaction with the services rendered. Coordinating the provision of emergency services during crisis periods. This may be coordinating the actual provision or coordinating with the HFS 34 designated crisis intervention program.
c, d, e, f, l, n	4. Communication and Interpersonal Skills Training	Specific skill training in communication, interpersonal skills, problem solving, conflict resolution, assertiveness, and other specific needs identified within the consumer's functional assessment. Individual or group interventions, including supportive activities, to increase social connections and meaning, and to improve communication skills and comfort in interpersonal relationships.
a, b, c, d, h	5. Community Skills Development and Enhancement	Problem solving, support, training, assistance, and cuing related to functional living skills living to assist the consumer to gain and utilize skills related to personal hygiene, shopping, laundry, benefit education, household tasks, money management, how to access transportation, medication adherence, parenting, independent living problem solving, self-management, connection to community resources, social skill development, and other day to day requirements of living. • May be provided in a one-to-one or group intervention, including supportive activities. • May include one-to-one therapeutic support to ensure that a consumer acquires the skills needed to attain independence.
j, k, l, m	6. Diagnostic Evaluations and Assessments	Diagnostic evaluations and assessments including the assessment process and summary to determine appropriate treatment and behavioral interventions, and the level of community support needed for an individual consumer. • Diagnostic Evaluations determine diagnosis, medication to be prescribed, as well as how to address clinical symptomatology, and should be performed by a person who holds a Safety and Professional Services license as a physician, a psychiatrist, psychologist, a Licensed Marriage and Family Therapist, a Licensed Professional Counselor or a Licensed Clinical Social worker. An Advanced Practice Nurse Practitioner with certification in behavioral health may also assess medication-related symptoms and needs.

Assessment Domains*	Service Title	Description and Examples of Activities
		• Diagnostic Evaluations and Assessments are conducted by mh/sa providers with specific credentials and training in the administration of these assessments/tests. • Assessments performed by a provider with a Bachelor Degree, or less training, or other non-behavioral health specialists including, for example, Occupational and Physical Therapists should be recorded under Service Array #1 "Assessment".
a, b, d, f, g, i, m	7. Employment Related Skill Training	Services that address the person's illness or symptom-related problems in order to secure and keep a job. Services to assist in gaining and utilizing skills necessary to undertake employment. May include: • Initial employment and education assessment, • Ongoing, on-site employment assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer that affect work, • Focus on work-related symptom management, anxiety reduction, and education about appropriate job-related behaviors, • On-the-job or work-related crises. (Does not include specific job seeking and placement activities.), • One-to-one therapeutic support, including peer support, • Activities related to preparation for seeking employment including assistance in appropriate personal hygiene and grooming, clothing choices, anxiety reduction, arranging transportation, and other issues related to symptoms or behaviors that hinder securing employment, and • Assistance in accessing or participating in educational and employment related services, and coaching/cuing in order to minimize the effects of the consumer's disabilities for a limited amount of time, to reach a higher level of independence.
i, j, k, m, n,	8. Medication Management	Major activities may include: • *Medication evaluation* – making an acute diagnosis and specifying target symptoms and initial severity, medication, • *Prescription* – prescribing the type and doses of medication(s) designed to alleviate the symptoms identified above, • *Medication monitoring* – monitoring changes in symptoms, occurrence and tolerability of side effects as well as reviewing data used in making medication decisions, and • *Individual client education* – increasing consumer knowledge and understanding of the symptoms being treated, medication being prescribed, the expected benefits, impact on symptoms, and identification of side effects. Assistance in helping the consumer develop his/her own compliance in adhering to scheduled medications.
j, m	9. Physical Health and Monitoring	All activities related to the consumer's physical health conditions, management of side effects and symptoms related to the consumer's mental illness or prescribed medications and assistance in helping the consumer to develop his/her own monitoring abilities, including supportive activities. Monitoring of weight and vitals.
i, k, l, m	10. Psychoeducation	A method of working in partnership to impart current information about mental illness and substance abuse, to assist with coping skills for supporting recovery, and to encourage problem solving strategies for managing issue posed by mental illness and substance abuse disorders. Family intervention geared toward coping strategies, support and problem solving skills to assist in fostering consumer's recovery. Activities must be performed for the direct benefit of the CCS consumer. Consultation to family members for treatment of their problems not related to the CCS consumer's is not part of this service. May include one-to-one therapeutic support, including supportive activities.
i, k, l, m	11. Psychotherapy	Individual or group psychotherapy. Performed by a psychiatrist, psychologist, or master's level psychotherapist only (In HFS 36, it is staff listed #1 through #8.).

Assessment Domains*	Service Title	Description and Examples of Activities
c, i, l, n	12. Recovery Education and Illness Management	Recovery education and Illness management are a broad set of strategies that promote hope, healing and empowerment. These strategies are designed to help individuals manage their illness, reduce their susceptibility to the illness, cope effectively with symptoms, identify supports that are effective, and advocate for receiving those supports. Major activities may include: • *Individual skills/illness self-management training* – focus on recovery training where outcome is to give the consumer self-assessment skills, and includes interventions such as modeling, role-playing, practice, homework, shaping and reinforcement. Community activities which focus on decreasing the symptoms of mental illness through various wellness activities. May include one-to-one therapeutic support, including supportive activities. • *Counseling* – Oriented toward problem solving and supportive activities provided in individually and in groups for consumers and their families to engage in recovery-based activities at home and in the community. Teaching individuals how their thinking styles and beliefs influence their feelings, and helping them to evaluate and change thoughts the lead to depression, anxiety, and anger. Includes cognitive-behavioral strategies to reduce severity and distress of persistent symptoms and promote personal insight within a group dynamic. • *Support to develop a crisis plan* – includes identification of early warning signs of crisis and details about preferred supports.
	13. Substance Abuse Treatment	Gender-based, strength based, and integrated treatment, including substance abuse assessments.
variable	14. Non-Traditional or Other Approved Services	Non-traditional services are identified for specific individuals, and are expected to accomplish treatment ends that traditional behavioral health services have not. • Non-traditional services billed to CCS must have a psychosocial rehabilitative purpose, are not merely recreational activities, and are not otherwise available to the individual. • Documentation: medical necessity of non-traditional services must be documented in the individual's record and through assessed needs in the treatment plan, including documenting the psychosocial rehabilitative benefits. The treatment plan must document the corresponding measurable objectives and goals of the non-traditional service. • These services will have specified, reasonable time limits (e.g. 3 months) and successful outcomes that are reviewed regularly by the service facilitator. Non-traditional services will be discontinued if measurable objectives and goals are not met in reasonable timeframe.
d, e, j, m	15. Psychosocial Rehabilitative Residential Supports	For services of residential staff only. Alternative licensed community living situations only include adult family homes; community based residential facilities (CBRFs), child foster homes, and child group homes. Includes psychosocial rehabilitation services only, no room, board, and other staff services. May include the following services: • communication and interpersonal skills training, • community skills development and enhancement, • diagnostic evaluations and specialized assessments, • employment related skill training, • medication management, • physical health and monitoring, • psycho education, psychotherapy, • recovery education and illness management, and • substance abuse treatment.