

General questions:

Q: Can you share the webinar slides?

A: *Yes, they can be found at <https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions>*

Q: Must a CPSS have NC certification?

A: *Yes.*

Q: How do you ensure that PSS are voluntary in nature?

A: *PSS providers should ensure that individuals want to receive services, complete informed consent, and ensure the individual can discontinue services at any time if they so choose.*

Q: Are there going to be revisions/updates to the PSS State funded service definition for individuals without insurance?

A: *Yes, once the Medicaid PSS policy is approved, the State funded service definition will be revised to reflect the updates.*

Q: Will the rate increase for PSS?

A: *This is under consideration.*

Q: What is the go live date for the proposed service definition?

A: *We anticipate that the service will go live sometime in 2020, likely late spring or early summer, if there are minimal edits/comments from CMS.*

Q: Will LME-MCOs have their own definitions of PSS?

A: *No.*

Q: How can we provide feedback on the PSS service definition?

A: *Feedback was provided through the stakeholder webinars. You will have another opportunity when the NC Medicaid policy posts for 45 comment period.*

Q: Will PSS continue to be a (b)(3) service after this goes live?

A: *No.*

Q: What age will PSS cover?

A: *18 years through 65 years old*

Q: Will the new service definition allow for clients with I/DD or in group homes to receive PSS?

A: *If an individual has a primary MH or SU diagnosis and co-occurring I/DD they are eligible. If they have only I/DD they are not eligible for the service. People living in a group home with a primary MH or SU diagnosis and co-occurring I/DD are not excluded from PSS, however they must want to receive the service, meet the entrance criteria, and be able to benefit from the service.*

- Q: How long will the public comment periods be, how long will it re-open, and where can questions be sent?
- A: *Public comment period has not occurred yet and will last for 45 days when it does occur. The contact for questions during the posting period will be included in the 45-day posting.*
- Q: Are the conversations between a CPSS and person receiving PSS confidential?
- A: *This service is covered by HIPPA and 42 CFR part 2 regulations, you must review both to determine when exceptions to confidentiality exist.*
- Q: Once the new policy is implemented, how long will providers have to get in compliance with any changes?
- A: *Once the policy goes into effect, providers will be expected to be in compliance with the changes. There will be a 90-day notification prior to the policy being implemented which will give providers lead time to begin to come into compliance. NC Medicaid and NC DMHDDSAS will issue a joint communication bulletin for the 90-day notification.*
- Q: How will the new service definition apply to peers working at LME-MCOs?
- A: *The PSS service definition will only apply to providers.*
- Q: In writing the service definition, has the upcoming Medicaid transformation been taken into consideration?
- A: *Yes*
- Q: Where can we find information on family partner support services?
- A: *Please email LeJay Parker (NC Medicaid) at lejay.parker@dhhs.nc.gov and Eric Harbour (NC DMHDDSAS) at eric.harbour@dhhs.nc.gov*
- Q: Can the exclusion for CST be reconsidered?
- A: *This is being reconsidered.*
- Q: Is this service for SMI or MI?
- A: *This service is for adults with mental illness and/or substance use disorders.*
- Q: This shift appears to move PSS from an outpatient service to an enhanced service. What is the clinical reasoning for making this an enhanced service?
- A: *The policy revision is not making PSS an enhanced service, it is moving it from the Medicaid (b)(3) service array to the State Plan.*
- Q: Can you please comment on the new draft as it may affect clients who are IDD and/or live in group homes?
- A: *PSS is a service for individuals with MH and/or SU, not primary IDD.*

Staffing:

- Q: Our agency has significant concerns about the ratio as it's currently written
- A: *NC Medicaid and DMHDDSAS are re-evaluating the ratio to allow the supervisor to supervise more CPSS, and for the CPSS caseload to be smaller*
- Q: Can paraprofessionals become Certified Peer Support Specialists?
- A: *They must meet the requirements to become a CPSS, which includes having lived experience with MH and/or SU*
- Q: Are all QPs expected to be CPSS as well?
- A: *This will be up to the provider agency; the minimum requirement is that the supervisor is a QP.*
- Q: Can only CPSS render the care, meaning no paraprofessional providers that are not certified will be able to provide the service?
- A: *Yes, only CPSS can render care. The new policy/service definition will not allow paraprofessionals to render care.*
- Q: How can an agency ensure that the lived experience of the PSS staff match the lived experience of the people receiving services?
- A: *It is up to each agency to ensure that the background, experience, and training of their CPSS closely match the lived experience of the people receiving services. If a PSS provider works with people that have severe mental illness, they should ensure that the PSS they hire have similar lived experience. Likewise, if the PSS provider works with people that have substance use issues, the PSS staff should have similar lived experience.*
- Q: Will the supervisor need to be a licensed clinician?
- A: *The minimum requirement to be a supervisor for PSS is a QP, and the rate is set based on the minimum requirement. The agency reserves the right to staff at a higher level, but the supervisor will need to at minimum be a QP.*
- Q: Can paraprofessionals work pending they are considering becoming a peer support specialist?
- A: *No. Staff must meet the requirements to become a CPSS. When the service definition goes live, staff must have their CPSS. Paraprofessionals will no longer be able to provide services under the PSS policy.*
- Q: With the supervisor requirement to provide face to face contact with the beneficiary- what are the expectations for these contacts? What paperwork will be associated with it?
- A: *We will expect them to review goals and the PCP/Wellness plan. Documentation should reflect the review of the goals and documents, and a service note should be written to reflect the contact. If referrals for additional services are needed, we would expect the QP to complete the paperwork to make those referrals and document the contact.*
- Q: Will CPSS be required to write PCPs?

A: Peer support specialist are not required to write PCPs, that will be the role of the QP. If that member is receiving an enhanced service, the expectation is that the peer support specialist program work will be added to the PCP.

Q: Does the QP supervisor have to be one FTE?

A: *The QP supervisor will be required to be full-time, dedicated to the PSS. It cannot be filled by more than one individual.*

Q: Can a QP go through the peer support training and provide service?

A: *The QP supervisor is full-time, dedicated to the supervisor position. They are not able to provide functions or supports to individuals receiving PSS service outside of their scope as defined by the policy, even if they are a CPSS.*

Training:

Q: If someone already has taken motivational interviewing, do they still need to take the continuing education training? Does the training have to be provided by a MINT trainer?

A: *They must have a certificate that identifies when the training was completed, the hours, and the trainer. The MI training must have been completed no more than 24 months prior. It is up to the hiring agency to determine if the training should count towards the requirement. All MI trainings must be facilitated by a MINT trainer.*

Q: Will there be more trainings to help people obtain their CPSS certification, especially in the western part of their state?

A: *Contact your LME-MCO and UNC Springboard (<https://pss.unc.edu/>) for upcoming CPSS trainings, as well as approved curriculum.*

Q: What/where is the three hours of Supervising Peer Support Specialists training online?

A: *UNC Springboard <https://bhs.unc.edu/supervising-nc-certified-pss>*

Q: I am concerned about the amount of training required, it seems like the training to become a CPSS should be sufficient.

A: *The training required by the PSS policy/service definition is specific to the roles and responsibilities of the provider agency, and not included in the CPSS training curriculum.*

Q: Will the continuing education hours be able to line up with CPSS certification requirements?

A: *Yes, the trainings for continuing education should count towards the recertification requirements.*

Training (continued)

Q: Where/who will offer the required trainings for the PSS policy?

A:

<i>Peer Support Services Policy (3 hrs.)</i>	<i>Agency can develop and provide</i>
<i>PCP Instructional Elements (3 hrs.)</i>	<i>Agency can develop and provide</i>
<i>Comprehensive Prevention and Intervention Crisis Plan Training (3 hrs.)</i>	<i>Under consideration</i>
<i>Documentation Training (3 hrs.)</i>	<i>Agency can develop and provide</i>
<i>Person Centered Thinking (12 hrs.)</i>	<i>Agency can develop and provide</i>
<i>Crisis Response (6 hrs.)</i>	<i>Under consideration</i>
<i>Motivational Interviewing (13 hrs.)</i>	<i>Must be offered by a MINT trainer</i>
<i>Peer Support Supervisor Training (3 hrs.)</i>	https://bhs.unc.edu/supervising-nc-certified-pss

Q: What are the plans for national CPSS trainings, the requirements, and the cost of trainings?

A: *Currently, there are no plans to require national CPSS trainings. We are continually evaluating the NC CPSS process.*

Q: Can you explain the thinking behind making MI one of the required trainings?

A: *Motivational interviewing is the foundation to almost all evidence-based practices and teaches staff ways to engage with individuals that are still early in the process of change.*

Authorization/Documentation:

Q: Is a PCP required for the service, or can a wellness plan be considered?

A: *We are considering allowing a wellness plan to be used if the individual is not receiving another level of care.*

Q: Can we use the PCP short form?

A: *No, this form currently isn't in use.*

Q: Is there a way to allow PCPs to be signed by a licensed clinician instead of a physician/psychiatrist/nurse practitioner?

A: *This is under consideration.*

Q: Can a psychiatric note from a hospital or referral with a diagnosis take the place of a CCA?

A: *No. The CCA must establish the need for PSS.*

Q: The PCP and CCA must be submitted 10 days prior to service delivery. How are the providers to get compensated for writing the PCP and CCA if it's done 10 days prior to service delivery?

- A: *We will be removing this language and have it align with other services. The CCA will be done separately, and writing the PCP is not a billable service.*
- Q: Will PSS have unmanaged hours before the official authorization is submitted?
- A: *This will be up to the LME-MCOs.*
- Q: Why is a CCA required, as this may be a barrier to getting services? Sometimes a PSS is the first one a client trusts and gets the individual to consider engaging in services.
- A: *This is under consideration.*
- Q: Does the CCA have to recommend Peer Support Services?
- A: *Yes*
- Q: Will there be a pass-through period?
- A: *This is under consideration.*
- Q: What ages will PSS cover?
- A: *PSS is part of the adult mental health service array, and available to individuals 18 and older.*
- Q: Will there be new service limits? For example, no more than 20 hours a week of services can be provided?
- A: *This is under consideration.*
- Q: Will an ASAM or LOCUS level be required?
- A: *No, PSS is not a clinical service and these level of care assessments will not be required*
- Q: What is the criteria for discharge? The criteria seems very open to interpretation.
- A: *If the person no longer wants to receive services, that is the beneficiary's choice; they don't have to. If the member is not making progress, which could be in combination with another approved service, peer service could work along with another service depending on what it was. If it was a service that that they couldn't receive, then discharge criteria would apply. If the person needed a higher level of care, it would depend on if the higher-level service allowed Peer Support to work in combination with it.*
- Q: Will a discharge summary still be required from the provider for discharge?
- A: *This is not required by NC Medicaid or NC DMHDDSAS, it would be up to the LME-MCO if a discharge summary will be required.*
- Q: Will the QP have to sign the CPSS' documentation for the duration of their employment?
- A: *Yes, the QP PSS Supervisor will have to sign all documentation.*
- Q: Can PSS be a stand-alone service?
- A: *Yes, if an individual wants to only receive PSS, that is allowable.*

Billing/Reimbursement:

Q: Will Peer Supports move to Medicaid?

A: *Peer Supports will move from the (b)(3) Medicaid waiver to the Medicaid State Plan.*

Q: Can the QP be eligible to provide/bill for services?

A: *If the QP is updating the PCP/Wellness plan, reviewing goals, or assessing the need for referrals and making referrals, and the individual is present, they can bill for that time.*

Q: Will PSS allow for billing of collateral contacts and phone calls?

A: *Indirect time, to include collateral contacts and phone calls, is part of the rate model, and cannot be billed for.*

Q: Can PSS be provided in an emergency department?

A: *At this time no, it cannot be billed for in an emergency department.*

Q: What is the reason for adding PSS to the State Plan Amendment?

A: *Having PSS be a (b)(3) service limits access due to funding. Moving it to the State Plan Amendment ensures access to funding and consistency across the state.*

Q: What changes require agencies to have national certification for this service?

A: *National certification is required to be a provider in the LME-MCOs network. This is not a change.*

Q: What is the productivity billable time that a CPSS will have to maintain to operate the program without a financial loss?

A: *This is a provider business model question we cannot answer.*

Q: Will there be a subgroup of billing codes for the QP?

A: *No.*

Q: Being that PSS will no longer be a Medicaid (b)(3) service, will a provider continue to need a contract with the LME-MCOs to provide the service?

A: *Yes, providers will need to continue to have a contract with the LME-MCO for this service to receive Medicaid and State funds for reimbursement.*

Q: A hospital emergency room is an outpatient setting, and should fall under the umbrella of 'office setting', shouldn't it? Office visit E&M codes are often used in an emergency room department by consulting providers because of this.

A: *No. For Medicaid billing purposes a hospital emergency room is a hospital setting, it is not an office setting. Additionally, Medicaid is already paying for the services rendered by the hospital*

emergency department, billing for an additional service would be double billing. Providers should not be billing E&M codes to provide services in an emergency department.

Q: PSS have been requested to work with syringe access programs and its participants. I would like to know how that service is covered if an agency does not bill out of Medicaid or any insurance company? How are you addressing that collaboration?

A: *This service definition is for Medicaid and State funded service providers. PSS providers must have a contract with their LME-MCO to provide and bill for this service.*

Scope of Work:

Q: Can peer supports be provided while another service is being provided, i.e.- peer supports during an outpatient therapy session, to provide support and advocacy while the beneficiary is interacting with their therapist.

A: *No, peer supports cannot be billed while another service/level of care is being billed.*

Q: Can a CPSS coordinate with an outpatient therapy provider?

A: *Yes, they can coordinate with an outpatient therapy provider.*

Q: What services will exclude standalone PSS services?

A: *Service exclusions are currently under consideration.*

Q: Why is transportation not part of the peer support definition when clearly many consumers do not have transportation.

A: *Transportation as a distinct service is not billable by behavioral health providers to Medicaid. If a CPSS is indicating that an intervention took place while driving, it must be clearly documented and align with the PCP/Wellness plan. Individuals with Medicaid can and should access Medicaid transportation in their area for support to get to appointments.*

Q: Could peer support services be included in medication assisted treatment regimens?

A: *Yes, this would be an appropriate use of PSS.*

Q: Why does a QP have to see the client in 30 days if they are requiring a CCA and PCP to receive the service?

A: *This is under consideration.*

Q: Could attending a AA/NA meeting be considered recreation?

A: *No. Attending an AA/NA meeting is not a billable service*

Q: Will this service be able to be offered in a medical setting?

A: *PSS can be provided to support an individual who is receiving services in a primary care setting (however not when the individual is meeting with the doctor.)*

Scope of Work (continued)

Q: Can PSS be billed if the person is receiving SA IOP?

A: *Yes, but not billed at the same time.*

Q: Can an individual only receive PSS, or will they be required to be receiving another/enhanced service?

A: *Yes, this can be delivered as a stand-alone service.*

Q: Will PSS be required to provide crisis services/supports?

A: *No, PSS will not provide 24/7/365 crisis response. They should support individuals in developing a crisis plan and be available to coordinate with the LME-MCO if an after-hours crisis occurs.*

Q: Will peers be able to help people engage in recreational activities?

A: *Peers can provide supports to an individual to help them engage in recreational activities. However, peers cannot provide transportation to and from recreational activities and bill. The expectation is that the individual needs some level of support from the peer to initially engage in the recreational activity, and that support should be clearly documented in the person-centered plan/wellness plan and the corresponding service note.*

Q: Why does the QP have to see the client within 30 days if you are requiring a CCA and PCP/Wellness plan to even receive the service?

A: *This is under consideration.*

Q: There is a definite gap in service ever since Community Support was taken away. Peer support has so many things that they can't provide, is this being taken into consideration?

A: *Peer Support Services are very different from Community Support, and it is not the intention of this policy revision to replace Community Support with Peer Support Services.*

Q: Some LME-MCOs are unfortunately using PSS to complete TMS functions. As a provider who provides both services, there's a lot of overlap in the functions of PSS and TMS, which creates confusion.

A: *This question should be asked to your LME-MCO. PSS and TMS are two different services, there should be minimal to no overlap in the services.*

Q: Can CPSS facilitate groups? They aren't trained on running groups, I thought PSS was supposed to be 1:1?

A: *If a CPSS has documented training in facilitating groups, they are able to facilitate groups. When a CPSS facilitates a group, they should bill the PSS Group code.*

Q: Will PSS mandate a crisis component be provided by peer support?

A: *No, PSS will not provide 24/7/365 crisis response. They should support individuals in developing a crisis plan and be available to coordinate with the LME-MCO if an after-hours crisis occurs.*

