Phone: 843.856.8226
Email: Info@mstservices.com
www.mstservices.com

# Multisystemic Therapy®
# Funding and Medicaid Standards


## Introduction

MST® Services' position on Medicaid funding for MST programs sums up our current "lessons learned" regarding the strengths and challenges of using Medicaid funding to support MST implementation. Medicaid funding has emerged as an important facilitator in the growth of MST and it is playing a critical role in the financial sustainability of many MST programs across the United States. However, we caution stakeholders against viewing Medicaid as a "silver bullet" solution to their funding troubles due to the potential challenges of using Medicaid funds to support the model-adherent implementation of MST. For the full "Position Statement **on Medicaid Funding for MST Programs" click here.**

The standards and service descriptions for Medicaid or other funding sources for MST of various states are summarized in this document. Information on each state's MST standards is provided as well as an assessment of how consistent these standards are with MST. Suggested elements to be included in an MST Medicaid Standard are presented in the MST Preferred Service Description section. For an example of how states can be rated using this preferred service description, review our Sample MST Preferred Service Description Rating Form.

While some states use the current Multisystemic Therapy H2033 HCPCS code (see page 18) for Medicaid billing, many states have created MST funding mechanisms under other HCPCS codes or have chosen to use pre-existing Medicaid codes such as those for "Intensive In-home Services". In the State Medicaid table in this document, rating information is provided on how consistent each state's standards are with the MST evidence base.

(Continued)

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# Multisystemic Therapy Funding and Medicaid Standards


## Introduction (Continued)

These state Medicaid standards are rated by placing them in one of four categories (i.e., Highly Consistent, Consistent, Mostly Consistent, or Minimally Consistent) by comparing them to the list of recommended program practices and requirements presented in the MST Preferred Service Description document. These recommended program practices and requirements have been developed to replicate the characteristics of clinicians, training, clinical supervision, consultation, monitoring and program support provided in the successful clinical trials of MST and have been refined through extensive experience with MST program replications throughout the United States and in growing a number of sites internationally.

The goals of MST programs include providing clinically effective, family-based services with high levels of provider accountability for outcome. Thus, the functional mission and current service array of the MST host agency must be examined for compatibility with the MST treatment approach. The Success of MST depends on the provision and proper management of these necessary resources.

For those individuals interested in assistance with RFP development, please refer to Draft MST RFP Template. This is helpful in writing an RFP as it contains the elements that should be included in the RFP for MST.

For technical assistance in developing funding or Medicaid standards for MST, please contact Melanie Duncan, Project Manager, at melanie.duncan@mstservices.com.

MST Services

Phone: 843.856.8226
Email: Info@mstservices.com
www.mstservices.com

# Multisystemic Therapy **Funding and Medicaid Standards**


## Table of Contents

# MST State Medicaid Table

| STATE / COUNTY | SERVICE DESCRIPTION MEDICAID / FUNDING STANDARD | LEVEL OF CONSISTENCY W/ MST EVIDENCE BASE | PUBLISHED RATE INFORMATION* (see footnote about activities allowed for billiing) | ADDITIONAL INFORMATION / COMMENTS |
|---|---|---|---|---|
| Alabama | No MST standard has been identified | N/A | | N/A |
| Alaska | No licensed MST teams operating | N/Ahjhjhjkhjk | | N/A |
| Arizona | The accepted definition of MST is: Arizona Multisystemic Therapy Program Description | **Consistent** - This standard is consistent with the MST evidence base due to the requirement that the "contractor will implement the MST service in strict adherence to the Blueprints Project MST model". AZ - MST Service Description Rating | | This state standard is silent in many critical areas including, quality assurance practices and staff training, program staffing and program operational requirements. The main strength is the requirement of implementation to be in strict adherence to the Blueprints Project MST model. |
| Arkansas | No licensed MST teams operating | N/A | | N/A |
| California | Copy of standard not obtained Outpatient Mental Health Services - Medi-Cal | N/A | | |
| Colorado | CO MST Medicaid Standard Federal H2033 Multisystemic Therapy | **Not Consistent** - This standard does not provide adequate specification of the MST model. CO - MST Service Description Rating | No published state-wide rate. Each provider negotiates rates with each BHO. | This standard fails to provide adequate specification of the service to insure adherent implementation of the MST model and gives almost no guidance regarding critical implementation requirements and target population criteria. |

# MST State Medicaid Table

| | | | | |
|---|---|---|---|---|
| Connecticut | CT Draft MST Medicaid Standard | Review under development | | |
| Delaware | Copy of standard not obtained | N/A | | |
| District of Columbia | Copy of standard not obtained Community Based Intervention (CBI) Level I | N/A | | |
| Florida | No MST standard has been identified | N/A | | N/A |
| Georgia | No MST standard has been identified | N/A | | N/A |
| Hawaii | HI MST Medicaid Standard | **Mostly Consistent** - This standard is mostly consistent with the MST evidence base. Fortunately the HI MST system has practice standards that demand adherence to the MST model in areas where this standard is silent (e.g. QA, MST licensure, etc.). HI - MST Service Description Rating | No rate published | |
| Idaho | No licensed MST teams operating | N/A | | N/A |
| Illinois | No MST standard has been identified | N/A | | N/A |

# MST State Medicaid Table

| | | | | |
|---|---|---|---|---|
| Indiana | No licensed MST teams operating | N/A | | N/A |
| Iowa | No licensed MST teams operating | N/A | | N/A |
| Kansas | No licensed MST teams operating | N/A | | N/A |
| Kentucky | No licensed MST teams operating | N/A | | N/A |
| Louisiana | Louisiana Behavioral Health Partnership (LBHP) Service Definitions Manual | **Consistent-** This standard is consistent with the MST evidence base. LA-MST Service Description Rating | The rate for MST ranges $36.01* (minimum for MA-level therapist) - $30.23* (minimum for BA-level therapist) per 15-minute unit set by LA Medicaid (H2033).<br><br>https://www.lamedicaid.com/prov web1fee_schedules/Multi_Fee.pdf | The standard requires that "The provider agency must have a current license issued by the MST Services." Almost all recommended criteria are specified in standard; however, program financial stability may be an issue due to the fact that phone and collateral contacts (even when clinically appropriate) have been disallowed as a billable activity. |
| Maine | Mainecare Benefits Manual: Behavioral Health Services | **Highly Consistent**- This standard is highly consistent with the MST evidence base. ME-MST Service Description Rating | The rate for MST is $31.07* per 15 minute increment as published here:<br><br>https://www.maine.gov/dhhs/audit/ rate-setting/documents/S65Behavio ral Health2-23-15.pdf | The Children's Home and Community Based Treatment Services rule within the Mainecare Behavioral Services Medicaid Assistance Program is inclusive of MST. |
| Maryland | MST Medicaid standard under development | Review under development | | N/A |
| Massachusetts | No MST standard has been identified | N/A | | N/A |

# MST State Medicaid Table

| | | | | |
|---|---|---|---|---|
| Michigan | MI MST Medicaid Standard document 1and MI MST Medicaid Standard document 2<br>Federal H2033 Multisystemic Therapy<br>MI_MICHIGAN PIHPCMHSP PROVIDER QUALIFICATIONS PER MEDICAID SERVICES and HCPCSCPT CODES | **Mostly Consistent** - This standard is mostly consistent with the MST evidence base due to the requirement that the "Master's level clinician who is a CMHP, certified by MST Services", even though it does not provide adequate specification of the MST model. MI-MST Service Description Rating | No rate published | While most MST criteria are not specified in this standard should be met "de facto" as licensure by MST Services is required. A weakness of the rate structure is that is only direct services, face-to-face with consumer or family members are billable. |
| Minnesota | No MST standard has been identified | N/A | | N/A |
| Mississippi | No MST standard has been identified | N/A | | N/A |
| Missouri | No MST standard has been identified | | | N/A |
| Montana | No licensed MST teams operating | N/A | | N/A |
| Nebraska | NE MST Medicaid Standard Document<br>Federal H2033 Multisystemic Therapy | **Highly Consistent**- This standard is highly consistent with the MST evidence base.<br>NE-MST Service Description Rating | The rate for MST is $38.24* per 15 minute increment is published on page 14 of the document found here:<br>http://dhhs.ne.gov/Documents/471-000-532.pdf | The standard requires agency to "be trained and certified in MST as defined by the institute of MST." Almost all recommended criteria are specified in standard and those not specified in the standard, should be met "de facto." |

# MST State Medicaid Table

| | | | | |
|---|---|---|---|---|
| Nevada | No MST standard has been identified | N/A | | N/A |
| New Hampshire | No licensed MST teams operating | N/A | | N/A |
| New Jersey | NJ Intensive In-Community Mental Health Rehabilitation Services (IIC Services) | **Not Consistent**- This standard is not specific to MST and is reported to be administered in such a way as to hinder the delivery of MST. NJ-MST Service Description Rating | The rate for MST is listed as set according to "contract pricing" as published on page 283 of this document. https://www.hdismedicaid.com/files/ NJ%202016.pdf | N/A |
| New Mexico | NM MST Medicaid Standard Federal H2033 Multisystemic Therapy (MST) code | **Highly Consistent** - This standard is highly consistent with the MST evidence base although it lacks specifying the significant exclusionary criteria for standard MST. NM - MST Service Description Rating | The rate for MST is $37.50 (for Masters, or Higher, Level), - 35.00* (for Bachelors Level) per 15 minute increment service (under H2033 code), but can be negotiated per provider, as published here: http://www.hsd.state.nm.us/uploads/FileLinks/e7cfb008157f422597cccdc11d2034f0Behavioral_Health_Fee_Schedule_Effective_8_1_2014_ corrected.pdf | |
| New York | No MST standard has been identified | N/A | | N/A |
| North Carolina | NC MST Medicaid Standard Federal H2033 Multisystemic Therapy (MST) | **Consistent** - This standard is consistent with the MST evidence base. While | No rate published. Rates are negotiated with MCOs, no set state-wide rate. | Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. |

# MST State Medicaid Table

| | | | | |
|---|---|---|---|---|
| | code NC LME Standards | this standard is intended to fund the use of MST within the evidence-based referral range of youth 12-17 years old, it was written with a broader age range of 7- 17 to enable the formal evaluation of using MST with youth down to an age of 7 years old in hopes of facilitating further development of the MST evidence base. NC - MST Service Description Rating | | |
| North Dakota | No licensed MST teams operating | N/A | | N/A |
| Ohio | OH Intensive Home Based Treatment Service Description Intensive Home Based Treatment (IHBT) Service | **Mostly Consistent** This standard is mostly consistent with the MST evidence base. OH - MST Service Description | | While many MST criteria are not specified in this standard, the rate structure only allows for MST to be reimbursed at a fifteen (15) minute increment rate and an MSTS license is required and therefore most MST criteria while not specified in the standard, should be met "de facto." |
| Oklahoma | OK MST Medicaid Standard Federal H2033 Multisystemic Therapy | **Not Consistent** - This standard does not provide adequate specification of the MST model. OK - MST Service Description Rating | | This standard fails to provide adequate specification of the service to insure adherent implementation of the MST model and gives almost no guidance regarding critical implementation requirements and target population criteria. |

| | | | | |
|---|---|---|---|---|
| Oregon | No MST standard has been identified | N/A | | N/A |
| Pennsylvania | PA MST Medicaid Standard | **Mostly Consistent** - This standard is mostly consistent with the MST evidence base. Fortunately the system has practice standards to the MST model in areas where this standard is silent (e.g. QA continued stay, discharge criteria, etc.). PA - MST Service Description Rating | Rates are negotiated with MCOs, no set state-wide rate. There are weekly rates for some providers. | N/A |
| Rhode Island | No MST standard has been identified. | N/A | | All MST providers are funded through two "Networks" of child-serving agencies contracted with the state Department of Children, Youth, and Families to provide services to Department-involved youth (including juvenile justice). MST services are Medicaid reimbursable for the state through "Costs not otherwise matchable" (CNOM) under the Rhode Island Global Consumer Choice, Section 1115(a), Demonstration Waiver. |
| South Carolina | SC Mental Health Services Not Otherwise Specified (MHSNOS) Service Description | **Mostly Consistent** - While this standard is not specific to MST it is mostly consistent with the MST evidence | No rate published | N/A |

| | | | | |
|---|---|---|---|---|
| | | base. Fortunately the SC MST system has practice standards that demand adherence to the MST model in areas where this standard is silent (e.g. QA, staff training, etc.). SC - MHS-NOH Service Description Rating | | |
| South Dakota | No licensed MST teams operating | N/A | | N/A |
| Tennessee | No MST standard has been identified | N/A | | N/A |
| Texas | No MST standard has been identified | N/A | | N/A |
| Utah | No licensed MST teams operating | N/A | | N/A |
| Vermont | No licensed MST teams operating | N/A | | N/A |
| Virginia | No MST standard has been identified | N/A | | N/A |
| Washington | Washington State MST Pilot Project Medicaid Standard<br><br>Federal H2033 Multisystemic Therapy | This standard was established for a specific pilot project and does not provide full specification of the MST model and therefore has not been reviewed. | | This standard was created for a limited pilot program which does not fully specify the service but does state it will fund “MST services as defined by MST, Inc.” |
| West Virginia | No licensed MST teams operating | N/A | | N/A |

| | | | | |
|---|---|---|---|---|
| Wisconsin | No licensed MST teams operating | N/A | | N/A |
| Wyoming | No MST standard has been identified | N/A | | N/A |

*** Footnote regarding activities allowed for billing. The range of activities that are 'Allowable' for billing generally varies greatly state by state and across Managed Care Organizations (MCOs) within states. As a result, the total number of 15-minute units that are billed for a single case of MST will be dramatically different in accordance to what is allowed to be billed as a reimbursable activity. These differences in the definitions of Allowable / Billable activities is a large contributor to why the 15-minute unit rates for MST vary so much across systems. An additional significant contributor to rate differentials is regional variation in staff salaries.**

Author(s): Keller Strother and Melanie Duncan

Date: 06/19/09

Topic: **Medicaid Funding for MST Programs**

Issue: Strengths and Weaknesses of Using Medicaid Funding for MST Programs

The purpose of this position statement is to summarize the "state of the learning" regarding the strengths and challenges of using Medicaid funding to support MST implementation. Medicaid funding has emerged as an important part of the MST landscape and is playing a critical role in the financial sustainability of many MST programs across the United States. However, we caution stakeholders against viewing Medicaid funding as a "silver bullet" solution to their funding troubles, due to the potential limitations and challenges of using Medicaid funds to support the model-adherent implementation of MST as outlined below.

**Strengths:**

- Many youth and families who can benefit from standard MST are Medicaid eligible.
- Medicaid funding allows states to receive partial federal support for their evidence-based MST programs.
- Once a funding standard for MST is added to the state plan, funding is readily available.
- Medicaid waivers, 1915(b) Managed Care waivers and 1915(c) Home and Community-based Services waivers, and the 1915(i) Home and Community-Based Services state plan option, can be used to give states the flexibility to structure the funding for MST in the form of a per diem, weekly or monthly, billing rate.

**Weaknesses:**

- Medicaid funding alone is often insufficient to support an MST program.
- Under the Rehabilitative Services Option of the Medicaid code (a.k.a.the 'Rehab' option), Medicaid funding will never fully sustain an MST program. (See below for more on this topic.)
- Not all families in need of MST meet the eligibility criteria for Medicaid.
- The current MST HCPCS (Healthcare Common Procedure Coding System) code available for use by states is based on a 15-minute billing increment. The nature of this increment, being a relatively short increment of time, is leading systems to establish reimbursement structures based on client contacts and is encouraging greater administrative/management focus on the billable nature of clinical work in practice settings. (See below for elaboration on each topic.)
- Under the Rehabilitative Services Option, the Centers for Medicare and Medicaid Services (CMS) is not able to create per diem, weekly or monthly billing rates for MST due to the number of non-allowable activities that are required as part of implementing MST. (See below for more.)
- Many Medicaid systems only reimburse for face-to-face contacts and, at times, only contacts with family members when the youth is present. This type of funding structure can easily lead to non-model adherent practices that over emphasize face-to-face contacts in clinical implementation. In MST implementation, a therapist who gets the same high-quality outcome with less face-to-face contact is doing a better job.
- A common revenue management practice in fee-for-service Medicaid systems is the use of "productivity" metrics to focus staff on certain activities that are viewed as most appropriate. Many organizations, however, define "productivity" solely on revenue generation (billable activity) rather than clinical outcomes. In the most extreme examples of this, administrators post lists of "productivity rates" (a.k.a. revenue generation rates) publicly within the agency to shame staff into engaging in more billable activity. When properly used, "productivity" metrics can be

used to ensure that therapist activities, as monitored through activity logging, are clinically appropriate, model-adherent and are focused on producing better outcomes for clients.

- No states currently have Medicaid funding available for the MST-Psychiatric adaptation of MST. This can lead to inappropriate referrals to standard MST programs of youth with significant psychiatric service needs and for whom these psychiatric service needs are viewed as the primary driver for the youth's inappropriate behaviors.

**CMS feedback regarding funding under the Rehab Options:**
Our understanding of the feedback from staff at the federal offices of the CMS is that the following types of services and expenses included in the delivery of MST are not allowable and can neither be reimbursed directly nor built into rates for MST under the Rehabilitative Services Option. It is our estimate that these kinds of activities constitute at least 10%, to over 30%, of an MST program's annual budget, depending on the program size, structure, and case-specific service requirements.

- Five-day MST orientation training
- Quarterly MST Booster training
- Ongoing training, work sample review, etc. with supervisor and/or teammates
- Staff time spent reading relevant clinical material for training purposes or reviewing reference materials
- General supervision activities, including on-site supervision and case review (The exception to this would be the rare situation when the MST client is present.)
- Administrative functions executed by the Supervisor
- Face-to-face delivery of marital therapies to adult caregivers without youth present (only allowable if issues are directly related to the youth's behavior or needs)
- Time spent trying to contact and engage families when "no shows" occur and/or when overall commitment to participation in treatment is low
- Staff meetings and non-clinical discussions
- "Flex funds"
- Court appearances
- Start-up expenses prior to client referrals
- Services delivered prior to authorization for billing

Two additional areas worthy of comment are phone contacts and collateral contacts. While CMS does allow these types of activities, they MAY or MAY NOT be allowable in individual states, depending on the standards established by each state.

- Phone contacts with caregivers
- Collateral contacts with significant others that affect the youth including, but not limited to, the neighborhood, social, educational, and vocational environments, as well as those from the criminal justice, child welfare, health and mental health systems.
- Phone contacts with collateral contacts

**Conclusions:**
While Medicaid funding can be a meaningful part of an MST funding strategy, it is seldom a sufficient source of funding on its own. MST program administrators, operating programs under the Rehabilitative Services Option, consistently report that Medicaid reimbursements can reliably cover about 40% to 60% of a model-adherent MST team's operating budget. States operating under waivers that grant the flexibility to structure funding for MST in the form of a per diem, weekly or monthly billing rate are often more successful in using Medicaid to fund a greater proportion, or even all, of an MST program's budget. Absent such a waiver, we recommend that MST programs create a multi-faceted funding stream that "braids" multiple sources of funding at a budgetary level and incorporates the available Medicaid reimbursements with these other sources of funding (e.g., state services funds from juvenile justice, mental health, etc.) in such a way that model adherence and client outcomes are always the primary focus for every MST clinician and program administrator.

# MST Preferred Service Description / Medicaid / Funding Standard

**Brief Service Description:** Multisystemic Therapy (MST) is a time-limited, intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the factors associated with delinquency across youths' key settings, or systems (e.g., family, peers, school, neighborhood). Using the strengths of each system to foster positive change, MST promotes behavior change in the youths' natural environment.

System Level Practices and Requirements:

- ☐ Requires valid program license with MST Services and the Medical University of South Carolina
- ☐ Rate structure for MST is a case rate (Per Diem, weekly, monthly, or flat rate) rather than hourly or fractional-hourly rate.
- ☐ Rate structure for MST under the Rehabilitative Services Option allows for reimbursement, either directly or built into the rates, for collateral contacts with significant others that affect the youth including, but not limited to, the neighborhood, social, educational, and vocational environments, as well as those from the criminal justice, child welfare, health and mental health systems.
- ☐ Rate structure for MST under the Rehabilitative Services Option allows for reimbursement either directly, or built into the rates, for phone contacts with caregivers and collateral contacts.

Quality Assurance Practices and Requirements:

- ☐ System monitors and tracks the adherence to the MST model
- ☐ System funds the collection of the MST Therapist Adherence Measure (TAM) by an independent third party

Staff Training Requirements (*Training includes the following segments administered by MST Services of Charleston, SC or a licensed MST Network Partner organization)*:

- ☐ Initial five day orientation training
- ☐ Ongoing quarterly one and one-half day booster training sessions
- ☐ Ongoing weekly telephone consultation

Supervisor Requirements:

- ☐ MST Clinical Supervisors are highly experienced Masters or Ph.D. level mental health or child welfare professionals

Therapist Requirements:

- ☐ MST Therapists are full-time Masters-level staff, or Bachelors-level staff with a minimum of five years appropriate clinical experience, in mental health or child welfare services
- ☐ MST Therapists are assigned to the MST program solely and have no other agency responsibilities

Program Staffing Requirements:

- ☐ Maintain a supervisory/direct service staff ratio of one supervisor per each team consisting of 2-4 full-time therapists
- ☐ One supervisor of AT LEAST 50% FTE is assigned to one MST team, or one full-time clinical supervisor to two MST teams. Determination of supervisor assignment should be based on the specific context and needs of the program.
- ☐ MST Supervisors carrying a partial MST caseload should be assigned to the program on a full-time basis
- ☐ Bachelors-level staff shall not make up more that 33% of the therapist positions of an MST team.

Program Operational Requirements:

- ☐ MST program is available to clients 24 hour/day, 7 day/week via an on-call system staffed by MST team members
- ☐ Duration of treatment is an average of 4 months with an expected range of 3 to 5 months
- ☐ MST caseloads do not exceed 6 families per therapists with an average caseload of 5 families per therapist over time and a normal range being 4 to 6 families per therapist

Admission Criteria (*All of the following criteria are necessary for admission)*:

- ☐ Referral / target ages of 12-17
- ☐ Youth is a chronic or violent juvenile offender
- ☐ Child is at risk of out-of home placement or is transitioning back from an out-of-home setting
- ☐ Externalizing behavior symptomatology resulting in a DSM-IV (Axis I) diagnosis of Conduct Disorder or other diagnosis consistent with such symptomatology (ODD, Behavior Disorder NOS, etc.)
- ☐ Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in main stream school settings due to behavioral problems
- ☐ Less intensive treatment has been ineffective or is inappropriate

Exclusion Criteria *(Any of the following criteria are sufficient for exclusion from this level of care):*

- ☐ Child meets criteria for out-of home placement due to suicidal, homicidal, or psychotic behavior or are those youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- ☐ Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- ☐ Referral problem is limited to serious sexual misbehavior
- ☐ Youth has an autism spectrum diagnosis

Continued Stay Criteria (*All of the following criteria are required for continuing treatment at this level of care)*:

- ☐ Treatment does not require a more intensive level of care
- ☐ Treatment plan has been developed, implemented and updated, based on the child/adolescent's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated
- ☐ Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident
- ☐ Family/caregivers are actively involved in treatment, or there are active, persistent efforts being made that are expected to lead to engagement in treatment

Discharge Criteria (*The following criteria indicate that the child/adolescent no longer meets medical necessity criteria for MST)*:

- ☐ Child's documented treatment plan goals have been substantially met, including discharge plan
- ☐ Individual/family no longer meets admission criteria, or meets criteria for a less or more intensive level of care
- ☐ Child and/or family have not benefited from MST despite documented efforts to engage and there is no reasonable expectation of progress at this level of care despite treatment

# Sample - MST Preferred Service Description / Medicaid / Funding Standard Rating Form

**Brief Description of State System:** This funding standard is used by the State Children, Youth and Families Department (CYFD). This service description is rated below by presenting an ”x” for those items met according to the State’s Medicaid requirement….Those items met “de facto” (i.e., in practice) by the providers, as practices required by the system in order to receive funding, are given a “1” for each item met. An example is the first item below. The state does not require a program license as a written requirement in this service definition, but as a matter of practice, all providers must have a valid program license with MST Services in order to receive funding under this standard. This practice requirement is managed as a part of the CYFD procurement and contract management process (e.g. it is a written requirement is all MST RFP that CYFD issues). All items that require further explanation have a footnote attached.

**Brief Service Description:** Multisystemic Therapy (MST) is a time-limited, intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the factors associated with delinquency across youths’ key settings, or systems (e.g., family, peers, school, neighborhood). Using the strengths of each system to foster positive change, MST promotes behavior change in the youths’ natural environment.

System Level Practices and Requirements:

- **1** Requires valid program license with MST Services and the Medical University of South Carolina
- ☐ Rate structure for MST is a case rate (Per Diem, weekly, monthly, or flat rate) rather than hourly or fractional-hourly rate.

Quality Assurance Practices and Requirements:

- **1** System monitors and tracks the adherence to the MST model
- **1** System funds the collection of the MST Therapist Adherence Measure (TAM) by an independent third party

Staff Training Requirements (*Training includes the following segments administered MST Services of Charleston, SC or a licensed MST Network Partner organization)*:

- ☒ Initial five day orientation training
- ☒ Ongoing quarterly one and one-half day booster training sessions
- ☒ Ongoing weekly telephone consultation

Supervisor Requirements:

- ☒ MST Clinical Supervisors are highly experienced Masters or Ph.D. level mental health or child welfare professionals

Therapist Requirements:

- ☒ MST Therapists are full-time Masters-level staff, or Bachelors-level staff with a minimum of five years appropriate clinical experience, in mental health or child welfare services

☒ MST Therapists are assigned to the MST program solely and have no other agency responsibilities

Program Staffing Requirements:

☐ Maintain a supervisory/direct service staff ratio of one supervisor per each team consisting of 2-4 full-time therapists

☒ One 50% FTE supervisor to one MST team or one full-time clinical supervisor to two MST teams

**a** MST Supervisors carrying a partial MST caseload should be assigned to the program on a full-time basis

☐ Bachelors-level staff shall not make up more that 33% of the therapist positions of an MST team.

Program Operational Requirements:

☒ MST program is available to clients 24 hour/day, 7 day/week via an on-call system staffed by MST team members

☒ Duration of treatment is an average of 4 months with an expected range of 3 to 5 months

☒ MST caseloads do not exceed 6 families per therapists with an average caseload of 5 families per therapist over time and a normal range being 4 to 6 families per therapist

Admission Criteria (*All of the following criteria are necessary for admission)*:

**b** Referral / target ages of 12-17

☒ Youth is a chronic or violent juvenile offender

☒ Child is at risk of out-of home placement or is transitioning back from an out-of-home setting

☒ Externalizing behavior symptomatology resulting in a DSM-IV (Axis I) diagnosis of Conduct Disorder or other diagnosis consistent with such symptomatology (ODD, Behavior Disorder NOS, etc.)

☒ Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in main stream school settings due to behavioral problems

☒ Less intensive treatment has been ineffective or is inappropriate

Exclusion Criteria *(Any of the following criteria are sufficient for exclusion from this level of care):*

☒ Child meets criteria for out-of home placement due to suicidal, homicidal, or psychotic behavior

☒ Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.

☒ Referral problem is limited to serious sexual misbehavior

☒ Youth has an autism spectrum diagnosis

Continued Stay Criteria (*All of the following criteria are required for continuing treatment at this level of care)*:

**1** Treatment does not require a more intensive level of care

☒ Treatment plan has been developed, implemented and updated, based on the child/adolescent's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated

**1** Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident

**1** Family actively involved in treatment, or there are active, persistent efforts being made that are expected to lead to engagement in treatment

Discharge Criteria (*The following criteria indicate that the child/adolescent no longer meets medical necessity criteria for MST)*:

☒ Child's documented treatment plan goals have been substantially met, including discharge plan

☒ Individual/family no longer meets admission criteria, or meets criteria for a less or more intensive level of care

☒ Child and/or family have not benefited from MST despite documented efforts to engage and there is no reasonable expectation of progress at this level of care despite treatment

1- This item is met "de facto" (i.e., in practice) by the providers, as practices required by the system in order to receive funding.

a – To date CYFD has funded full-time supervisor positions for all MST teams but has not required that all MST supervisors carry a partial case load.

b - CYFD has established a standard age range for referrals of 12-17 years old. This standard is included in the MST Goals and Guidelines documents for each MST team.

**Strengths of State Service Definition:** Almost all criteria met and specified in standard. Most notably, staff, staff training, program operational requirements, and discharge criteria are comprehensive and well clarified. Admission criteria focuses on important target population conditions (e.g., anti-social behavior, at risk for out of home placement)

**Needs of State Service Definition:** Standard does not require agency to be licensed to by MST Services, Inc. of Mt. Pleasant, S.C. Rate structure for MST is a fifteen (15) minute increment rate. Quality assurance practices and requirements not specified in the standard. Possibility that program staffing requirements such as supervisory/direct service staff ratio being 2/ 2-4 and supervisors carrying a partial MST caseload being on a full-time basis may not be occurring as requirements are not in the standard.

# HCPCS Temporary National Coding decisions for 2003

(These items will appear in the 2004 HCPCS Update)

**I. THE FOLLOWING LISTING OF HCPCS NATIONAL CODES WERE ESTABLISHED IN 2002, BUT INADVERTANLY LEFT OUT OF THE 2003 HCPCS UPDATE AS POSTED ON THE WEB ON OCTOBER 21, 2002. WE APOLOGIZE FOR ANY INCONVENIENCE. PLEASE INCLUDE THE FOLLOWING IN THE LIST OF NATIONAL HCPCS CODES AND MODIFIERS FOR USE IN 2003**

## "S" modifiers ADDED effective 7/1/2002

SM – Second surgical opinion
(Short Description: Second opinion)

SN – Third surgical opinion
(Short Description: Third Opinion)

## "S" CODES ADDED effective July 1, 2002:

S9484 Crisis intervention mental health services, per hour
(Short Description: Crisis intervention per hour)

S9490 Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
(Short Description: HIT corticosteroid diem)

S9806 RN services in the infusion suite of the IV therapy provider, per visit
(Short Description: RN infusion suite visit)

S9900 Services by authorized Christian Science Practitioner for the process of healing, per diem. Not to be used for rest or study. Excludes in-patient services.
(Short Description: Christian Sci Pract visit)

## "S" MODIFIER ADDED effective 10/1/2002

SQ Item ordered by home health

### "S" CODES ADDED effective October 1, 2002

S0104 Zidovudine, oral, 100 mg

S0135 Injection, pegfilgrastim, 6 mg

S0201 Partial hospitalization services, less than 24 hours, per diem

S0207 Paramedic intercept, non-hospital-based ALS service (non-voluntary), non-transport

S0315 Disease management program; initial assessment and initiation of the program

S0316 follow-up/reassessment

S0320 Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month

S1040 Cranial remolding orthosis, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)

S2262 Abortion for maternal indication, 25 weeks or greater

S2265 Abortion for fetal indication, 25-28 weeks

S2266 Abortion for fetal indication, 29-31 weeks

S2267 Abortion for fetal indication, 32 weeks or greater

S3655 Antisperm antibodies test (immunobead)

S8004 Radioimmunopharmaceutical localization of targeted cells; whole body

## S codes ADDED effective 1/1/2003

S5100 Day care services, adult; per 15 minutes

S5101 per half day

S5102 per diem

S5105 Day care services, center-based; services not included in program fee, per diem

S5110 Home care training, family; per 15 minutes

S5111 per session

S5115 Home care training, non-family; per 15 minutes

S5116 per session

S5120 Chore services; per 15 minutes

S5121 per diem

S5125 Attendant care services; per 15 minutes

S5126 per diem

S5130 Homemaker service, NOS; per 15 minutes

S5131 per diem

S5135 Companion care, adult (e.g. IADL/ADL); per 15 minutes

S5136 per diem

S5140 Foster care, adult; per diem

S5141 per month

S5145 Foster care, therapeutic, child; per diem

S5146 per month

S5150 Unskilled respite care, not hospice; per 15 minutes

S5151 per diem

S5160 Emergency response system; installation and testing

S5161 service fee, per month (excludes installation and testing)

S5162 purchase only

S5165 Home modifications; per service

S5170 Home delivered meals, including preparation; per meal

S5175 Laundry service, external, professional; per order

S5180 Home health respiratory therapy, initial evaluation

S5181 Home health respiratory therapy, NOS, per diem

S5185 Medication reminder service, non-face-to-face; per month

S5190 Wellness assessment, performed by non-physician

S5199 Personal care item, NOS, each

**Please correct TYPO - Code S9150 was incorrectly entered as S9105.**
**The code is S9150 EVALUATION BY OCCULARIST added effective 4/1/2002**

**"S" CODE DELETED EFFECTIVE 12/31/02. PLEASE MAKE THE CORRECTION TO YOU DATABASE**.

S8433 discontinued 12/31/2002 and cross-walked to code A4280

**(The following "T" code appeared on the 2002 list of Temporary Codes. The code is however being deleted – removed from the HCPCS as if it never existed because the National Panel made the decision to establish a National "A" code in its place. The code does not appear in the 2003 HCPCS.)**

DELETED 12/31/02: T1501 UNDERPAD, REUSABLE/WASHABLE, ANY SIZE, EACH (Short description: Reusable underpad)

## II. THE FOLLOWING NEWLY ESTABLISHED CMS MODIFIERS AND CODES ARE BEING ADDED EFFECTIVE JANUARY 1, 2003. THEY DID NOT APPEAR IN THE 2003 HCPCS UPDATE AS POSTED ON THE WEB ON OCTOBER 10, 2002. PLEASE ADD TO YOUR 2003 HCPCS DATABASE

**"Q" Code added effective January 1, 2003**

Q3000 SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT, RUBIDIUM RB-82, PER DOSE
(Short description: Rubidium RB-82)

**CMS Modifiers added effective January 1, 2003**

CA PROCEDURE PAYABLE ONLY IN THE INPATIENT SETTING WHEN PERFORMED EMERGENT ON AN OUTPATIENT WHO EXPIRES PRIOR TO ADMISSION
Short Description = Procedure payable inpatient)

CB SERVICE ORDERED BY A RENAL DIALYSIS FACILITY (RDF) PHYSICIAN AS PART OF THE BENEFICIARY'S BENEFIT, IS NOT PART OF THE COMPOSIT RATE, AND IS SEPARATELY REIMBURSABLE
(SHORT description = Separately reimbursable serv

********** **11/7/02/ckr**

**III. THE FOLLOWING HCPCS CODES AND MODIFIERS ARE BEING ADDED, REVISED, OR DISCONTINUED. EFFECTIVE DATES ARE AS SPECIFIED BELOW. THESE MODIFICATIONS TO THE HCPCS SYSTEM DID NOT APPEAR IN THE 2003 HCPCS UPDATE, AS POSTED ON OCTOBER 22, 2002 AT**
**http://www.cms.hhs.gov/medicare/providers/pufdownload/anhcpcdl.asp**
**PLEASE MAKE THE APPROPRIATE CHANGES TO YOUR 2003 HCPCS DATABASE.**

**"A" Codes modified effective April 1, 2003**

A4232 Change payment indicator to "i"

A4632 Change payment indicator to "i"

**"C" modifier revised, effective April 1, 2003**

CB Language of long and short descriptions revised to read as follows:
SERVICE ORDERED BY A RENAL DIALYSIS FACILITY (RDF) PHYSICIAN AS PART OF THE **ESRD** BENEFICIARY'S **DIALYSIS** BENEFIT, IS NOT PART OF THE COMPOSIT**E** RATE, AND IS SEPARATELY REIMBURSABLE
Short Description: ESRD bene part A SNF-sep pay

In addition, the effective date of the above code is changed from January 1, 2003 to April 1, 2003.

**"C" Code added effective January 1, 2003**

C1884 EMBOLIZATION PROTECTIVE SYSTEM
Short Description: Embolization protect syst

**"G" Code discontinued effective March 31, 2003** (Refer to replacement code Q3031)

G0025 COLLAGEN SKIN TEST KIT
Short Description: Collagen skin test kit

**"G" modifier added effective April 1, 2003**

| | |
|---|---|
| GF | NON-PHYSICIAN (E.G. NURSE PRACTITIONER (NP), CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA), CERTIFIED REGISTERED NURSE (CRN), CLINICAL NURSE SPECIALIST (CNS), PHYSICIAN ASSISTANT (PA)) SERVICES IN A CRITICAL ACCESS HOSPITAL<br>Short Description: Nonphysician serv C A Hosp |

**"G" Code discontinued effective March 31, 2003**

G0025

**"G" Code cancelled for implementation effective January 1, 2003**

G0296

**"H" Codes added effective April 1, 2003**

| | |
|---|---|
| H2010 | Comprehensive Medication Services, per 15 minutes<br>Short Description: Comprehensive med svc 15 min |
| H2011 | Crisis Intervention Service, per 15 minutes<br>Short Description: Crisis interven svc, 15 min |
| H2012 | Behavioral Health Day Treatment, per hour<br>Short Description: Behav Hlth Day Treat, per hr |
| H2013 | Psychiatric health facility service, per diem<br>Short Description: Psych hlth fac svc, per diem |
| H2014 | Skills Training and Development, per 15 minutes<br>Short Description: Skills Train and Dev, 15 min |
| H2015 | Comprehensive Community Support Services, per 15 minutes<br>Short Description: Comp Comm Supp Svc, 15 min |
| H2016 | Comprehensive Community Support Services, per diem<br>Short Description: Comp Comm Supp Svc, per diem |
| H2017 | Psychosocial Rehabilitation Services, per 15 minutes<br>Short Description: PsySoc Rehab Svc, per 15 min |

| | |
|---|---|
| H2018 | Psychosocial Rehabilitation Services, per diem<br>Short Description: PsySoc Rehab Svc, per diem |
| H2019 | Therapeutic Behavioral Services, per 15 minutes<br>Short Description: Ther Behav Svc, per 15 min |
| H2020 | Therapeutic Behavioral Services, per diem<br>Short Description: Ther Behav Svc, per diem |
| H2021 | Community-Based Wrap-Around Services, per 15 minutes<br>Short Description: Com Wrap-Around Sv, 15 min |
| H2022 | Community-Based Wrap-Around Services, per diem<br>Short Description: Com Wrap-Around Sv, per diem |
| H2023 | Supported Employment, per 15 minutes<br>Short Description: Supported Employ, per 15 min |
| H2024 | Supported Employment, per diem<br>Short Description: Supported Employ, per diem |
| H2025 | Ongoing Support to Maintain Employment, per 15 minutes<br>Short Description: Supp Maint Employ, 15 min |
| H2026 | Ongoing Support to Maintain Employment, per diem<br>Short Description: Supp Maint Employ, per diem |
| H2027 | Psychoeducational Service, per 15 minutes<br>Short Description: Psychoed Svc, per 15 min |
| H2028 | Sexual Offender Treatment Service, per 15 minutes<br>Short Description: Sex Offend Tx Svc, 15 min |
| H2029 | Sexual Offender Treatment Service, per diem<br>Short Description: Sex Offend Tx Svc, per diem |
| H2030 | Mental Health Clubhouse Services, per 15 minutes<br>Short Description:  MH Clubhouse Svc, per 15 min |
| H2031 | Mental Health Clubhouse Services, per diem<br>Short Description:  MH Clubhouse Svc, per diem |
| H2032 | Activity Therapy, per 15 minutes<br>Short Description: Activity Therapy, per 15 min |

H2033 Multisystemic Therapy for juveniles, per 15 minutes
Short Description: Multisys Ther/Juvenile 15min

H2034 Alcohol and/or Drug Abuse Halfway House Services, per diem
Short Description: A/D Halfway House, per diem

H2035 Alcohol and/or Other Drug Treatment Program, per hour
Short Description: A/D Tx Program, per hour

H2036 Alcohol and/or Other Drug Treatment Program, per diem
Short Description: A/D Tx Program, per diem

H2037 Developmental Delay Prevention Activities, Dependent Child of Client, per 15 minutes
Short Description: Dev Delay Prev Dp Ch, 15 min

**"K" Codes added effective April 1, 2003**

K0552 SUPPLIES FOR EXTERNAL INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH

K0560 METACARPAL PHALANGEAL JOINT REPLACEMENT, TWO PIECES, METAL (E.G., STAINLESS STEEL OR COBALT CHROME), CERAMIC-LIKE MATERIAL (E.G., PYROCARBON), FOR SURGICAL IMPLANTATION (ALL SIZES, INCLUDES ENTIRE SYSTEM)

K0600 FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATOIN OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM
Short Description: Functional neruomuscularstim

K0601 REPLACEMENT BATTERYFOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 1.5 VOLT, EACH
Short Description: Repl batt silver oxide 1.5 v

K0602 REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 3 VOLT, EACH
Short Description: Repl batt silver oxide 3 v

K0603 REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, ALKALINE, 1.5 VOLT, EACH
Short Description: Repl batt alkaline 1.5 v

**Multisystemic Therapy (MST) Specific Language for use in Requests for Proposals (RFP)**
Revision Date: 041011

**Contents:**



**MST Target Population & Local Statement of Need**
MST is designed to meet the needs of youth, 12 to 17 years old, at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system. The bidder must provide a detailed description of the targeted population.

**Exclusions:** The bidder must state that they will exclude the following youth:

- Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- Youth referred primarily due concerns related to active suicidal, homicidal, or psychotic behaviors or whose psychiatric problems are the primary reasons leading to referral, or who have severe and serious psychiatric problems.
- Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior).
- Youth with pervasive developmental delays.

The following information is provided to demonstrate the need for MST in the intended geographic service area:

- Number of new referrals to the juvenile justice system annually = _____
- Number of youth currently on probation = _____
- Number of probation youth arrested on at least 2 separate occasions = _____
- Number of youth placed out-of-home due to antisocial or delinquent behaviors in the last 12 months = _____
- Estimate of number of youth at risk of out-of-home placement = _____
- Estimate of number of youth that will be referred to MST annually = _____

If the bidder assumes that referral sources other than the justice system will be served by this program, the bidder must carefully describe the characteristics on the targeted youth and all relevant inclusion and exclusion criteria. All youth behavioral characteristics must fall within the range targeted by MST and supported in the MST research.

**Geographic service area targeted for proposal**
MST implements services in the client's home and community with services available to the client 24 hours per day and 365 days per year. Contact is often very frequent during the initial weeks of treatment, tapering toward the end of treatment. This requires that the targeted service area require no more that a 90-minute commute time from the most central point with the majority of clients within a reasonable distance within that limit.

Bidders must provide a detailed description of the service area based on time needed to reach the clients' homes. It is recommended that the description provide referral sources with a clear boundary to assure clear communication.

The geographic area should also detail any relevant or significant political (county, municipality), judicial, funding or management entity districts that would be included in the service area.

**Overview of MST**
Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multi-systemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

MST typically targets chronic, violent, and/or substance abusing juvenile offenders at high risk of (or returning from) out-of-home placement and their families.

MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which youth are embedded. MST strives to promote behavior change in the youth's natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate change.

The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

MST is provided using a home-based model of services delivery. This model helps to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists have low caseloads), and enhances the maintenance of treatment gains. The average duration of MST treatment is approximately 4 months.

Evaluations of MST have demonstrated:
- reduced long-term rates of criminal offending in serious juvenile offenders,
- reduced rates of out-of-home placements for serious juvenile offenders,
- extensive improvements in family functioning,
- decreased mental health problems for serious juvenile offenders,
- favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services.

**Program Capacity**
Program capacity reflects both the average caseload size as well as the average length of treatment of clients served. MST research has indicated that the return of improved client

outcomes tends to diminish after an average of 4 months of treatment, that is, longer treatment may not produce significantly improved results. Capacity can be significantly impacted by poor referral streams, therapist turnover and poor management of the resource of the therapist's time. Research has indicated that MST treatment typically lasts from 3 to 5 months (average of 4 months) and that caseloads range from 4 to 6 families (average of 5 families). Caseload size may be impacted by such characteristics as the average time of the cases in treatment on a caseload (newer cases require significantly more time), number of problem youth in the home and the relative complexity of the youth's behavior (e.g., youth with multiple distinct referral behaviors.)

In general, the bidder should calculate the program at full capacity by estimating that each therapist will treat 15 families per year. Any reduction to that estimate must be justified in the proposal. The bidder may estimate a slightly lower capacity (no less than 80% of full capacity) in the first program year due to various start-up factors.

**Referral Policy & Procedures**

The bidder will describe the intended referral process in detail. A flow chart is recommended but not required to illustrate the process. The proposal must include, but not be limited to the following:

- The name, address and contact person from each agency approved to make referrals directly to the MST program. This may include any community boards charged with the responsibility for managing referrals for services within the MST geographic service area.
- The method by which the MST program will advise each referral source of the availability of space in the MST program.
- The method by which intended referral will be screened to assure appropriateness for MST
- The method by which the targeted youth and family will be contacted to secure permission and commitment to engage in the program. Include timing requirements (e.g., "the family will be contacted within 72 hours of the receipt and acceptance of the referral.) Include how the family will be informed of the referral by the referring agency.
- The general guideline regarding communication with the referring agency after acceptance of the referral, or if the referral is not accepted for any reason.
- Any steps that are required to assure funding approval or court approval, if needed.

**Operational Timeline**

| Activity | Time Allocation | Target Completion Date |
|---|---|---|
| Pre-Bid Conference | 1 Day Meeting | Set by funding agency. |
| RFP Issue: Mail and Posting | 1 Day | Set by funding agency. |
| RFP Bidder Response Development | Typically 14-21 Days | Set by funding agency. |
| RFP Bidder Response Due | Date | Set by funding agency. |
| RFP Responses reviewed by Selection Committee | Typically up to 14 Days | Set by funding agency. |
| Final Selection Announced | Date | Set by funding agency. |
| MST Services Program Development Process | 30 – 90 Days starting at formal selection | |
| Site Readiness Review Meeting | 1 Day – within 60 days prior to startup. | |
| Physical Location Setup | Typically 30 Days prior to startup. | |
| Staff Recruitment | Typically 60 – 90 Days prior to startup. | |
| Accept Client Referrals | Typically 2-3 weeks prior to program startup | |
| MST 5-Day Orientation | 5 Consecutive Days – typically 60-90 days following initiation of staff | |

| | | |
|---|---|---|
| | recruitment. | |
| Program Startup (available to provide client services) | Typically the Monday following MST 5-Day Orientation | |
| Quarterly Boosters | 1.5 Days – 90 days following startup and every calendar quarter thereafter | |
| Initial Program Review (PIR) | 6 Month Period – 180 days following startup | |
| Subsequent PIRs | Every 6 Month Period | |

**Licensing and Program Requirements**
All programs must be licensed by MST Services prior to program startup. The bidder must state agreement to this requirement in the proposal, but holding a license at the time of proposal submission is not required. A letter of support for this proposal is recommended from MST Services, 710 Johnnie Dodds Blvd., Suite 200, Mt. Pleasant, SC 29464; (843) 856-8226. Administratively, the relationship is structured as a license agreement for MST between the Medical University of South Carolina (MUSC) and the bidder organization. MST Services is the MUSC-affiliated organization that grants these license agreements and provides the sole program development and training services in MST throughout the United States and internationally.

To insure qualification for licensure, the bidder must meet the following program requirements:

| | **MST Program Requirement** | **Evidence Required for Proposal** |
|---|---|---|
| 1 | MST Therapists are full-time employees assigned solely to the MST program. | Statement in proposal indicating that all MST therapists will be full-time employees of the bidder, and that the therapists will be assigned solely to MST. |
| 2 | MST Therapists do not have <u>any</u> non-MST program responsibilities in the agency, do not carry <u>any</u> additional non-MST cases, and do not have other part-time jobs outside of the agency. | Statement in proposal indicating agreement to this requirement. |
| 3 | MST staff are allowed to work a flexible schedule as needed to meet the needs of the families they are serving. | Statement in proposal indicating agreement to this requirement. |
| 4 | MST staff are allowed to use their personal vehicles to transport clients. | Agency policy regarding client transport in personal vehicles. |
| 5 | MST staff have use of either cellular phones or pagers so that clients can contact them quickly and conveniently. | Statement in proposal indicating agreement to this requirement. |
| 6 | MST Therapists operate in teams of no fewer than 2 and no more than 4 therapists (plus the Clinical Supervisor) and use a home-based model of service delivery. | Statement in proposal indicating agreement to this requirement. |
| 7 | MST Clinical Supervisor is assigned to the MST program a minimum of 50% time per MST Team. | Statement in proposal indicating agreement to this requirement. |
| 8 | MST Clinical Supervisor conducts weekly team clinical supervision, facilitates the weekly MST telephone consultation and is available for individual clinical supervision for crisis cases. | Statement in proposal indicating agreement to this requirement. |
| 9 | MST caseloads do not exceed 6 families per therapist and the normal range is 4 to 6 families per therapist. . | Statement in proposal indicating agreement to this requirement. |
| 10 | Overall average duration of treatment is 3 to 5 | Statement in proposal indicating |

| | | |
|---|---|---|
| | months. | agreement to this requirement. |
| 11 | Each MST Therapist tracks progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly. | Statement in proposal indicating agreement to this requirement. |
| 12 | The MST program has a 24 hour/day, 7-day/week on-call system to provide coverage when MST Therapists are on vacation or taking personal time. This system is staffed by members of the MST team. | Copy of proposed on-call system. |
| 13 | With the buy-in of other organizations and agencies, MST is able to "take the lead" for clinical decision-making on each case. Stakeholders in the overall MST program have responsibility for initiating these collaborative relationships with other organizations and agencies while MST staff sustain them through ongoing, case-specific collaboration. | Statement in proposal indicating community stakeholder agreement to this requirement. |
| 14 | The MST program excludes youth living independently, youth referred primarily for psychiatric service needs (i.e., suicidal ideation and behavior, actively homicidal, actively psychotic), youth referred primarily for sex offenses (in the absence of other antisocial/delinquent behaviors) and youth with pervasive developmental delays. | Statement in proposal indicating agreement to this requirement. |
| 15 | Referrals to non-MST compatible programs (e.g., any form of mandated group treatment, day treatment programs, etc.) are not made while youth are in MST, especially on a "standard" or routine basis. | Statement in proposal indicating agreement to this requirement. |
| 16 | MST program discharge criteria are outcome-based rather than duration-focused. | Statement in proposal indicating agreement to this requirement. |
| 17 | Referrals for additional services after clients are discharged from the MST program are carefully planned and limited to those that can accomplish specific, well-defined goals. The assumption is that most MST cases should need minimal "formal" after-care services. | Statement in proposal indicating agreement to this requirement. |
| 18 | All MST staff, who have been working for more than 2 months, participate in a 5-day orientation training. | Statement in proposal indicating agreement to this requirement. |
| 19 | MST Supervisor and Therapists are Masters-prepared (clinical-degreed) professionals. | Job description for MST therapist. |

| | **MST Recommended Program Practices** | **Evidence Required for Proposal** |
|---|---|---|
| 20 | MST Clinical Supervisors are, at minimum, highly skilled Masters-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy). | Job description for MST Supervisor. |
| 21 | MST Clinical Supervisors have both clinical authority and administrative authority over the | Organizational chart indicating line of authority for MST and position of |

| | | |
|---|---|---|
| | MST Therapists they supervise. | program within bidder's organization. |
| 22 | A "Goals and Guidelines" document is in place. If multiple referral or funding sources exist, separate "Goals and Guidelines" documents are recommended for each. | Statement in proposal indicating agreement to this requirement. |
| 23 | Funding for MST cases is in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, "productivity", etc. | No statement required for this proposal. The funding agency has already determined the reimbursement system. |
| 24 | The MST program has formal outcome-tracking systems in place. | Statement of what data will be collected, by whom, how often, by what method, how the data will be stored, and how data will be analyzed. (See Program Evaluation Section) |
| 25 | Adequate flex funds are allocated per family (recommended $100/family) to allow therapists to use funds for purposes such as engagement building and one-time help for families with pressing practical needs. | Statement in proposal indicating agreement to this requirement. |
| 26 | The MST program uses outcome-focused personnel evaluation methods. | **Not required**, but if intended, statement in proposal indicating agreement to this requirement. |

**Staff Training Requirements**
The Bidder MST program staff shall be trained by MST Services of Charleston, South Carolina or a licensed MST Network Partner organization. The cost of this training is

Option 1: "is covered by the funding agency and is not to be included in the bid. "
Option 2: "should be included in the budget proposed by the bidder."

This training will include both pre-service and ongoing in-service training and consultation. Training and consultation for clinical staff shall be provided in three ways.

First, five days of intensive orientation training shall be provided for all staff who will engage in treatment and/or clinical supervision of MST cases. Second, one and one-half day booster sessions shall occur on a quarterly basis. Third, treatment teams and their supervisors shall receive weekly telephone consultation from trained MST staff.

The objectives of the initial five-day training program shall be:

- to familiarize participants with the scope, correlates, and causes of the serious behavior problems addressed with MST treatment;
- to describe the theoretical and empirical underpinnings of MST;
- to describe the family, peer, school, and individual intervention strategies used in MST;
- to train participants to conceptualize cases and interventions in terms of the principles of MST; and
- to provide participants with practice in delivering multi-systemic interventions.

The multi-media approach to training includes didactic and experiential components. The participants are required to practice the MST approach through critical analysis, problem solving exercises and role-plays. It is expected that participants will have read the MST treatment manual (textbook) prior to the initial training.

Quarterly booster sessions are designed to provide training in special topics related to the target populations/problems being treated by the MST therapists/clinicians, and to address issues that may arise for individuals and agencies using the approach (e.g., ensuring treatment integrity, individual and agency accountability for outcomes, inter-agency collaboration, etc.). The booster sessions are also designed to allow for discussion of particularly difficult cases.

Weekly telephone consultation is provided via one-hour conference calls in which the treatment team and supervisor consult with the MST Services (or MST Network Partner) Expert regarding case conceptualization, goals, intervention strategies, and progress. The weekly consultation is designed to assist the team and supervisor in clearly articulating treatment priorities, identifying obstacles to success, and developing strategies aimed at successfully navigating those obstacles. In addition to this weekly consultation, it is expected that the contractor will provide onsite supervision by staff who have obtained an advanced degree in a clinical discipline (i.e., psychology, counseling, social work, psychiatry) and have had additional clinical experience with family-based services prior to receiving MST training.

All MST therapists/clinicians and MST supervisors shall attend all required training.

**Service Plan Development Requirements**
The Bidder shall state agreement to the following requirements for service plan development:

- Identify the multiple determinants of anti-social behavior for each case.

- Identify and document the strengths and needs of the adolescent, family, and the extra-familial systems (e.g.; peers, school, neighborhood, etc.).

- In collaboration with family members, identify and document problems throughout the family and extra-familial systems (e.g.; peers, school, neighborhood, etc.) that explicitly need to be targeted for change.

- Require MST therapists to write a service plan for each family. This plan will incorporate the desired outcomes of the key participants/ stakeholders involved in the family's treatment (e.g.; parents, probation, social services, school personnel, etc.). This plan shall be sent to the referring agency caseworker/client manager within ____ days from the time of referral to MST. The treatment plan will identify family/client strengths, help the client/family define specific goals, provide instruction in ways to prevent the recurrence of delinquent behavior and other family conflict, and set up resources and skills to maintain ongoing progress.

- Have the MST supervisor review and approve all service plans.

**Service Provision Requirements**
The Bidder shall state agreement to the following requirements for service provision:

1) Have MST therapists attempt face-to-face contact with each family within 24 hours (immediately, if an emergency) from time of referral to MST. If unable to make face-to-face contact within 24-72 hours, the referring unit of the agency shall be notified immediately.

2) Provide comprehensive MST treatment to each family that is individualized and family-centered. The treatment process shall begin with goal setting that addresses the changes that the family would like to see over the treatment period (typically, approximately four months). This process shall focus on specific areas of action to be addressed on a daily or weekly basis. Any barriers to treatment success shall be addressed as soon as they are identified.

3) Collaborate with the family in developing an enduring social support network in the natural environment.

4) Have MST therapists provide a range of goal-directed services to each client/family that may include but shall not be limited to:

a) Improving parenting practices.

b) Increasing family affection.

c) Decreasing association with deviant peers.

d) Increasing association with pro-social peers.

e) Improving school/vocational performance.

f) Engaging youth/family in positive recreational activities.

g) Improving family/community relations.

h) Empowering family to solve future difficulties.

i) Teaching appropriate parenting skills, such as:

- Alternatives to corporal punishment.
- Appropriate supervision of children.
- Age appropriate expectations.
- Choices and consequences.
- Displays of greater parent/child affection and trust.

j) Family and marital interventions consistent with MST principles.

k) Individual interventions for parents and youth consistent with MST principles.

l) Aiding the family in meeting concrete needs such as housing, medical care and legal assistance and assisting in making available follow-up support resources as needed.

m) Teaching the family organizational skills needed to provide a positive environment (e.g. teaching budgeting skills, etc.).

n) Referring and linking the family with follow-up services when necessary to ensure continued success meeting the family's MST treatment goals.

o) Transporting youth/family when necessary and facilitating family plans to access transportation themselves on an ongoing basis.

p) Providing services in the client's home, or, at the client's request, at a location mutually agreed upon by the therapist and client.

q) Having MST therapists provide services to the youth/family for an average of four months. If needed, a family responding positively to treatment, may receive services for a longer duration for more difficult problems, if approved in writing by the referring agency.

r) Providing a termination or extended services request

- At the end of four months, submit a progress report to referring agency.
- Discuss termination recommendations with the referring agency representative, in person. The staffing shall occur no later than seven days prior to the anticipated closure of the case. A written termination report, using the required agency format, shall be submitted to the referring worker no later than seven days after the case closure. The client's family may be invited to attend the staffing. The termination report shall be approved, in writing, by the MST supervisor.
- Conduct a termination interview with the family to summarize the progress made during treatment, options to maintaining progress, and the family's satisfaction with the MST services provided. The referring caseworker/client manager should be invited to the termination interview.
- Contact the youth and the most involved parent in each family served by MST and administer a follow-up evaluation at __, ___ and ___ months after termination according to guidelines established by the department/agency contract. If a home visit is not possible, a telephone contact shall be made and documented. This evaluation shall determine the status of the family and whether placement of the youth has occurred.

**Quality Assurance Requirements**
The Bidder shall state agreement to the following requirements for Quality Assurance:

1) Register the program and all staff at the MST Institute (www.mstinstitute.org).

2) Register each family treated at the MST Institute secure website using HIPPA approved procedures.

3) Complete termination summaries on all families and close out each terminated family on the MST Institute secure website.

4) Complete yearly evaluations of workers to assess knowledge of and compliance with, MST philosophy and intervention strategies. MST adherence data may be used as part of this worker evaluation.

5) Participate in quality assurance evaluation activities as designated by the agencies. Activities include, but are not limited to group meetings, site visitations, audio-taped reviews of direct sessions, and peer review of policies and procedures.

6) Monitor the adherence of program staff to the MST model by collecting the MST Therapist Adherence Measure -Revised (TAM-R) data as specified by MST Services. In addition, MST therapists are required to complete the MST Supervisory Adherence Measure (SAM) at least bi-monthly by logging on directly to the MST Institute website.

Option 1: “The bidder must contract with the MST Institute for the collection of TAMs using a designated call center. The bidder must state that full cooperation will be offered to assure timely collection of TAM-R data.”

Option 2: “The agency must provide a detailed description of how TAM-R data will be collected and how data will be entered onto the MSTI secure website. The data collection and scoring of these measures is estimated to take one and ½ hours of administrative time per week per MST staff member (a total of six hours per week of administrative time for a team consisting of a supervisor and four therapists).”

**Records maintenance and reporting Requirements:**
The Bidder shall state agreement to the following requirements for records maintenance and reporting:

1) Maintain a case record for each case accepted. This record shall include, but is not limited to, the following:

    a) Client referral sheet.

    b) Date of initial request for service (i.e., Referral Date).

    c) Results of the strength and needs assessment.

    d) Service plan.

    e) Goal attainment summary.

    f) Ongoing progress reports, at least monthly.

    g) Placement status determination, including date.

    h) Termination summary.

    i) Other material as may be specified by the referring agency/department.

2) Collect, maintain and report to the agency, on a quarterly basis, information documenting progress towards achieving the program outcome objectives.

3) Allow department/agency representatives full access to all case files and administrative records for the purpose of contract monitoring.

**Local Stakeholder Support**
Letters of support from local stakeholders are requested as evidence of community commitment to implementing the MST Program. Letters generally fall into one of four categories:
1) Stakeholders contributing funding to support the program: These letters should describe the structure and amount of the funding.
2) Stakeholders making referrals to the program: These letters should describe the type and number of referrals expected on an annual basis.
3) Stakeholders collaborating with the program: These letters should provide indications of how the stakeholder agency will support the MST program through collaboration.
4) MST Services letter of support: This letter documents that the bidder has made contact with MST Services and that MST Services will support the bidder if successful.

**Technical Assistance from MST Services**

Option 1: “Bidders are free to contact MST Services for technical assistance in the completion of this proposal. The contact information is:”

**For more information**

**MST Services**

**San Francisco**
1100 Moraga Way
San Francisco, CA 94556

**Atlanta**
3490 Piedmont Rd NE
Suite 304
Atlanta, GA 30305

843.856.8226
www.mstservices.com info@mstservices.com

Option 2: “Bidders are requested to not contact MST Services directly for technical assistance. Instead, all questions and requests for information must be directed to: NAME & CONTACT INFORMATION”