

LME-MCO Alternative Service Request Form for Use of DMHDDSAS State Funds For Proposed MH/DD/SAS Service Not Included in Approved Statewide NCTracks Service Array

Approved: 04-22-08

Revised: 3/20/2017

Note: Submit completed request form electronically to the State Services Committee via ContactDMHQuality@dhhs.nc.gov and DMHRateRequests@dhhs.nc.gov. Also copy the Division Liaison assigned to your LME-MCO.

a. Name of LME-MCO Cardinal Innovations Healthcare		b. Date Submitted originally submitted: 11/26/2019 Resubmitted 3-24-2020
c. Name of Proposed LME-MCO Case Support YP215		
d. Type of Funds and Effective Date(s): <i>(Check and Complete Applicable Dates)</i> State Funds Only: ☒ Effective <u>12/01/2019</u> ☒ New Request ☐ Revision to Previously Approved Alternative Service		
e. Submitted by LME-MCO Staff (Name & Title) Emily Bridgers Regulatory Affairs Manager	f. E-Mail Emily.Bridgers@cardinalinnovations.org	g. Phone No. 704-939-7891 704-467-4552
Instructions: This form has been developed to permit LME-MCOs to request the establishment in NCTracks of an Alternative Service to be used to track state funds through a unit-based tracking mechanism. Complete items 1 through 27, as appropriate, for all requests. LME-MCO Alternative Service Request for Use of DMHDDSAS State Funds		
Requirements for Proposed LME-MCO Alternative Service <i>(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)</i>		
1	Alternative Service Name, Service Definition and Required Components <i>(Provide attachment as necessary)</i> Case Support YP215	
2	Rationale for proposed adoption of LME-MCO Alternative Service to address issues that cannot be adequately addressed within the current NCTRACKS Service Array Consumer access issues to current service array	

	• Consumer barrier(s) to receipt of services • Consumer special services need(s) outside of current service array • Configuration and costing of special services • Special service delivery issues • Qualified provider availability • Other provider specific issues This service is designed to augment member care by allowing providers to complete tasks, which have otherwise not been completed by providers because there was no reimbursement method for these activities. Or providers have completed but this is not sustainable without funding to support. It allows providers to coordinate with all agencies who may be involved in the member's care. This service will be solely for uninsured members that have no other funding stream (Medicaid, private insurance) and may assist as applicable these members in applying to access those benefits. These services will be limited to those outpatient providers that serve as a safety net provider in the local community for the indigent population and will be utilized to assist member not only in linkage to appropriate behavioral health services, but medical services, community services, and other needed supports. This service will also be used to fill in treatment gaps when members are unable to receive their typical site-based programming activities or face-to-face services, but those providers are still able to provide supports to the members through telephonic or tele-health methods.
3	Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition or clinical policy The service includes activities with and/or on behalf of a recipient of MH/DD/SA services including: case support activities performed by an individual at a provider agency for members that do not have other services in place that would be responsible for these case support activities. The service is designed to meet some of the broad healthcare needs, educational, vocational, residential, financial, social and other non-treatment needs of the individual. The service includes the arrangement, linkage or integration of multiple service and providers involved in the member's care. This includes making referrals to enhanced service providers and following up to ensure services are initiated. Interventions include strategies and actions for the purposes of coordination treatment and assisting the member in connection to community supports. These are typically associated with members receiving services through the walk-in clinic or advanced access provider, or may be provided as a follow up after acute crisis episode when enhanced services are not clinically indicated but some time limited periodic support is needed to ensure successful stabilization after these treatment episodes. The following strategies and actions may occur in addition to the above treatment intervention. Note this is not an all-inclusive list but some typical activities. 1. Activate referrals and connections to other providers 2. Initiate bed finding/placement activities 3. Assist in connection to housing resource 4. Monitor individual's safety, medical and psychiatric status (beyond time spent in the clinical activities) 5. Provide food, hydration, and comfort items for those individuals where this is needed to stabilize 6. Peer Support Specialist services to educate on WRAP plans, Advanced Directives, etc. (time limited while at the clinic, may also link member to Peer Support Services for ongoing support) 7. Provide community resource information 8. Assist in benefit coordination, inclusive of assisting member to complete paperwork to apply for needed benefits 9. Assist in applying for patient assistance programs for medication or 10. Assist in coordination with physical health providers including linkage and referral to these providers 11. Identify natural supports 12. Monitor as needed based on first evaluations where transfer to more intensive services in needed and is being coordinated.

4	Please indicate the LME-MCO's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME-MCO Alternative Service: (Check one) ☐ Recommends ☐ Does Not Recommend ☐ Neutral (No CFAC Opinion) Due to the tight turnaround of the timing of this submission, the proposed service will be advance to CFAC for review but was not completed prior to this submission.
5	Projected Annual Number of Persons to be Served with State Funds by LME-MCO through this Alternative Service Approximately 5000 members are estimated
6	Estimated Annual Amount of State Funds to be Expended by LME-MCO for this Alternative Service \$300,000
7	Eligible NCTracks Benefit Plan(s) for Alternative Service: (Check all that apply) <u>Assessment Only:</u> ☐ GAP <u>Child MH:</u> ☒ All ☐ CMSED <u>Adult MH:</u> ☒ All ☐ AMI <u>Child DD:</u> ☒ CDSN <u>Adult DD:</u> ☒ All ☐ ADSN <u>Child SA:</u> ☒ All ☐ CSSAD <u>Adult SA:</u> ☒ All ☐ ASCDR ☐ ASWOM ☐ ASTER <u>Veteran:</u> ☒ AMVET
8	Definition of Reimbursable Unit of Service: (Check one) ☐ Service Event ☒ 15 Minutes ☐ Hourly ☐ Daily ☐ Monthly ☐ Other: Explain _____
9	Proposed NCTracks <u>Maximum</u> Unit Rate for LME-MCO Alternative Service Since this proposed unit rate is for Division funds, the LME-MCO can have different rates for the same service within different providers. What is the proposed <u>maximum</u> NCTRACKS Unit Rate for which the LME-MCO proposes to reimburse the provider(s) for this service? \$25.00
10	Explanation of LME-MCO Methodology for Determination of Proposed NC Tracks <u>Maximum</u> Unit Rate for Service (Provide attachment as necessary) The historic rate paid for case support ranged from \$15-\$25 per unit, this is the current estimate of what will be paid to provider for this time. Because various levels of staff may provide this (Clinician, Peer Support Specialist, QP, AP, etc.). Typical hourly rates for staff were considered and average for this rate.

11	Provider Organization Requirements Case Support must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. Provider must be approved by the LME/MCO to deliver this service.
12	Staffing Requirements by Age/Disability <i>(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)</i> Persons who meet the requirements specified for professional or paraprofessional status for the appropriate disability population or qualified professional or paraprofessional status for the appropriate disability population according to 10 NCAC 14V.
13	Program and Staff Supervision Requirements Supervision is provided according to supervision requirements specified in 10 NCAC 14V and according to licensure/certification requirements of the appropriate discipline.
14	Requisite Staff Training Staff will receive training based on the functions they are performing as part of this service. For Paraprofessional staff performing case support functions, the agency will have an outlined training plan for these staff, including escalation training for additional support by clinical staff when indicated.
15	Service Type/Setting • Location(s) of services • Excluded service location(s) This is an indirect periodic service where the case support staff arranges, coordinates, and monitors services on behalf of the recipient. This service is not billable to Medicaid. This service is provided in any location.
16	Program Requirements • Individual or group service • Required client to staff ratio (if applicable) • Maximum consumer caseload size for FTE staff (if applicable) • Maximum group size (if applicable) • Required minimum frequency of contacts (if applicable) • Required minimum face-to-face contacts (if applicable) Includes face-to-face and telephone time in contact with the member, collateral, and other agency personnel. This service can also be delivered via tele-health. The frequency and amount of this service is based on the individual's needs. The activities must be directly related to support to the member and not strictly for administrative activities such as scheduling clinic appointments, appointment reminders, forwarding messages to staff, phone calls for cancellation of appointments, etc. • Staff Travel Time is not covered under this service • Preparation or completion of documentation such as service notes, time sheets, etc. is not covered under this service • Structured services including Evaluations, Outpatient Treatment/ Habilitation or After-hours services are to be reported to the appropriate service type. • This service is not utilized for members that have enhanced services in place that are actively still being delivered, or services that are expected to provide case support activities.

17	Entrance Criteria • <i>Individual consumer recipient eligibility for service admission</i> • <i>Anticipated average level of severity of illness, or average intensity of support needs, of consumer to enter this service</i> The recipient is eligible for this service when: A. The individual meets a State Benefit Plan eligibility criteria AND B. There is a DSM-5 diagnosis present, or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a). AND C. Level of Care Criteria, LOCUS/CALOCUS, ASAM, or SNAP/SIS deemed eligible for services based on a documented developmental delay or disability. AND D. The recipient is experiencing difficulties in at least one of the following areas: 1. Needs assistance applying for Medicaid 2. Has financial concerns, but is unsure what resources may be available. 3. Has unmet, identified, needs from multiple agencies. 4. Needs advocacy and service coordination to direct service provisions from multiple agencies.
18	Entrance Process Identification of a member's need for Case Support would be identified at the time of the provider assessment or presentation to a walk-in clinic/open access or may be identified by providers having to suspend typical operations due to the pandemic. This service should be part of the individual's treatment plan and have a valid service order prior to service initiation, but when utilized for the pandemic this may be completed retroactively. Screening should occur prior to service initiation that members does not have any other active services that would duplicate interventions and determine the treatment modalities for safe delivery of the service for the member and provider.
19	Continued Stay Criteria • <i>Continued individual consumer recipient eligibility for service</i> The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply: A. Recipient has achieved initial service plan goals and additional goals are indicated. B. Recipient is making satisfactory progress toward meeting goals. C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved. D. Recipient is not making progress; the service plan must be modified to identify more effective interventions. E. Recipient is regressing; the service plan must be modified to identify more effective interventions. F. Recipient has not been linked to other more appropriate behavioral health services.
20	Discharge Criteria • <i>Recipient eligibility characteristics for service discharge</i> • <i>Anticipated length of stay in service (provide range in days and average in days)</i> • <i>Anticipated average number of service units to be received from entrance to discharge</i> • <i>Anticipated average cost per consumer for this service</i>

	Consumer's level of functioning has improved with respect to the goals outlined in the service plan, or no longer benefits from this service. The decision should be based on one of the following: 1. Consumer is not making progress, or is regressing, and all realistic treatment options within this modality have been exhausted. 2. Consumer has moved to a bundle service where case support activities are included.
21	Evaluation of Consumer Outcomes and Perception of Care The expected outcome of this service is to support consultation with other agencies and professionals who are assessing and addressing the identified cognitive and behavioral deficits of the recipient and to facilitate referrals to appropriate treatment services on a short-term basis. Agencies will evaluate this service as part of overall satisfaction surveys. Utilization of this service will also be monitored to ensure that this is not utilized as a replacement for other more appropriate basis and that this is not used on a long-term basis but as a time limited support for activities that are not otherwise included in other services but help address behavioral health needs and other social determinant of health needs.
22	Service Documentation Requirements • <i>Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record?</i> ☒ Yes ☐ No <i>If "No", please explain.</i> Documentation is required of this service should be maintained in the provider's medical record for the individual and a full service note is required for all dates of service. This should include a note of the activities performed, amount of time spent, agencies contacted, if applicable, and signature and credentials of the individual providing the service. Service orders can be completed by fully licensed clinicians or for IDD-Qualified professionals.
23	Service Exclusions • <i>Identify other service(s) that are limited or cannot be provided on the same day or during the same authorization period as the proposed Alternative Service</i> This service should not be provided to members linked with enhanced services when these are actively being provided. This service also cannot be provided to members receiving Comprehensive Clinical Supports. Specifically, if members are actively receiving Assertive Community Treatment (ACTT), Community Support Team (CST), Substance Abuse Intensive Outpatient (SAIOP), Substance Abuse Comprehensive Treatment (SACOT), Intensive In-Home Services (IIHS), Multi-Systemic Therapy (MST), High Fidelity Wraparound Services or other services that already have case support activities included.
24	Service Limitations • <i>Specify maximum number of service units that may be reimbursed within an established timeframe (day, week, month, quarter, year)</i> 20 units per day (5 hours) is the maximum. It is not expected that this high of a frequency would be ongoing. Using the maximum hours would be time limited while connecting an individual to a more intensive service. Typical utilization would be expected to be up to 8 units on a given day, and for most members this would not be a daily service. The service can be delivered up to daily for members that need specific daily support due to social isolation due to the pandemic, who require daily check in for medication reminders, etc. The records should clearly support the reason for this frequency, and these would typically be limited to 1-2 units per day.
25	Evidence-Based Support and Cost Efficiency of Proposed Alternative Service

	• Provide other organizational examples or literature citations for support of evidence base for effectiveness of the proposed Alternative Service This service is based upon clinical judgment of member's support needs. There is evidence that supports that when members broader needs are addressed, they show increased stability with managing behavioral health needs, and a reduction in crisis episodes.		
26	LME-MCO Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service Cardinal Innovations Healthcare Quality Management Department will monitor this service for quality and fidelity to the definition through billing audit review. Service utilization will be monitored at least quarterly.		
27	A. Is this a service currently being covered under Medicaid waiver ['in lieu of' or b(3)] or using local or other non-state funds? ☐ Yes ☒ No (skip to B)- A.1. If YES, date begun under ☐ Medicaid waiver ☐ Non-state funds Date: If pending Medicaid review, date submitted: __/__/__ A.2. If the service requested here is not the same, please describe variation and why: B. If NO to 27A, will this service be submitted to Medicaid for consideration as an 'in lieu of' or b(3) service in the next year? ☐ Yes ☒ No		
Division Use Only			
28	Division Additional Explanatory Detail (as needed)		
29	Division Review, Action, and Disposition	Date Completed	Responsible Party