

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		b. Date Submitted	
Alliance Health		4/17/20	
c. Name of Proposed LME-MCO Alternative Service			
Psychosocial Rehabilitation (PSR) During Disaster			
d. Type of Funds and Effective Date(s): (Check and Complete Applicable Dates)			
State Funds Only: ☐ Effective ___/___/___ to End of Fiscal Year ☒ New Request ☐ Revision to Previously Approved Alternative Service			
e. Submitted by LME-MCO Staff (Name & Title)		f. E-Mail	
Carlyle Johnson, Ph.D.		cjohnson@alliancehealth.org	
		g. Phone No.	
		(919) 651-8415	
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>See attached Medicaid In Lieu Of Service Request</i>		
2	Rationale for proposed adoption of LME-MCO Alternative Service to address issues that cannot be adequately addressed within the current NCTRACKS Service Array In situations such as natural disasters and pandemics that limit service access, this service definition allows increased flexibility to provide an array of individualized services through a combination of in-person and virtual communication approaches, to promote continued engagement in care.		

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 <i>See attached Medicaid In Lieu Of Service</i>
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 urgent need for submission during 2020 coronavirus pandemic, time was not available to request CFAC input
5	Projected Annual Number of Persons to be Served with State Funds by LME-MCO through this Alternative Service <i>N/A: Since this service will be used during declared state and national disasters, the estimated number served will vary depending upon the unique circumstances of the disaster, including the type, breadth and duration of the emergency situation. The number served through this service is expected to be the same or lower than the number that would have been served through the non-disaster service equivalent.</i>
6	Estimated Annual Amount of State Funds to be Expended by LME-MCO for this Alternative Service <i>N/A: Since this service will be used during declared state and national disasters, the estimated amount of state funds to be expended will vary depending upon the unique circumstances of the disaster, including the type, breadth and duration of the emergency situation. The number served through this service is expected to be the same or lower than the number that would have been served through the non-disaster service equivalent.</i>
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 \$5.89 per 15 minute unit <i>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?</i> \$5.89 per 15 minute unit
10	Explanation of LME-MCO Methodology for Determination of Proposed NCTracks <u>Maximum</u> Unit Rate for Service <i>(Provide attachment as necessary)</i> <i>See attached Medicaid In Lieu Of Service</i>
11	Provider Organization Requirements Psychosocial Rehabilitation services shall be delivered by a team of practitioners employed by mental health, substance abuse, or intellectual or developmental disability provider organizations that meet the requirements of 10A NCAC 27G and the provider qualification policies, procedures, and standards established by DMH/DD/SAS. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being credentialed by the LME-MCO. Additionally, the organization shall achieve national accreditation with at least one of the designated accrediting bodies within one year of enrollment as a provider with the LME-MCO. The organization shall be established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina, capable of meeting all of the requirements of the LME-MCO credentialing process, DMH/DD/SAS Communication Bulletins, the DMH/DD/SAS Records Management and Documentation Manual, and service implementation standards. The provider organization shall comply with all applicable federal and state requirements. During periods of declared state or national emergencies when in-person attendance will be limited or not allowed, this service allows provision of remote PSR services to members at community locations, through the use of a range of electronic and telecommunication approaches. Providers must be able to provide services through telehealth and telephonic means and must ensure that staff supervision requirements are met through telephonic/telehealth.
12	Staffing Requirements by Age/Disability The program shall be under the direction of a person who meets the requirements specified for QP status according to 10A NCAC 27G .0104. The QP is responsible for supervision of other program staff, which may include APs and Paraprofessionals who meet the requirements according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served.
13	Program and Staff Supervision Requirements <i>See Staffing Requirements by Age/Disability above</i>
14	Requisite Staff Training <i>All staff will complete required training as described in Clinical Coverage Policy 8-A and as required by DHHS and Alliance Health.</i>
15	Service Type/Setting Psychosocial Rehabilitation is a service that shall be available five hours a day minimally and the setting shall meet the licensure requirements of 10A NCAC 27G .1200. During periods of

	designated state or national emergencies, these services may be provided from non-facility locations such as staff residences or community settings.
16	Program Requirements This service is to be available for a period of five or more hours per day, at least five days per week, and it may be provided on weekends or in the evening. The number of hours that an individual receives PSR services must be specified in his or her PCP. If the PSR provider organization also provides Supported Employment or Transitional Employment, these services are to be reported separately including reporting of separate costs.
17	Entrance Criteria The individual is eligible for this service when all of the following criteria are met: A. There is a mental health diagnosis present; B. Level of Care Criteria are met; C. The individual has impaired role functioning that adversely affects at least two of the following: a. employment, b. management of financial affairs, c. ability to procure needed public support services, d. appropriateness of social behavior, or e. activities of daily living; and D. The individual's level of functioning may indicate a need for psychosocial rehabilitation if the individual has unmet needs related to recovery and regaining the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.
18	Entrance Process Individuals are referred to this service after completion of a comprehensive clinical assessment for individuals who are initiating treatment. Individuals may also transition to this service as a referral from other levels of care such as outpatient services and Community Support Team
19	Continued Stay Criteria The individual is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's Person Centered Plan or the individual continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following applies: A. The individual has achieved initial rehabilitation goals in the Person Centered Plan goals, and continued services are needed in order to achieve additional goals. B. The individual is making satisfactory progress toward meeting rehabilitation goals. C. The individual is making some progress, but the specific interventions need to be modified so that greater gains, which are consistent with his or her rehabilitation goals, are possible or can be achieved. D. The individual is not making progress; the rehabilitation goals must be modified to identify more effective interventions. E. The individual is regressing; the Person Centered Plan must be modified to identify more effective interventions.
20	Discharge Criteria The individual meets the criteria for discharge if any one of the following applies: The individual's level of functioning has improved with respect to the rehabilitation goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and ANY of the following applies: A. The individual has achieved rehabilitation goals, discharge to a lower level of care is indicated. B. The individual is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted. C. The individual requires a more intensive level of care or service.

	Providers are encouraged to err on the side of caution related to any potential discharges during periods of recognized state or national disasters, recognizing that many community and social supports may not be readily available.
21	Evaluation of Consumer Outcomes and Perception of Care This service includes interventions that address the functional problems associated with complex or complicated conditions related to mental illness. These interventions are strength- based and focused on promoting recovery, symptom stability, increased coping skills and achievement of the highest level of functioning in the community. The focus of interventions is the individualized goals related to addressing the individual's daily living, financial management and personal development; developing strategies and supportive interventions that will maintain stability; assisting the individual to increase social support skills that ameliorate life stresses resulting from his or her mental illness.
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> Minimum standard is a full weekly service note.
23	Service Exclusions PSR may not be provided during the same authorization period with the following services: Partial Hospitalization and ACTT.
24	Service Limitations <i>Maximum of 10 hours (40 units) per week</i>
25	Evidence-Based Support and Cost Efficiency of Proposed Alternative Service This service is a modification of an existing service, during a period of state or national disaster, to improve the capacity of the service provider to maintain continuity of care. There is strong empirical evidence supporting both the clinical benefits and the cost efficiency of services that improve access to care.
26	LME-MCO Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service Due to the unpredictable and variable nature of community disasters, monitoring approaches will be tailored to unique characteristics of each disaster period. Priority will be given to monitoring of member continuity of care and provider capacity to maintain service continuity.
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: <u>3/10/20</u> If pending Medicaid review, date submitted: <u> </u>/<u> </u>/<u> </u> 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 <i>See attached Medicaid In Lieu Of Service Definition</i>		
Division Use Only			
28	Division Additional Explanatory Detail (as needed)		
29	Division Review, Action, and Disposition	Date Completed	Responsible Party