



## North Carolina Department of Health and Human Services

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### MEMORANDUM

**TO:** Legislative Oversight Committee Members  
Local CFAC Chairs  
NC Council of Community Programs  
County Managers  
State Facility Directors  
LME Board Chairs  
Advocacy Organizations  
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS  
State CFAC  
NC Assoc. of County Commissioners  
County Board Chairs  
LME Directors  
DHHS Division Directors  
Provider Organizations  
NC Assoc. of County DSS Directors

**FROM:** Dr. Craigan L. Gray  
Leza Wainwright *lw*

**SUBJECT:** Implementation Update #59  
CAP MR/DD Update  
Proposed Service Definition Revisions  
Role of the Licensed Professional in a CS Agency  
DMH/DD/SAS Stakeholder CM Workgroup

Community Support Steering Committee  
Residential Level III and IV  
Communication

### CAP-MR/DD Update (Released as a CAP Update on 7-21-09 REVISED for Implementation Update)

#### Proposed Reduction in State Funds for Individuals Receiving CAP-MR/DD Funding

Per proposed legislation, SB202, SECTION 10.21B “*CAP-MR/DD recipients are not eligible for any State-funded services except for those services for which there is not a comparable service in the CAP-MR/DD waiver. The excepted services are limited to guardianship, room and board, and time-limited supplemental staffing to stabilize residential placement.*”

Therefore, if the proposed legislation is codified, **for individuals who receive CAP-MR/DD funding, state funded services will no longer be available except for the following: room and board, guardianship, and time-limited supplemental staffing during transition to a residential placement.**

Based on these *pending* changes, the Local Management Entities (LME) have been working with case managers and provider agencies to determine services and supports needed for individuals who have been receiving both CAP-MR/DD funds and State funded services. In these individual reviews conducted by the LMEs some individuals may meet medical necessity criteria for specific CAP-MR/DD services that would meet the service/support need previously provided by State funded services/supports. In these cases, the case manager in concert with the individual, guardian/family and the planning team, can complete a plan of care/person centered plan (POC/PCP) revision to request additional CAP-MR/DD services.

**In all cases services/supports may only be requested when the individual meets the medical necessity criteria for the specific CAP-MR/DD service. The LME should not terminate or reduce the state-funded services if a revised plan**

**will be submitted to ValueOptions until the revised Person Centered Plan has had time to be processed through ValueOptions.**

This communication is to provide guidance and requirements related to submission of POC/PCP revisions to ValueOptions. Case managers will complete the POC/PCP revision and cost summary including specific language regarding the State funded service previously provided with justification/medical necessity for the additional CAP-MR/DD services and supports. The cost summary will include the specific State funded services previously received, including the name of the State service, frequency received, beginning and end dates. **This requirement is effective for all POC/PCP revisions related to the reduction in State funds submitted to ValueOptions on or after July 27, 2009.** Questions regarding this requirement should be directed to the Local Management Entity.

#### **Required Documents for DD Submissions to ValueOptions**

An incomplete submission for a recipient age 21 and over will be returned to the case manager as Unable to Process and the case manager must resubmit the entire request. An incomplete submission for a recipient under age 21 will be handled under Lack of Information procedures. In an effort to provide clarification the following are the required documents for DD submissions to Value Options for review to occur:

#### **Continued Need Review (CNR): CAP**

- PCP with signatures and cost summary
- MR2
- CTCMs – all services requested and Targeted Case Management
- NC SNAP (four pages and Summary Report/Supplemental Information sheet)
- For equipment/supplies – justification/assessment, physician order or prescription, price quote (two quotes required for Home Modifications/ Augmentative Communication /Vehicle Adaptation )
- Proof of insurance for Vehicle Adaptation
- Completed Risk Identification Tool
- Non CAP Medicaid supplies billed through the LME require prescriptions

#### **POC (Initial CAP)**

- PCP with signatures and cost summary
- MR2 with prior approval date and number
- CTCMs - all services requested and Targeted Case Management
- NC SNAP (four pages and Summary Report/Supplemental Information sheet)
- Current Psychological
- For equipment/supplies – justification/assessment, physician order or prescription, price quote (two quotes required for Home Modifications/Augmentative Communication/Vehicle Adaptation)
- Proof of insurance for Vehicle Adaptation
- Completed Risk Identification Tool
- Non CAP Medicaid supplies billed through LME require prescriptions

#### **Revision (CAP)**

- PCP update with signatures and cost summary
- CTCMs
- For equipment/supplies – justification/assessment, physician order or prescription, price quote (two quotes required for Home Modifications/Augmentative Communication/Vehicle Adaptation)
- Proof of insurance for Vehicle Adaptation

#### **TCM Request (Concurrent Request – There Must Be a Current PCP in ValueOption System)**

- PCP update/revision page with goals reviewed/dates and update/revision signature page dated within 90 days;  
**Or**  
Current PCP with review dates entered and corresponding update/revision signature page dated within 90 days;  
**Or**  
Annual rewrite of PCP with signature page dated within 90 days.
- CTCM
- ***Initial TCM request requires NCSNAP and Comprehensive Clinical Assessment (current psychological) be submitted with Intro or Complete PCP and CTCM***

#### **CAP Provider Change Only**

- Cost summary
- CTCM to discharge previous provider

- CTCM to add new provider

### **Person Centered Plan Instructions: CAP-MR/DD ONLY!!!**

In the *PCP Instruction Manual* there is an item that needs revision and clarification. On page 35, *section III: Legally Responsible Person* includes the CAP Choice statement. All individuals who receive CAP funding or their legally responsible person (LRP) must sign to confirm their understanding of their choice to participate in the CAP-MR/DD waiver. Therefore, this section III must be signed by either the guardian (LRP) or **the individual, in the event they are their own guardian** and check all three of the boxes since the CAP choice statement is not included in Section II on the signature page.

ValueOptions will return CAP PCPs as Unable to Process if all three boxes are not checked including the CAP choice statement and section III is not signed by the LRP or the individual who is their own guardian.

### **Proposed Revisions to Clinical Coverage Policy 8A Service Definitions**

Proposed revisions to seven service definitions in Attachment E of Clinical Coverage Policy 8A, Enhanced Mental Health and Substance Abuse Services, have been posted to the Division of Medical Assistance (DMA) web site at <http://www.ncdhhs.gov/dma/mpproposed/index.htm>. Comments from stakeholders and the public are invited and will be accepted for 45 days (through August 30, 2009). The revised service definitions include:

- Assertive Community Treatment Team (ACTT)
- Community Support Team (CST)
- Intensive In-Home (IIH)
- Mobile Crisis Management (MCM)
- Multi-Systemic Therapy (MST)
- Substance Abuse Comprehensive Outpatient Program (SACOT)
- Substance Abuse Intensive Outpatient Program (SAIOP)

### **Role of the Licensed Professional in a Community Support Provider Agency**

The following serves as further clarification of Implementation Update #55 and #56 regarding the role of the licensed professional in a Community Support provider agency. As outlined in Implementation Update #56, an agency that provides Community Support services must have at a minimum, a full-time licensed professional on staff as of January 1, 2009 per Section 6.1, General Information of DMA Clinical Coverage Policy 8A, <http://www.ncdhhs.gov/dma/mp>.

Effective August 1, 2009, the licensed professional(s) will provide clinical expertise and oversight for the provision of medically necessary services. The licensed professional(s) will provide or make provisions for the following:

- Assure clinically appropriate assessment, person centered planning and therapeutic interventions are delivered within the specific service definition.
- Assure clinically appropriate services are delivered to eligible recipients within the service definition (right person, right treatment, right intensity, frequency and duration).
- Assure that staff operate within their appropriate scope of practice for services delivered.
- Coordinate with quality assurance and quality improvement functions of the agency.
- Assure that clinical supervision is provided to staff (qualified professionals, associate professionals, para-professionals and Certified Peer Specialist) delivering the specific service.
- Monitor professional/ethical conduct of direct service staff (includes, but not limited to, confidentiality, client's rights, appropriate boundaries, etc.).

Some agencies provide services that require a licensed professional as part of the staffing requirement (e.g. SAIOP, ACTT). This licensed professional cannot serve as the agency's licensed professional for Community Support. The agency must employ at a minimum a full-time licensed professional(s) to carry out the above listed functions.

The provider agency assumes responsibility to employ the number of licensed professionals necessary to carry out the above clinical oversight functions at each enrolled service site.

Policies, procedures and protocols will be in place to describe the agency's method for implementation of the required licensed professional functions and be able to demonstrate documented evidence of compliance.

Documentation which provides evidence of the licensed professional's participation and compliance with this policy is required. Documentation may include:

- NC license (as stated in Section 6.2.1.1 of Clinical Coverage Policy 8A)
- Evidence of implementation of best practice standards

- Ongoing and periodic reviews of service records including assessments, person centered plans, service notes and outcomes to ensure the use of appropriate therapeutic interventions.
- Review of staff supervision plans and supervision notes
- Quality Assurance (QA) and Quality Improvement (QI) activities to include:
  - Licensed professional signature on QA and QI plans and reports
  - Results of personnel record and staff credential reviews
  - Training records
  - Consumer surveys
  - Peer review results
  - Staff meeting minutes
- Other documentation to support compliance

### **Establishment of DMH/DD/SAS Stakeholder Case Management Workgroup**

In conjunction with DMA's Case Management Steering Committee, the Division of Mental Health/Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has formed an internal Case Management Workgroup. This workgroup includes representatives from DMH/DD/SAS, LMEs, providers, advisory and advocacy councils, and most importantly, consumers and family members. The group will meet every other week during the case management project and will be responsible for the DMH/DD/SAS vetting of all materials and documents generated by the steering committee. DMH/DD/SAS is grateful to those who have agreed to join in this task important to consumers of behavioral healthcare services. The effort will be chaired by Foster Norman (CEO, Southeastern Center LME) and Dave Richard (Executive Director, ARC of NC).

### **Community Support Steering Committee**

Due to draft legislation that proposes the elimination of the Medicaid service Community Support by June 30, 2010, DMH/DD/SAS and DMA are in the process of developing a Community Support Steering Committee to strategically evaluate, plan and facilitate the transition of adults and children/adolescents utilizing this service. The Committee will begin its work within August and will be comprised of Community Support service recipients/families, providers, LME's, DMA and DMH/DD/SAS representatives and other key stakeholders. Meetings are tentatively scheduled on a weekly basis through the end of September. All information regarding the transitional planning for this service will be posted on the DMH/DD/SAS and DMA website.

### **Residential Level III and IV**

The proposed FY 2010 budget reduces funding levels for Child Residential Level III and IV services for both Medicaid and state funded consumers. The leadership of the Department of Health and Human Services believes this provision, currently under review by a joint conference committee of the NC General Assembly, will be included in the final approved FY 2010 budget. While the timeline has yet to be confirmed, guidance has been given to the LMEs, the local agencies overseeing the proposed reduction, to begin a triage process of all children/youth in these services.

LME staff, operating under System of Care practices and principles, are gathering current clinical information in order to prioritize a review of each child/youth in level III and IV. The Child and Family Team process is being used to plan for transition to alternate levels of care based on medical necessity. LME staff will work closely with other local child and family serving agencies through local community collaboratives to plan for and provide a local system of care to effectively serve all youth in their home community.

For more information about this transition including specific guidance to LMEs, providers and agency partners as well for contact information for your local System of Care Coordinator, please go to the following link:

<http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm>.

### **Communication**

We know that accurate information is a key component in ensuring that the system runs smoothly so that consumers have timely access to appropriate services and providers are reimbursed properly for services delivered. Leadership of provider agencies and Local Management Entities (LMEs) must be aware of the questions being raised by their staff and community in order to adequately address those issues. Leadership in the Department of Health and Human Services (DHHS) must be able to track the questions and concerns that are brought to the state level to determine the areas needing the most clarification and/or concentrated statewide training.

Currently, staff of provider agencies and LMEs, at every level of their respective organizations, are contacting many staff in the Department on a wide variety of issues. This has, unfortunately, occasionally resulted in the dissemination of inaccurate information when the DHHS staff person contacted was not the best-informed person to respond to the inquiry. It has also resulted in different answers being given to the same question when multiple DHHS staff are contacted. Finally,

it has meant that provider agency, LME and DHHS leadership cannot systematically address the concerns of their staff, community, and the system as a whole.

To address these issues, we have agreed to implement the following communication pattern, effective immediately:

- LME staff should direct their questions, through their management channels, to the LME Director or designee. If the LME Director or designee wants information or clarification from DHHS, that individual should contact the assigned DMH/DD/SAS LME liaison. The liaison will be responsible for referring the question to the most appropriate DHHS responder. The LME liaisons will also be responsible for compiling the requests for clarification and information that they receive for review by DHHS leadership to identify trends and instructions, processes, policies and/or procedures that are causing the most concern in the system.
  - This guidance does not apply to specific reporting procedures for which the communication protocol has already been established – such as incident reporting, referral of providers to DHSR, Program Integrity or the DMH/DD/SAS Accountability Team, etc.
  - LME Finance staff may contact the DMH/DD/SAS Budget and Finance Team directly with questions regarding state funds and payments.
- Provider staff should direct their questions, through their management channels, to the provider agency director or designee. If the provider agency director or designee has questions or seeks clarification, they should contact the appropriate individual in the Local Management Entity in whose catchment area they deliver services. If the provider agency director does not receive a timely response, believes the information they have received is not accurate, or receives different interpretations from different LMEs, they should first contact the LME director. If that contact does not address the concerns to the agency director's satisfaction, the director or designee may contact Dick Oliver, LME System Performance Liaison Team Leader ([Dick.Oliver@dhhs.nc.gov](mailto:Dick.Oliver@dhhs.nc.gov), (919) 715-1294), or one of the LME liaisons for assistance.

This communication protocol is not meant to inhibit questions or communication in any way. Rather, it is intended to ensure that questions are addressed promptly at the appropriate level in the system and that answers are given in a timely and accurate fashion by ensuring that the best informed individual on any given topic is responsible for the response.

Unless noted otherwise, please email any questions related to this Implementation Update to [ContactDMH@ncmail.net](mailto:ContactDMH@ncmail.net).

cc: Secretary Lanier M. Cansler  
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