NC DMHDDSAS Benefit Plan Streamlining Overview

Effective 08/01/14 version 06/11/14

In order to reduce the administrative requirements of the submission of Federal claims and State shadow claims, the following changes go into effect 8/1/2014:

1. **Reduced Number of Benefit Plans**: The number of Benefit Plans is reduced from 35 to 10. The remaining 10 Benefit Plans are a subset of the existing plans, and so should not necessitate submission of new eligibility for most consumers. The following Benefit Plans remain in effect August 1, 2014: AMI, CMSED, ADSN, CDSN, ASTER, CSSAD, ASWOM, ASCDR, and AMVET. GAP (Generic Assessment Payment) has been added and collapses the six age/disability specific Assessment Only benefit plans and can be used starting 7/1/14.
    a. See below Benefit Plan Crosswalk from current to remaining ones in effect 8/1/14 forward.
    b. See attached Benefit Plan Eligibility Criteria. The reduction of the number of Benefit Plans collapses current Benefit Plans, and should not result in current consumers becoming ineligible for services.
    c. See attached Benefit Plan Diagnosis Array. This array also includes the DSM-5 diagnosis descriptions effective 8/1/14.
2. New Policy: **The LME-MCO authorization and claims adjudication process must ensure that consumers who receive State/Federal funded services meet the eligibility criteria of the Service Definition or the Benefit Plan, whichever is strictest. The LME-MCO must maintain documentation to support this determination, and make it available to the Division or its agents upon request.** By ensuring that these criteria are met during the authorization determination process, the LME-MCO can assure the consumer meets those criteria at the time the service is authorized.
    a. **Semi-Automated Benefit Plan Determination**: Benefit Plan eligibility may be determined through a semi-automated process for five Benefit Plans: AMI, CMSED, ASTER, CSSAD and GAP.
        - The automated portion of the process should be based on the consumer's age at the time of service and their **primary** diagnosis, where primary diagnosis is the main focus of attention or treatment.
            - The process cannot be fully automated because there are some non-covered DSM-5 diagnoses that share the same ICD-9 codes as covered/included DSM-5 diagnoses.
            - LME-MCOs would need to ensure services are not authorized for non-covered diagnoses and providers would need to be trained not to submit claims for persons with non-covered diagnoses. For example, ICD-9 code 291.0 includes "Alcohol intoxication delirium, without use disorder", as well as several covered diagnoses.
            - The LME-MCO would need to have a procedure to monitor and verify that disallowed diagnoses are not being billed and maintain evidence that this verification is occurring per procedure.
        - **Note:** This Semi-Automated Benefit Plan determination is *allowed* for these five Benefit Plans; it is not required and Benefit Plan eligibility can continue to be determined individually by clinical staff of the LME-MCO and/or providers.
    b. **Individual Benefit Plan Determinations**: The remaining Benefit Plans (ASWOM, ASCDR, ADSN, CDSN, and AMVET) must continue to be determined individually, as they require review of several individual and clinical characteristics beyond the primary diagnosis and age group.

3. **Benefit Plan End Dates**: Given compliance with the above policy, LME-MCOs may choose the end date for Benefit Plans consistent with their policies and procedures. (It cannot go beyond the day before the consumer's 18th birthday for children.) This is allowable as long as the authorization process ensures the consumer meets both the criteria for the Benefit Plan and the Service Definition at the time the service is authorized. The exception to this is the GAP Benefit Plan which is only good for 60 days.
4. **Implementation**: The Benefit Plans that are expiring will be end-dated effective July 31, 2014 dates of service. Any consumers actively receiving services who are in these Benefit Plans only (and not in one of the remaining plans) will need to be switched to one of the remaining plans by this date. This is consistent with the August 1, 2014 implementation date for the DSM-5 diagnostic criteria, as stated in Communication Bulletin # 141 dated April 16, 2014. Inclusion in DMHDDSAS Benefit Plans after July 31, 2014 shall be based on the covered DSM-5 diagnoses and eligibility criteria listed in the Diagnosis Array and Eligibility Criteria documents. ICD-9 diagnosis codes covered in FY14 (see the last tab in the attached Diagnosis Array workbook) will continue to be allowed for claims adjudication in NCTRACKS through the end of FY15, for the Benefit Plans that are not expiring.

In addition to these changes, LME-MCOs are reminded of the following:

- All services provided as per published Service Definitions shall be reported through the UCR process (NCTRACKS). This is important for performance measures such as penetration rates, timely access to care, engagement, follow-up, etc., as well as Federal reporting.
- LME-MCOs can utilize existing approved statewide Alternative Service Definitions, or develop and request approval for new Alternative Service Definitions, to fill service gaps not met with current service definitions. Services reported under Alternative Service Definitions can help with performance measures, while NonUCR-funded services do not.
- LME-MCOs can request LME-, provider- or consumer-specific rates utilizing the DMH Rate Request form. This should be considered when beneficial for ensuring effective practices are available to consumers, to promote utilization of the least restrictive intervention (e.g., Facility Based Crisis instead of Inpatient levels of care), to ensure reimbursement is sufficient for provider costs, and to prevent cost-shifting from one service or payer to another. The LME-MCO shall ensure that their Medicaid Waiver and State/Federal rates are consistent.
- LME-MCOs can only bill the State for the amount paid to the provider (not more). If services are not reimbursed on a fee-for-service basis (e.g., case rates and other funding methods may be utilized) claims must still be reported through NCTRACKS to capture service events.
- The Benefit Plan Criteria Descriptions also indicate which sub-populations are priorities for State and Federal funding. LME-MCOs should ensure that limited resources are utilized for priority populations.

Cross-Walk from FY14 Benefit Plans to FY15 Benefit Plans

Line #	FY14 Benefit Plan Code	Benefit Plan Description	FY15 Benefit Plan
1	ADAO	Adult DD Assessment Only	GAP
2	ADCS	Adult DD Crisis	ADSN
3	ADIDD	Adult Disability Intellectual Dev. Dis.	See Note 3
4	**ADSN**	Adult with Developmental Disability	ADSN
5	ADTNC	Adult DD Transitional Non-Covered	See Note 1
6	AMAO	Adult MH Assessment Only	GAP
7	AMCEP	Adult MH Community Enhancement Program	AMI
8	AMCS	Adult MH Crisis	AMI
9	**AMI**	Adult with Mental Illness	AMI
10	AMSRE	Adult MH Stable Recovery	AMI
11	AMTNC	Adult MH Transitional Non-Covered	See Note 1
12	**AMVET**	Adult MH Veteran and Family	AMVET
13	ASAO	Adult SA Assertive Outreach and Screening	GAP
14	**ASCDR**	Adult SA IV Drug Communicable Disease Risk	ASCDR
15	ASCJO	Adult SA Criminal Justice Offender	ASTER
16	ASCS	Adult SA Crisis	ASTER
17	ASDSS	Adult SA DSS Involved	ASTER
18	**ASTER**	Adult SA Treatment Engagement and Recovery	ASTER
19	ASTNC	Adult SA Transitional Non-Covered	See Note 1
20	**ASWOM**	Adult SA Women	ASWOM
21	CDAO	Child DD Assessment Only	GAP
22	CDCS	Child DD Crisis	CDSN
23	**CDSN**	Child with Developmental Disability	CDSN
24	CDTNC	Child DD Transitional Non-Covered	See Note 1
25	CMAO	Child MH Assessment Only	GAP
26	CMCS	Child MH Crisis	CMSED
27	CMECD	Child MH Early Childhood Disorder	CMSED
28	**CMSED**	Child MH Serious Emotionally Disturbed	CMSED
29	CMTNC	Child MH Transitional Non-Covered	See Note 1
30	CMVET	Child MH Veteran and Family	AMVET
31	CSAO	Child SA Assertive Outreach and Screening	GAP
32	CSCS	Child SA Crisis	CSSAD
33	CSMAJ	Child SA MAJORS SA/JJSAMHP	See Note 2
34	**CSSAD**	Child with SA Disorder	CSSAD
35	CSTNC	Child SA Transitional Non-Covered	See Note 1
new	**GAP**	Generic Assessment Payment (NEW - replaces AO codes, all disabilities)	GAP

Yellow Highlighted Benefit Plans remain in place for FY15

Notes:

1. Do not submit claim if consumer is not eligible for any Benefit Plan. If consumer is eligible, but payer is not State/Fed, the service may be billed under the appropriate Benefit Plan. See Benefit Plan Eligibility Criteria document for additional information.
2. MAJORS funds should all be drawn down through NonUCR, eliminating need for a specific Benefit Plan.
3. There is no special funding in FY15 for ADIDD, and so no longer needed.