

**Alternative or “in Lieu of” Service Description
Residential Services – Complex Needs for IDD with co-occurring MH**

1. Service Name and Description:

Service Name: Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis (Residential Services – Complex Needs)

Procedure Code: H0018 HA -Children
H0018 HB- 18-20

Description:

Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral characteristics.

2. Information About Alliance Population to be Served:

Population	Age Ranges	Projected Numbers	Characteristics
Individuals with I/DD and other co-occurring MH diagnosis	Age 10 -21	225	Individuals with I/DD diagnosis and meet the ICF/IDD level of care consistent with the Innovations Wavier. The individual also has co-occurring MH diagnosis or significant behavioral challenges for which services and supports require significant experience and expertise in dual diagnosis. This individual’s care management acuity is predicted to be in the moderate to high range. Care coordination will be provided in accordance with the Alliance care management program model and in compliance with NC Medicaid’s Tailored Plan care management framework.

3. Treatment Program Philosophy, Goals and Objectives:

Treatment Program Philosophy:

The members being served through Residential Services – Complex Needs will benefit most by a multi-disciplinary approach with staff who are trained to treat ID/DD, mental health, and severe behaviors. The care management agency (AMH+ or CMA) will coordinate in an ongoing manner with the provider.

The services will use a comprehensive team model, members will be able to receive more integrated treatment interventions that ensure all diagnoses, including medical needs and social determinants of health, are being fully assessed, treated, and supported. Residential Services –

Complex Needs is provided in a small group home or alternative family living (AFL) setting with very structured supports.

The service is supported by a team of professionals with expertise in working with individuals with behavioral challenges. This team includes psychologists and licensed clinicians who are routinely involved and readily accessible for the development of behavioral intervention plans and during crisis events to provide support for assessment and de-escalation. A psychiatrist or other physician with behavioral health expertise within the provider organization will be available for consultation, and close coordination with outpatient psychiatric care will be ensured. Modalities and interventions are individualized based on the unique needs of the members, and behavioral plans will be developed and implemented for all members.

Families/caregivers/guardians will be actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential settings, such as the members' own homes or family homes and generalized into the community or other settings. Comprehensive care coordination will occur with other stakeholders such as schools, employers, natural supports, and primary care providers. The focus will be on strategic planning across systems, with the ongoing development of a strong natural support structure to reduce the need for paid supports.

At a minimum, family therapy or training/supportive services will be provided to the family/caregiver/guardian twice per month or more frequently, as needed. During therapeutic leave visits, the residential provider staff will join the member in his/her home environment for a portion of that time to offer in home supports and training to the caregiver and other family members to generalize skills to the home environment. In the 30- 60 days prior to discharge, the frequency of these visits and coaching will increase, using a fading approach as warranted. The residential provider and care manager will also ensure that the caregivers are connected to local supports through community organizations, support groups or individual services when it is determined necessary for optimal family functioning.

A key component of this service is assessing members' preferences and strengths and helping connect members to community activities and interests. The goal is to develop natural supports that can be sustained as the services fade. Whenever possible, providers will connect members to activities that can be maintained as members transition back to their homes. When the distance between the residential setting and the home community makes this challenging, the residential provider will connect members with similar activities in their local communities prior to discharge to ensure continuity of these supports and will assist the care coordination in the transitioning activities back to the individual's community of discharge.

Education and vocational components are key to successful outcomes for members with complex needs. The residential provider will be expected to work jointly with the schools for these members. In cases where a school transfer does occur due to the location of the residential setting, the provider will coordinate with both the sending and receiving schools to ensure continuity as well as keeping the care coordination informed of activities. The residential provider will assist the family in advocating with the school to ensure that appropriate components are in place (such as a 504 plan or IEP) and that the behavior plans are used consistently across all settings with modifications as needed. This support may involve the residential provider working directly with

the member in the school setting to provide temporary coaching for consistency across settings for members' adjustment and transitioning.

Vocational interests also will be assessed by the residential provider and the member will be provided opportunities to engage in employment. This support may occur through connections to formal resources such as educational transition coordinators, Vocational Rehabilitation, Supported Employment, occupational tracks in school or informal connections with local community businesses willing to support the member. When necessary, the residential provider will assist in transitioning these formal resources or helping with informal resources in members' home communities in preparation for discharge.

Trauma is expected to be common amongst the recipients of this service. While not all members may require formal trauma-focused therapy, a trauma-informed approach is necessary to ensure past experiences are considered and that the member has a positive treatment experience. Whenever possible, appropriate specific evidenced-based interventions/best practices will be incorporated into individual treatment programming. These interventions may include, but shall not be limited to: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Motivational Interviewing (MI), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Positive Behavior Supports (PBS), Functional Behavioral Analysis/Assessment, etc. All interventions should be adjusted to account for any cognitive challenges for the individual.

Objectives and Goals:

- Enable learning, resiliency and living in the community at the least restrictive level of care.
- Provide active treatment and therapeutic MH/Behavioral interventions to enable the development of necessary skills to live as independently as possible in the community.
- Gain additional family and caregiver personal skills addressing co-occurring disorders affecting community functioning.
- Provide support so that level of functioning is restored or developed so that individual can reach highest level of functional capacity; and
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability.

4. Expected Outcomes:

- Reduction in behaviors or challenges warranting this level of care
- Improvement in skill development
- Reduction in crisis episodes
- Reduction of mental health symptoms
- Ability to transition back to the family setting or less restrictive setting home within six months
- Improvement on standard outcome measures utilized at routine treatment intervals, at completion of treatment and during follow up care whenever possible
- Objective improvement in school or work as indicated in progress notes, employee reviews, treatment team meetings, etc.
- Improved coordination with physical health stakeholders to promote wellness, stability, and whole person care.

5. Utilization Management:

Residential Services – Complex Needs is a daily service and billed as a per diem rate. Prior Authorization is required. Initial authorization for services may not exceed 90 days. Reauthorization must be conducted every 90 days

Entrance Criteria

Children and adults (ages 10 -21) are eligible for this service when **ALL** of the following criteria are met:

- The member meets the functional eligibility requirements for the NC Innovations 1915(c) waiver program **but are not enrolled** in the NC Innovations waiver AND
- The member has a primary intellectual disability/developmental disability AND
- A co-occurring mental health diagnoses or significant behavioral challenges AND
- The member has experienced multiple placements and has difficulty functioning in community settings or has severe needs that less restrictive clinical services would not be appropriate.

Functional eligibility for the NC Innovations waiver means the member meets ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities) level of care criteria as summarized below:

- Has been diagnosed with an intellectual disability prior to the age of 18 OR
- Has been diagnosed with a related condition prior to the age of 22 that is likely to continue indefinitely (such as a developmental disability or a traumatic brain injury) AND
- Has substantial limitations in three of six major life activity areas (self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living) AND
- Requires active treatment to enable the member to function as independently as possible and prevent or delay loss of optimal functional status. Active treatment is defined as a “continuous program that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services.”

Continued Stay Criteria

The member 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 member’s PCP; or the member continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

- The member has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms.
- The member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP.
- The member is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible, OR

- The member fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The member's diagnoses should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria

The individual meets the criteria for discharge if any one of the following applies:

- The individual has achieved goals and is no longer in need of Residential Services - Complex Needs.
- The individual is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services, OR
- The individual or legally responsible person no longer wishes to receive Residential Services-Complex Needs.

Prior to discharge, the care management entity shall be involved in the discharge planning.

Service Exclusions

This service is intended to be a comprehensive service, without the need for additional services until the member is within 60 days of discharge. However, the following services when clinically appropriate will be allowed to be authorized during the same period as approved by the Utilization Management team, but must be included in the plan, and coordination occurring.

Outpatient:

Psychiatric services: Some members may have established psychiatric providers that it will not be clinically indicated to transfer to a new provider and that should remain in place

Outpatient therapy: Primary responsibility for therapy provision is within the residential service. However, individualized cases in which specialized therapy requiring specific expertise and training is needed will be considered based on the member needs

Psychological Testing: If necessary to have complete updated psychological testing occurred this can be billed separately. However, this does not include screenings, or ongoing clinical assessment that is expected as part of the psychologist involvement in the programming

Crisis Services:

Mobile Crisis: Provider must have licensed clinicians available for first responder functions included face-to-face assessment. However, if this has occurred and additional assistance is needed mobile crisis can be utilized in attempt to provide additional support to divert from inpatient

Inpatient Admission: While it is the overall intent that proactive strategies and planning will reduce the need for formal inpatient treatment, in the event that member does become

and imminent risk to self or others and de-escalation has not been effective this service can be utilized when medically necessary.

EPSDT Special Provision

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- 1) That is unsafe, ineffective, or experimental or investigational.
- 2) That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

- 1) If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- 2) IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria,

including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem.

A. Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:

Provider Requirements

Residential Services – Complex Needs will be delivered by staff employed by mental health or substance abuse provider organizations that:

- Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the requirements of 10A NCAC 27G unless provided by a federally recognized Tribal provider or Indian Health Service (IHS)) Provider. Those providers must demonstrate substantial equivalency as established in 25 USC 1621t and 1647a.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services. infrastructure necessary to provide services.

- Are members of the Alliance provider network or an IHS provider.
- Are established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina or federal or tribal entity.
- Achieve national accreditation with one of the accrediting bodies approved by the N.C. Department of Health and Human Services (DHHS) within one year of enrollment as a provider with NC Medicaid or meet substantial equivalency as allowed by 25 USC 1621t and 1647a.

At a minimum, providers are required to have access within their own agencies to Qualified Professionals, Licensed Clinical Staff, Psychologists, and medication prescribers. Based on the members' individual needs, other services (such as Nursing Services, Occupational Therapy and Physical Therapy) also may be utilized as adjuncts to treatment. The level of involvement of these additional services will be based on the comprehensive clinical assessment and psychiatric assessments of the members and adjusted throughout treatment. Routine nursing may be a standard part of the Residential program, if indicated based on the population served.

Staffing Requirements

- A minimum of one Qualified Professional and either an Associate Professional or a Paraprofessional with two years of experience with the population served will be available at all times, with two awake staff present anytime there are two or more individuals in the home, including sleep hours.
- A Licensed Clinician will be available for crisis response at all times and will serve as the first responder. This clinician will assess whether de-escalation and recommendation of strategies/interventions can be done via phone or face-to-face intervention. This clinician could also request assistance from the Doctoral Level Psychologist, if needed.
- A Doctoral Level Psychologist must be involved in the programming and consultation and available for crisis response via telephone at a minimum with face-to-face follow up within 24 hours, as necessary.
- Psychiatric Involvement – All members are expected to receive a full psychiatric assessment, preferably by a Child and Adolescent Psychiatrist for members under 18, by an MD or DO. These

services can be billed separately, but the residential provider is responsible for coordinating and ensuring this assessment occurs. Any exceptions based on clinical needs of the member must be documented and coordinated with the care coordinator.

For members already established with psychiatric providers, all efforts should be made to maintain continuity with these practitioners whenever possible. The residential provider is expected to have a psychiatrist or other physician with extensive behavioral health experience/training with the population being served (e.g., developmental pediatrician) employed with the company who can provide consultation as necessary and who can assist with interfacing with the community psychiatrist, if different.

- Training in a standardized program for working with individuals with dual diagnosis is required within six months of operations. The Provider will specify the specific training elements, hours required and accepted training platforms for documentation of training completion (e.g., training modules through College of Direct Support or similar programming).
- Credentialing Process: Clinicians associated with the program will be credentialed according to policy.

Supervision:

Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 or recognized tribal code and according to licensure or certification requirements of the appropriate discipline and jurisdiction.

B. Unit of Service:

Services	rate	unit of service
Residential-Complex Needs	450.00	daily
Physician	Medicaid fee schedule	Per CPT code

C. Anticipated Units of Service per Person:

This service is a daily per diem, 30x6 months = 180 units

D. Targeted Length of Service: six (6) months.

E. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.

This comprehensive service is specifically designed to meet the needs of individuals with I/DD with complex, co-occurring MH challenges. Currently, there are gaps in expertise and focus in either ICF/IDD or PRTF providers with this level of expertise. This gap causes extensive delays

in placement and also multiple placements due to inability of the provider to offer the level of intervention and supports required for the individual.

This time limited service is designed to provide the necessary interventions and supports, along with the generalization of skill development to the care givers, allowing the individual the ability to return to their community. Typically, ICF/IDD placements are long term, often becoming lifelong rather than supporting AFL or supported living arrangements.

This is a community-based model that aligns with the vision of the Home and Community based standards. This service will help to reduce the number of people currently on the Alliance registry of unmet needs who need supports and reduce the use of the crisis system which is not designed for this population. This service is designed to work towards more successful outcomes long term, and step people down to less restrictive settings as they are ready to make those moves throughout their life.

Residential – Complex Needs is not intended to replace use of ICF-IID or the Innovations Waiver but will be utilized to prevent people from accessing higher levels of care in the absence of services and address the unmet needs of Medicaid eligible consumers to have the opportunity to get the therapeutic interventions and active treatment needed to live in the community.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)

Encounter data will be filed daily for each day services are rendered to the client. Provider would collect and report/provide access through sharing of the health record to all encounter data. At a minimum, this would include time spent on direct and indirect contacts.

Description of Monitoring Activities:

Alliance will monitor admissions and concurrent stay through Utilization Management and Review processes. The care management agency will also monitor the individual's progress in the service, the quality of the service and maintain the care plan as outlined in the Alliance Care Management Program. Alliance Network management will monitor individuals receiving Residential-complex needs at a minimum annually for compliance. Ongoing monitoring of complaints, incident reports, quality of care reviews, audits etc. will occur annually or as needed.