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 Healthcare	**3-12-2018**

***c.* Name of Proposed LME-MCO Alternative Service**

Peer Support Transition- YA344 (note this is to be used only for those members discharging from Acute settings, receiving Peer Support under the Peer Bridger model from approved providers) This code was previously approved for use under Five County, and modifications to the definition to align with existing (b)(3) Peer Support

***d.* Type of Funds and Effective Date(s):** *(Check and Complete Applicable Dates)*

State Funds Only: ☐ Effective 12/01/2021 to End of Fiscal Year

☒ New Request ☐ Revision to Previously Approved Alternative Service

e. **Submitted by LME-MCO Staff (Name & Title)**	*f.* **E-Mail**	*g.* **Phone No.**
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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 though 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
	(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.)

1	**Alternative Service Name, Service Definition and Required Components** Peer Support Services are structured and scheduled activities for adults ages eighteen (18) and older with a diagnosis of mental health or substance use disorders. Peer Supports are provided by North Carolina Certified Peer Support Specialists. Peer Support Service is an individualized, recovery-focused service that empowers members to manage their own recovery by being hopeful, resilient and responsible. Interventions of Peer Support staff serve to enhance the development of natural supports, as well as coping and self-management skills. Interventions of Peer Support staff also may provide supportive services to assist a member with community integration and maintaining wellness following treatment. Peer Support Services emphasize personal safety, self-worth, confidence, growth, community engagement, boundary setting, planning, self-advocacy, personal fulfillment, positive social supports and effective communication. Services emphasize the acquisition, development and expansion of rehabilitative skills needed to move forward in recovery. Peer Support Services should be collaborating with the other clinical service providers, such as an outpatient therapist and/or a psychiatrist. If members are not engaged in these clinical services, Peer Support Specialists should provide education on these services and help to coordinate initiation as clinically appropriate. If these services are recommended, but members are not yet willing to engage, this should be documented in the service notes. This should include a plan for evaluating the ongoing effectiveness of Peer Support, if the member is not willing to engage in services that are consistent with clinical practice guidelines. Part of the role of the Qualified Professional is to ensure that the member is assessed for and connected to clinically appropriate services. Examples of specific interventions include, but are not limited to, the following. • Instill Hope: Assisting the member to talk about his/her experiences through modeling of sharing recovery stories and use of recovery language as a means to instill hope and reduce stigma • Self-Determination: Cultivating the member's ability to make informed, independent choices; helping the member develop a network of contact for information and support • System Navigation: Helping the member navigate the system for psychiatric and general medical treatment and connecting with community resources; assisting the member with writing letters or making telephone calls about an issue related to his/her recovery • Individual Advocacy: Encouraging members to speak on their own behalf and take initiative to self-direct their recovery; guiding the member toward taking a proactive role in whole health management • Pre-Crisis and Post-Crisis Support: Assisting the member with the development of a personal crisis plan, and/or a Psychiatric Advance Directive (PAD) and sharing with appropriate supports – including developing the Wellness Recovery Action Plan (WRAP); helping the member identify early signs of relapse and how to request help to prevent a crisis; supporting the member in seeking less restrictive alternatives to admission to locked hospital facilities, jails and Emergency Departments, as clinically indicated • Housing: Assisting the member with learning how to maintain stable housing through bill paying, abiding by rental agreements, cleaning and organizing his or her belongings, etc. • Education/Employment: Assisting the member in gaining information about going back to school or job readiness training; coaching the member about discussions with employer regarding reasonable accommodations for wellness recovery needs • Whole Health Wellness Activities: Teaching the member about the benefits of nutrition, meditation/relaxation, exercise, development of natural supports, etc. The focus is on linking members to wellness activities in the community. Activities reflect empowerment, increasing independence, skill maintenance, planning and enhancement and show fading of professional supports. For Peer Support Transition:

	In addition to the above, Peer Support Specialists will implement the service under a Peer Bridger model. This model is designed to quickly engage members at the time of discharge from acute services (preferably on the date of discharge, first meeting the member at the acute service setting ensuring Peer Support does not overlap any billing with the acute provider) to ensure that these members connect to follow up services within 7 days to meet the contracted standards. Referrals will be made to directly to these providers from the Acute settings, providing sufficient clinical information and discharge recommendations so that the Peer Support Specialist can immediately focus on engagement and bridge the member's treatment while he/she is being linked to appropriate ongoing care.
2	**Rationale for proposed adoption of LME-MCO Alternative Service to address issues that cannot be adequately addressed within the current NCTRACKS Service Array** Peer Support will provide: • An evidenced based approach for recovery • Rapid engagement; including multiple attempts to connect with members in the community • An effective relapse prevention strategy • Role models for breaking the cycle of addiction and successful community living, • Immediate aftercare support for those discharged from an inpatient or residential • setting, and as a step-down from facility-based crisis program, • A response to the high rate of no-shows to service appointments, • Early intervention with resistance issues; motivational enhancement and change-supportive strategies, • Potential reduction of re-admissions to state facilities and community hospitals, and • Flexibility of frequency, intensity and duration of support as the member progresses through treatment
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** Professional treatment of mental illness and/or substance abuse must be supported with linkage to basic resources and services such as housing, employment, medical care, transportation to services, linkage with recovery self-help programs and other benefits and services through strategies that promote independence and recovery. While these services are currently available through the waiver as a (b)(3) service, these also need to be available to members in need of state funded service. Using evidence-based practice principles requires that trained, recovery-oriented peer support is crucial to retention of members within the clinical treatment programs, and provides the best opportunity for long-term recovery.
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)**
5	**Projected Annual Number of Persons to be Served with State Funds by LME-MCO through this Alternative Service** It is expected that over 400 individuals in AH counties will be able to be served under this definition. Expanding the definition to allow for targeted use with more flexibility in authorizations given the high risk nature of these members under a Peer Bridger model of implementing, will allow for engagement immediately as the time of discharge to connect to treatment and assist with follow

	through. This number is an estimate due to the bringing on new counties and allowing for expansion system wide.
6	**Estimated Annual Amount of State Funds to be Expended by LME-MCO for this Alternative Service** Alliance cannot project with accuracy the amount of additional state money that will be used given the use of Peer Specialist for hospital discharge will be an additional use of the service. Alliance will review paid claims amounts and number served on a monthly basis, and will adjust our benefit plan accordingly, following a 6-month baseline period. Other controls will involve continued pre-authorization for the Individual and group for the non-transition members. Provider selection criteria such as proof of required training and piloting with a limited set of Providers for the Peer Support Transition portion will be utilized to monitor this during the initial 6 month period to make any necessary adjustments to rates, deliverables, and provider expectations.
7	**Eligible NCTracks Benefit Plan(s) for Alternative Service:** *(Check all that apply)* ***Assessment Only:*** ☐ ***GAP*** ***Child MH:*** ☐ ***All*** ☐ ***CMSED*** ***Adult MH:*** ☒ ***All*** ☒ ***AMI*** ☒ ***ATCLI*** ***Child DD:*** ☐ ***CDSN*** ***Adult DD:*** ☐ ***All*** ☐ ***ADSN*** ***Child SA:*** ☐ ***All*** ☐ ***CSSAD*** ***Adult SA:*** ☒ ***All*** ☒ ***ASCDR*** ☒ ***ASWOM*** ☒ ***ASTER*** ☒ ***ASOUD*** ***Veteran:*** ☐ ***AMVET***
8	**Definition of Reimbursable Unit of Service:** *(Check one)* ☐ ***Service Event*** ☒ ***15 Minutes*** ☐ ***Hourly*** ☐ ***Daily*** ☐ ***Monthly*** ☐ ***Other: Explain_____***
9	**Proposed NCTracks Maximum 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 maximum NCTRACKS Unit Rate for which the LME-MCO proposes to reimburse the provider(s) for this service?* **YA344 - $19.00**

10	**Explanation of LME-MCO Methodology for Determination of Proposed NCTracks Maximum Unit Rate for Service** *(Provide attachment as necessary)* The current rates paid for Peer Support Individual is $12.00, and Peer Support Group $2.71. Previously in the new Alliance counties, this was cited: "…with the addition of use of Peer Support for acute service transition the providers have projected a need for an initial rate of at $16.86 but also have expressed that this may not be sufficient depending on activities that are not billable to cover staff time." To cause the least potential interruption, this will be reviewed closely after implementation to measure both improved member outcomes, provider costs, units, and unbillable activities.
11	**Provider Organization Requirements** Peer Support Services must be delivered by staff employed by a MH/DD/SA provider organization that meet the provider qualification policies, procedures, and standards established by Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the requirements of 10A N.C.A.C. 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being a member of the Alliance Health provider network. The organization must be 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. Staff should follow the North Carolina Peer Support Specialist Code of Ethics and Values for the Peer Support Definition (all ethical issues shall be governed by policies and procedures established within the hiring entity): http://pss.unc.edu. The provider ensures documented clinical oversight to certified Peer Support Specialists and Qualified Professionals by a licensed clinician at least monthly. Supervision should address member-specific dimensions of wellness, progress and outcomes and should ensure appropriate collaboration/coordination of care.
12	**Staffing Requirements by Age/Disability** *(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)* Peer Support must be delivered by individuals who have the life experience of being diagnosed with a serious mental illness or substance use disorder and must be North Carolina Certified Peer Support Specialists who **meet all of the below** • Self-identify as an individual with life experience of being diagnosed with a serious mental illness or substance use disorder which meets federal definition • Are well established in their own recovery, • Are currently in recovery and are stable, • Have a high school diploma or GED equivalency, • Are supervised by a Qualified Professional (QP), • Are not a family member of the member who receives Peer Support services Peer Support Staff must follow the NC Peer Support Certification Guidelines under the Behavioral Health Resource Plan (BHRP), School of Social Work, UNC Chapel Hill or other approved curriculum and training for certification of Peer Support Specialists.
13	**Program and Staff Supervision Requirements** Staff who intend to provide Recovery Peer Support must be supervised by a Qualified Professional. The current standards for clinical supervision will be in force, including an individualized, competency-based clinical supervision plan for every paid staff member or contracted provider of

	Peer Support that includes measurable goals designed to alleviate gaps in knowledge, skills or abilities. Peer Support groups for psychoeducation that are facility-based shall not exceed a ratio of 1:15; this includes group activities such as Wellness Recovery Action Planning, illness management, etc. Group activities that are focused on interactive skill development and practice in the community or other non-facility based settings shall not exceed 1:5. The QP supervising Peer Support staff may not exceed 1:8 full time equivalents QP to Peer Support staff ratio. Peer Support staff can bill for time developing Psychiatric Advanced Directives as well as Wellness Recovery Action Plans, Recovery Assessment Scale (RAS) measurement and pre and/or post-crisis plans. For Peer Support being delivered upon discharge from Acute services using the Peer Bridger model, only providers approved by Alliance and all deliverables in the contracts must be met to bill for training.
14	**Requisite Staff Training** Staff must be appropriately trained in working with the population including training on motivational enhancement and recovery culture within 90 days of employment. Within one year the staff must have completed 40 hours of training in all tasks outlined by the DHHS peer support contractor (BHRP, UNC School of Social work. MCO approved curriculums) with the four peer training domains: 1. Professional responsibility, 2. Relationship building, 3. Education and other peer support interaction, and 4. System competency. More information is available at **http://bhrp.sowo.unc.edu/files/NCDMH Curriculum check sheet 2008typewriter.pdf.**
15	**Service Type/Setting** Services may be provided in any location, with the exception of the Peer Support staff person's place of residence. The intent of this service is to be community-based, rather than office-based. Eighty percent (80%) of contacts must be face to face with the member. Travel time may be billed when the certified Peer Support staff is providing an intervention. The purpose of the travel is to help the member access an activity related to this service. Billable activities also include telephone time with the member and collateral contact with persons who assist the member in meeting his/her rehabilitation goals. For Peer Transition Services, initial contact should be made at the discharging facility, in the community, or the member's home to engage in the setting most appropriate for the member. It should not be expected that members come to provider office locations to become connected to these services.
16	**Program Requirements** Peer Support groups for psychoeducation that are facility-based shall not exceed a ratio of 1:15; this includes group activities such as Wellness Recovery Action Planning, illness management, etc. Group activities that are focused on interactive skill development and practice in the community or other non-facility based settings shall not exceed 1:5. The QP supervising Peer Support staff may not exceed 1:8 full time equivalents QP to Peer Support staff ratio. Peer Support staff can bill for time developing Psychiatric Advanced Directives as well as Wellness Recovery Action Plans, Recovery Assessment Scale (RAS) measurement and pre and/or post-crisis plans.
17	**Entrance Criteria**

	The member is eligible for this service when • Member is an adult age eighteen (18) and older with identified needs in life skills; • Member has a DSM-5 diagnosis of mental health and/or substance use disorder; • Member meets LOCUS Level 1 "Recovery Maintenance and Health Management" or greater on the LOCUS or ASAM Level 1. • There are no alternative services that would be more clinically appropriate based on the identified needs of the member. The member is experiencing difficulty in at least one of the following areas, or lacks useful life experience, in one of the following areas. • Is receiving or has recently received crisis intervention services • Is experiencing functional problems in the residence, community, church, school, job or volunteer activity • Is missing appointments or frequently is late • Is in active recovery from substance use/dependency and is in need of mutual support from a peer for relapse prevention support • Needs to develop self-advocacy skills • Needs to maintain a routine of daily whole health management The member must be able to be receptive to services in an unstructured environment without professional presence. Members are also eligible for this service when • They are in the special population receiving treatment planning, have Serious and Persistent Mental Illness (SPMI) and reside in an Adult Care Home determined to be an Institution for Mental Disease; • They have SPMI and are transitioning from Adult Care Homes and State Psychiatric Institutions; • They are diverted from entry into Adult Care Homes due to preadmission screening and diversion.
18	**Entrance Process** • ***Integration with team planning process*** • ***Integration with Person Centered Plan and clinical assessment*** The recommendation for Peer Support must be identified by a Professional through a clinical assessment and treatment planning process, including network Providers, Mobile Crisis Team, Hospitals, ADATC and Alliance Clinical staff. Goals and interventions for Peer Support must be identified on a Person-Centered Treatment plan that was developed within the first 5 hours of Peer Support treatment for the member. The PCP should be coordinated in development with anyone of the member's choosing and established providers.
19	**Continued Stay Criteria** Consumer needs continued assistance to achieve desired outcomes on the Person-Centered or treatment plan. New goals are identified on the Person-Centered or treatment plan. The consumer is making reasonable progress toward goals identified on the plan.
20	**Discharge Criteria**

	Member meets criteria for higher level of care (e.g., return to use that impacts the member's functioning, multiple hospitalizations, multiple crisis episodes, etc.); or • Member no longer wishes to receive Peer Support services; or • Member has achieved two (2) years of abstinence from misuse of substances; or • Member has achieved two (2) years of successful wellness/ recovery from mental illness; or • Goals of the Service Plan have been substantially met; or • Individual designed Pre Crisis/Post Crisis and Crisis Plan have worked for two years to avoid involuntary treatment and hospital emergency room usage • ***Anticipated length of stay in service (provide range in days and average in days)*** Average length of stay will vary based on the individualized needs of the member. For Peer Support transition services the length of stay will be no greater than 90 days, with the possible transition to longer term peer support when indicated. For state funded Peer Support an average length of stay would be anticipated to be between 180 days and 2 years. • ***Anticipated average number of service units to be received from entrance to discharge*** The average units per consumer is anticipated to be 40-60 units per month, but may be higher based on the individualized needs of the member. • ***Anticipated average cost per consumer for this service*** For Peer Support Transition Services, the average cost per member is estimated at $1009.20 For Peer Support Individual and Group, the average cost per member is estimated at $2610.00 per year, but may vary depending on phase in treatment.
21	**Evaluation of Consumer Outcomes and Perception of Care** • ***Describe expected outcomes, and identify how outcomes for this service will be evaluated and reported*** This service could accompany a primary SA or MH service. Depending on the type of primary service, NC-TOPPS would be required to be completed on time and submitted by the primary service provider (the clinical home), and an analysis of relevant items related to accessibility from the Initial schedule of the TOPPS for the individuals engaged in Recovery Peer Support will be pursued. The Recovery Assessment Scale (RAS) is a required outcome measurement tool that will guide treatment goals and interventions. Administration of the RAS is required upon admission and at least every six (6) months to monitor progress and outcomes. The service will support recovery, and the expected outcome will reduce the need for a higher level of care. This service promotes integration into the community at large and self-reliance. • Compared to previous twelve (12) months without Peer Supports there will be Psychosocial Rehabilitation • Reduced crisis and psychiatric hospital utilization because the member has reliable contacts and a customized Crisis Plan • Shortened hospital stays **Reduction in use of formal treatment based services: Intensive Outpatient Programs**
22	**Service Documentation Requirements**

	• ***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?*** ☒ ***Yes*** ☐ ***No*** ***If "No", please explain.*** • ***Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc.*** A Master's level behavioral health professional fully-licensed by the state of North Carolina with at least two years of post-Master's Degree experience with the population served orders this service. The need for the service must be reflected in the Individual Support Plan, Person Centered Plan or Service Plan-when members are not in other enhanced services. The plan must be in place after the first 5 hours of treatment. Full service note per event that documents the purpose, intervention and consumer's response to the service. Recovery Assessment Scale (RAS) at admission and at least every 6 months
23	**Service Exclusions** • ***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*** For Peer Support Individual and Peer Support Group Codes: Peer Support may not be provided during the same time / at the same place as any other direct support Medicaid service. Peer Support may not be provided during the same authorization period as the following services: • ACTT • Community Support Team Peer Support may be provided during the same time as ACTT and Community Support Team during a 30 day transition phase for step-down to Peer Supports. Members ages eighteen (18) to twenty-one (21) may not live in a child residential treatment facility. For Peer Support Transition Service Code: Peer Support may not be provided during the same time of day as any other billable treatment services (Medicaid or State services) Peer Support Transition may not be provided during the same authorization period as ACTT. It may overlap on a limited basis with other services during the transition period of 90 days from acute service discharge, provided there is coordination with other service providers and that intervention do no duplicate those expected to be provided within the other treatment services. Example: SAIOP or SACOT may overlap with Peer Support transition for member leaving facility based crisis or ADATC if this is deemed part of these services to engage the consumer in mutual support activities, consistent with the goals of the PCP.
24	**Service Limitations** Units are billed in fifteen (15) minute increments. For Peer Individual and Peer Group Services:

	To allow for initial member engagement and the development of an Individual Support Plan (ISP), Person Centered Plan (PCP) or Service Plan, the first five (5) hours (20 units) of service do not require prior authorization. After the first five hours/20 units, the service must be pre-authorized. The need for the service must be reflected in the Individual Support Plan, Person Centered Plan or Service Plan. The Recovery Assessment Scale (RAS) must be completed and submitted with each Treatment Authorization Request (TAR). Authorizations can be up to follow but should be individualized based on member's needs: • Initial Authorization – First 90 days (or when a member is experiencing a period of instability): no more than 20 hours per week individual or group • Step down to sustaining support – After first 90 days, and up to subsequent 90 days no more than 15 hours per week except when necessary to address short-term problems/issues. • Intermittent Support – After 180 days, no more than ten 10 hours per week of individual and/or group. A maximum of twenty (20) units of Individual and/or Group Peer Support services can be provided in a twenty-four (24) hour period by any one Peer Support staff. No more than eighty (80) units per week of services can be provided to a member. A week is defined as Sunday through Saturday. If medical necessity dictates the need for more service hours, consideration should be given to interventions with a more intense clinical component; additional units may be authorized as clinically appropriate. TARs should be individualized to reflect mutually agreed upon meeting frequency and duration. For Peer Support Transition Service Code: A maximum of 40 units per month, up to 90 days of service can be provided without authorization for members in the designated targeted populations when the provider successfully connects with the member at discharge and ensure completion of the follow up appointments with 7 days.
25	**Evidence-Based Support and Cost Efficiency of Proposed Alternative Service** National Practice Guidelines for Peer Support (SAMHSA) https://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf Financial Peer Support Services: https://knowledge.samhsa.gov/resources/financing-peer-support-through-medicaid Peer Bridger Project - New York Association of Psychiatric Rehabilitation Services, Inc. https://www.nyaprs.org/peer-bridger
26	**LME-MCO Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service** Providers are currently monitoring through Utilization Review, and Quality Management Reviews to ensure appropriate clinical delivery of the services. Additional review and monitoring will occur for providers implementing the Peer Support Transition. Rates, utilization, and provider productivity will also be monitored for the transition services.
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_X_Medicaid waiver_☐_Non-state funds Date: 04/01/07 **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**