

Please see the complete FAQ below from several Question-and-Answer sessions as well as emails and calls received from providers between 2/21/2023 and 4/10/2023 surrounding Alliance's new in lieu of service, Long-Term Community Supports and the new state codes mentioned in JCBs #J408 and #J417.

This FAQ is extensive, and a full comprehensive list of questions asked and answered. Please review this list in its entirety as your questions has most likely been addressed. If you have a member specific question, please send that to our transition mailbox at CMMemberTransition@alliancehealthplan.org.

Should you have a question not addressed here, please send that to your Provider Relations Specialist and they will funnel it to the Implementation Team. Please note, that we will refer you back to this document if that question has been addressed.

Frequently Asked Questions:

Service Definition and Service Implementation:

- 1. How much 1:1 is required for this in lieu of (ILO) and group service? Providers were told they needed to have a specific number of hours. For example, with Level II.**
 - a. There are no specified 1:1 hours for this in lieu of service.
- 2. How do we determine the number of hours a person may need for Supervised Living?**
 - a. In the ILO, all hours are paid at a per diem rate.
- 3. For supervised living, will it be a daily rate or authorization based on hours?**
 - a. This ILO has a daily rate.
- 4. How different is what Alliance has submitted from Partners' and Vaya's version of LTCS?**
 - a. Our LTCS mirrors that of Partners and Vaya
- 5. Does Day Activity have to be licensed?**
 - a. This ILO does not specify Day Activity be licensed but the staffing must be different between the programs.
- 6. Will group homes with 5 or 6 beds be allowed?**
 - a. Yes, Alliance has received approval from the State and existing .5600 group homes with 5 or 6 beds have been grandfathered and are allowed. New group homes must have 4 or fewer beds moving forward.
- 7. Is the LTCS service definition posted on Alliance's website yet?**
 - a. Yes, it located in the Document Library on our website and has also been attached to this announcement.
- 8. What is the defining difference between level 4 and 5?**
 - a. The service definition outlines the differences and differentiates between the levels. Please refer to the current definition, which is attached to this announcement.
- 9. Is this ILO service only for long-term care group providers?**
 - a. This is for Medicaid eligible recipients receiving state funded services.
- 10. How long is the LTCS authorization period?**
 - a. 180-days

Cross Walk, Level of Care, and Rates:

1. **Is there are crosswalk?**
 - a. Yes, it has been shared a few times in Provider News and is also linked to this announcement.
2. **One of my individuals whose needs have increased is now at a level 2, is he able to get 1:1 supervision?**
 - a. Please send member specific questions to the transition mailbox at CMmembertransition@alliancehealthplan.org Also, if any member has been cross walked to a lower or higher level of care than deemed appropriate by his team, a new service authorization request (SAR) can be submitted for another level of care, which UM will review and render a decision.
3. **Does this change apply to residential State operated healthcare facilities that house 200+ individuals?**
 - a. No, this is only for state funded community-based services.
4. **What criteria determines a member's Level of LTCS?**
 - a. It is defined in the service definition by the setting and the member's supervision needs in the ILO, Long-Term Community Supports service definition. Please note, we have been cross walking based on how the majority of our members live and how services are provided. If your agency is offering a service outside of the typical definition or providing additional services that are not clinically necessary, a lower level of care may be cross walked but you are able to show how a higher or different level of care is clinically appropriate by submitting a SAR with justification and our UM Team will review and render a decision.
5. **Will upcoming communication be specific to each agency and include the specific individual names and crosswalk?**
 - a. No, it will not be agency specific with member names but it will have the levels so you can cross reference internally.
6. **Have the rates been released for each level?**
 - a. Yes, they were included in previous Provider Updates and the updated crosswalk with the rates have been attached to this announcement.
7. **Is Alliance determining what level a member will transition to?**
 - a. Yes, our UM and Care Management departments have created a crosswalk and will transition members with a current authorization.
8. **If the member does not have Medicaid - what service will they transition to if they are residing in a state funded AFL -YM850 7 days a week?**
 - a. It will crosswalk to YM846.
9. **Why is Group Living Low (group home residents) transitioning to LTCS Level 3 which is Supported Living (paid roommate & must have roommate agreement)? Why is Group Living Moderate (group home residents) transitioning to LTCS Level 4 which states "no overnight staffing required."**
 - a. The goal of Long-Term Community Supports is to provide supports to members with the least restrictiveness as possible, while teaching skills to gain as much independence as they can. Group Living Low, Moderate and High all had levels of services as part of those services. Now members can receive other services besides group living if they choose. Because a group home provides 24-hour staff coverage does not automatically mean every member at the program clinically requires 24-hour coverage, which is why

there was differentiation between the levels describe programming required and the clinical need of the members. Our medical and clinical teams spent time working on the crosswalk knowing that it would not cover every individual's situation, however, most persons. If you feel a member is inappropriately placed and the person needs a higher level of service, you can seek authorization for the service you believe the member needs.

10. In reference to CLS rates, which rate on the crosswalk is correct, or will there be a modifier for the crosswalk?

- a. The CLS rates on the cross walk did specify standard and COVID rates depending on what service the member transitioned from. The new rate for state funded CLS will not have a modifier and will not differentiate between a COVID rate, standard rate, or what service is being transitioned. **The new rate is \$6.33 per 15-minute unit for YM851.**

Authorizations:

- 1. For any individuals we have receiving residential supports in a group home, will they automatically transition to this service effective April 1? Or will we need to do another SAR?**
 - a. If there is a current auth on file, we will use the crosswalk and we will transfer the member to the appropriate service. If by chance the member's authorization ends 3/31/2023 then a new SAR would need to be submitted. If the authorization expires shortly after 4/1/2023 please be prepared to submit a reauthorization. For example, if an authorization ends 4/5/2023. We will transfer the authorization from 4/1/2023 to 4/5/2023. You will need to submit a reauthorization starting 4/6/2023. Transitioned authorizations will start 4/1/2023 and will end the original authorization date that is on file, if current.
- 2. If we have a current SAR with an approved level of care and the individual's level has changed, how do we go about applying for a different level of care for this individual?**
 - a. You would need to submit a SAR, updated PCP, and clinical information to support the change. You can submit a SAR at any point requesting a different level of care.
- 3. What if the auth expires on or after April 1st, what service do we request?**
 - b. Please submit a SAR for the LTCS or the new State residential codes depending on what service was cross walked or if you believe the cross walked service is not the appropriate level of care you can submit a SAR for any service, but you will need to include clinical justification.
- 4. What documentation is required for the 180-day LTCS reauthorizations after June 30th?**
 - a. A PCP, signed service order, and clinical justification. Also, remember a psychological should be completed every 5 years- if one has not been done in the past 5 years, please make every attempt to schedule one and include the findings with the clinical documentation.
- 5. Can the prior goals and documentation of the old Y code services be used to bill the LTCS and new Y code services during the crosswalk period until we can switch the documentation out?**
 - a. Yes, we know you need to get all documentation in order. Please use the Technical Assistance period to submit all updated PCPs, service orders, and documentation as soon as you can.

6. On the authorization itself what is the difference between the “Approved Units/Days” and the “# of the Auth Units in the Current Episode”? (see screenshot below)

Service Approved:
Approved Units/Days:
Used Units/Days:
Approved Service Start Date:
Approved Service End Date:
Provider Name and Site:
Authorization #:
Episode Start Date:
of Auth Units in Current Episode:

- a. “Approved Units/Days” are the approved number of units for the authorization or reauthorization period after being reviewed by UM. “# of Auth Units in Current Episode” is an internal field that you can disregard.
7. For individuals moving from Y Code to state funded CLS can we ask for additional hours, if clinically justified?
- a. Yes, you can submit a SAR at any time to ask for a new service or additional hours. Please include clinical justification to support the new service or increased hours.

PCP Updates, Service Orders, and Documentation Requirements:

1. What is the documentation requirement?
 - a. Documentation will need to follow Medicaid definition guidelines in APSM manual #2.
2. Doesn't the PCP/ISP need to be updated to reflect the new service for members transitioning from Y codes to LTCS? Do we need a signed service order?
 - a. Yes, the PCPs need to be developed or updated to reflect the correct service with a signed service order completed by a Physician, Licensed Psychologist, Physician Assistant, Nurse Practitioner, Licensed Psychological Associate, LCSW or LCSW-A, LMFT or LMFT-A, LMHC, or an LMHC-A.
3. Do we need to update the PCP for services moving from the old Y codes to the new Y codes?
 - a. Yes, all PCPs will need to be updated to reflect the new codes. Providers will have a 90-day technical assistance period to update documents, PCPs and gather any needed signatures but all needs to be in place as soon as possible for the members.
4. Can the timeframe be extended?
 - a. No, the time frame will not be extended at this time. Should we need to revisit this in the future we will do so, but at this time 6/30/2023 is a hard deadline to have documentation in place. This transition was announced in early February and to date there have been 4 information sessions and several notices in Provider News.
5. Can you please share specifically where to find the APSM 45-2
 - a. <https://files.nc.gov/ncdhhs/RMandDM%203rd%20Edition%209-1-16.pdf>
6. Should documentation be completed on a Full-Service Note or Service Grid Documentation? Also, will there be new or different documentation required for this in lieu of service (LTCS)? Will documentation used for Group Living Moderate be sufficient?

- a. Using a full service note or a service grid would be up to your agency, but grid notes would meet the required guidelines in APSM 45-2. Additionally, please look at APSM 45-2 as it outlines Medicaid documentation for ILOs and all compliance guidelines for Medicaid services.
- 7. How will cross walking state funded services work with physicians' signatures being required?**
 - a. Medicaid requirements are different from State funded and there will be differences. Please refer to APSM 45-2 and the content of Long-Term Community Supports as well as the FAQ.
- 8. Is the person's plan going to continue to be the "Developmental Disabilities B-3 and/or IPRS Support Plan," or will it be the "ISP" required for Innovations services? I could not find "in lieu of" defined in the Service Records Manual, and since both can apply to different Medicaid services, I wasn't sure.**
 - a. ILOs are essentially a functional Medicaid definition that is MCO specific but approved by the State. The plan used should be a Person-Centered Plan or PCP.
- 9. Is there the need for an FL-2 or MR-2 for LTCS?**
 - a. No there is no need for FL-2's or MR-2's for LTCS. There is a need to have a PCP and signed service order in place.
- 10. Do we back date the PCPs, service orders, and other documents that may need a signature to 4/1/2023?**
 - a. No, do not back date. Use the actual signed date in those documents but please submit them as soon as you are able.

Transition and Contracting:

- 1. When will the transition take place?**
 - a. Per original state guidance, we have transitioned members as of 4/1/2023.
- 2. Will Alliance be adding to contracts automatically or do we need to request be added?**
 - a. Yes, codes will be added automatically and will not need to be requested.
- 3. Will Alliance be adding the new residential codes YM846, YM847 and YM848 automatically to contracts as well.**
 - a. Yes, we will add those automatically to provider contracts based on the member's current service and where they will be cross walked.
- 4. Will this be added to the provider contract automatically for providers serving folks with IPS services who have Medicaid?**
 - a. Yes, we are working with IT to move authorizations and add codes to the contract.
- 5. Will all services be transitioned over on April 1st meaning there is nothing for the providers to do at this point, correct?**
 - a. Yes, current, and active authorizations were transitioned as of April 1st. If there are any member specific questions or if you do not see your member's authorization in place by Tuesday, April 11th please let us know by emailing, CMmembertransition@alliancehealthplan.org.
- 6. If Alliance is automatically transitioning, what is the timing expectation for providers to update the PCP's?**

- a. Alliance has implemented a 90-day technical assistance period starting 4/1/2023. All updated PCPs, service orders, and documentation related to this transition will need to be in ACS by 6/30/2023.
- 7. For clarification: We shouldn't put any authorizations in the system? You hope for everything to be automatically done?**
 - a. Correct. For current authorizations, IT will transition the authorizations for providers.
- 8. Are you going to offer these services to members that do not currently have state funded residential services? We have 2 members living in group homes, but they don't currently have state residential services.**
 - a. Phase 1- ensure everyone is transitioned to the correct service for continuity of care. The State-funded members to the new State-funded codes and the Medicaid-eligible members to the new ILO. After that we will look at the financing for State-funded. In the meantime, the only new members admitted to these services will be those coming out of a state hospital or crisis setting.

Day Programs, Developmental Therapy, and Personal Assistance:

- 1. What if they are not in a day program?**
 - a. Day programming is written into the definition and the authorization may not be approved if that is not provided as there isn't a separate approval for day programming for this service. Providers should document refusals and look at transitioning members to another service if appropriate. Additionally, providers should ensure the member is engaging in some type of meaningful activity if they continue with LTCS, since this is a habilitative service.
- 2. How will companies providing LTCS that share clients be reimbursed? Will Alliance be working to facilitate contracting between the providers? Example: Provider A serves clients in an AFL home and the client attends a day program at Provider B. Will both providers continue to be paid as of 4/1/2023 for services rendered?**
 - a. Alliance will not facilitate contracting between providers. We both providers to seek any internal legal advice as they create their contracting agreements. Day program providers should be reimbursed by the LTCS provider at a cadence agreed upon by both parties.
- 3. If someone lives in the community with Personal Assistance but does not have Medicaid, what State service will be in place for those folks on 4/1 since they won't qualify for the in lieu of service?**
 - a. If they are in the community and receiving PA, they will most likely crosswalk to state funded CLS.
- 4. What if a member refuses to attend Day Activities?**
 - a. Since LTCS is active treatment there is an expectation that the member's decision to participate is revisited regularly to encourage participation in meaningful day activities due to their benefits to the members' health and well-being. Members have choice and may choose not to participate but providers need to document their efforts to encourage and the member's decision in their notes due to this being a habilitative service.

5. **What if a member is expressing that they want to continue to attend their current day program, but the Long-Term Community Support Provider has not contacted us?**
 - a. For member specific concerns please contact CMMemberTransition@alliancehealthplan.org
6. **If someone already has a meaningful day through Supported employment or another funding source, and we are not the provider, do we just document in the PCP and not worry about having meaningful day goals and documentation?**
 - a. Meaningful or any other day service goals should be included in the person-centered plan and include the SE or other day provider.
7. **For individuals that were receiving DT and PA should the hours crosswalk evenly? For example: individual has 4 hours a week of DT and 6 hours a week of PA, should the authorization reflect enough units for 10 hours a week for the authorization period?**
 - a. Yes, the hours should crosswalk evenly.
8. **Can meaningful day be provided by a different funding stream like Supported Employment?**
 - a. Yes, the only caveat is the Day program staff cannot be the same as the LTCS staff. Also, Day Supports cannot be authorized separately. ADVP, Supported Employment and PSR may be authorized and billed separately.
9. **Does the transition period apply to finding day services and developing the goals for the meaningful day?**
 - a. Yes. If the meaningful day services are provided by a different provider than LTCS that provider can add the goals to the PCP during the treatment team meeting. If LTCS and meaningful day is offered by the same LTCS provider (but it must be different staff) each team should be creating goals for the members.

ADVP:

1. **If a person attends ONLY day program and currently gets ADVP, will they crosswalk to LTCS 1 if they have Medicaid?**
 - a. Day programming with Medicaid will most likely be transitioned to CLS or LTCS Level 1, it depends on the service. If further clarification is needed, please send an email to CMmembertransition@alliancehealthplan.org for member-specific questions.
2. **What are we doing for the ADVP service that is ending?**
 - a. ADVP services are not ending and will continue even if the member is transitioned to LTCS. Providers will not need to sub-contract with this type of service provider.
3. **Is there information about which form will be required annually for doctor signature? FL-2, MR-2, etc.**
 - a. These services do not require an FL-2 or an MR-2.
4. **Does Alliance plan to end or sunset ADVP?**
 - a. While ADVP is an aging service Alliance does not plan to end the service however there is a referral freeze on ADVP and no new members can be added at this time.
5. **Will the ADVP service code change?**
 - a. No, the code will remain YP620, and providers can implement and reauthorize services as they normally would.

New Members and New Sites:

1. **How can a group home be placed on the referral list to be able to accept clients for services?**
 - a. We are not adding new group homes but rather transitioning existing authorizations and members to the new in lieu of service. We will announce Phase II implementation at a later date.
2. **Will Alliance accept new admissions under the new services?**
 - a. No, not yet. The individuals currently receiving state services that are state funded and not Medicaid eligible will be transitioned first. Medicaid eligible recipients will be the transitioned after that to LTCS. Only new members who are transitioning from a hospital or crisis program or other acute situations will be considered for admission. Members must be referred or assigned to care management to be considered for these services. This is Phase I of the transition and Phase II priorities will be allowed once this transition is completed.

Care Management:

1. **With the addition of this new service definition, can we assume group home members will be eligible for care management?**
 - a. Yes, that is correct. They will be Medicaid recipients and eligible for Care Management.
2. **Since this is a Medicaid service, the member cannot receive this new service and Care Management from the same provider, correct?**
 - a. This should fall into conflict free Care Management because of the member's diagnosis and HCBS but please see the conflict free CM policy located [here](#) to confirm for each of your members.
3. **What is the timeframe to reassign the member to another agency for Care Management?**
 - a. We believe conflict free care management would be in effect for this service. Providers who are CMAs or believe conflict free Care Management would be activated for a member should send the member information to the following mailbox: Practicetransformation@alliancehealthplan.org The Practice Transformation Team will assist you in any TCM transitions.

General Questions:

1. **Will there be a slide deck for providers to reference?**
 - a. Yes, the slide deck and recorded information session will be posted later this week.
2. **Where is the definition of State funded CLS on the Alliance website?**
 - a. We pulled it from JCB #J408 and #J417. The JCBs are listed [here](#) and [here](#).
3. **Can a person served receive both State-funded and Medicaid services?**
 - a. If you are a Medicaid recipient and covered by an ILO, you will most likely not be eligible for State-funded services. This rule is typically related to residential supports but please read the JCBs and service definitions closely to determine if there are other services

where they can receive both. For example, there would be a conflict if LTCS is being used but you try to get another Day Support provider to bill state-funded services as day programming is included in LTCS.

- 4. What's the criteria for a person who may receive LTCS? How is a level determined? Is this service transitioning from Innovation Waiver? Can members receive this service without having Innovation Waivers residing in the 5600C facility?**
 - a. The entrance criteria can be found in the service definition and each level is outlined. Members on the Innovations Waiver are not affected by this change. This in lieu of service, Long-Term Community Supports, is for state funded, Medicaid eligible members. Innovation Waiver members are not eligible.
- 5. Where do we send member specific questions?**
 - a. CMmembertransition@alliancehealthplan.org
- 6. Who are the new State-Funded codes for?**
 - a. They are for state-funded members who do not have Medicaid. Medicaid Eligible members will transition to the new ILO, LTCS.
- 7. Is this considered an HCBS service and is compliance required and who writes the plans?**
 - a. This is considered an HCBS service that requires compliance with HCBS guidelines. Also, the provider is responsible for the treatment plan.
- 8. Is a psychological needed every 5 years?**
 - a. While it is not required, that is best practice, and we encourage providers to update a member's psychological every 5 years.