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: 3/20/2020**

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** **Trillium Health Resources**		***b.*** **Date Submitted** **03/20/2020**
c. **Name of Proposed LME-MCO Alternative Service** **Assertive Engagement – YA341**		
d. **Type of Funds and Effective Date(s):** *(Check and Complete Applicable Dates)* **State Funds Only:** ☒ Effective 03/01/2020 to End of Fiscal Year ☐ New Request ☒ Revision to Previously Approved Alternative Service		
e. **Submitted by LME-MCO Staff (Name & Title)** **Cindy Ehlers Executive Vice President**	***f.*** **E-Mail** **cindy.ehlers@trilliumnc.org**	***g.*** **Phone No.** **2526700199**

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** Assertive Engagement Assertive engagement is a way of working with adults and/or children with a MH/ID/DD/SU and who do not or are unable to effectively engage with treatment services. Assertive Engagement is a critical element of accessing care for habiliatation and recovery as it allows flexibility to meet member's particular needs in their own environment or current location (i.e. hospitals, jail, shelters, streets, etc.) It is designed as a short term engagement service targeted to populations or specific member circumstances that prevent the individual from fully participating in needed care for mental health, intellectual developmental disability, or addiction issues. Use of Assertive Engagement is limited to the following times: • First 30 days following the provision of a crisis service (mobile crisis, behavioral health crisis care in an emergency department) • First 30 days following hospital discharge (community-based hospital, state psychiatric hospital) • First 30 days following ADATC or a detox/facility based crisis service discharge • During a natural disaster or as an alternative for telehealth in lieu of other services

2	**Rationale for proposed adoption of LME-MCO Alternative Service to address issues that cannot be adequately addressed within the current NCTRACKS Service Array** Trillium Health Resources ("Trillium") experiences a large number of referrals of individuals deemed to be at significant risk of harm, including hospitalization, who do not readily initiate and engage in services without assertive efforts to engage them in services. Or for members who cannot engage in services as the result of social distancing or sheltering in place due to state of emergency or natural disaster. This situation is also common to higher intensity outpatient treatment services, whereas members meet medical necessity criteria for that level of care. There is currently no service in the IPRS service array that permits billing and payment for providers who must work to build relationships in a variety of settings, including jails, inpatient facilities, and facility based crisis, and in the community or telephonic outreach. The most comparable service, Assertive Outreach, is intended for homeless individuals only, and is an attempt to engage individuals until admission to services. Trillium finds a need to fund providers to work with difficult cases to promote treatment engagement and retention as a way of reducing the need for crisis services and stopping the cycle of re-admission to higher levels of care or to provide care during times of states of emergency or natural disaster.
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** Assertive Engagement is a method of working with members who have a MH/ID/DD/SU diagnosis and have difficulty engaging in traditional services or are unable to as the result of a state of emergency or natural disaster . Additionally, these members aged 3 up to 64 may also have a history of erratic or non-engagement in treatment, have a history of erratic or non-adherence to medication resulting in symptom manifestation and/or relapse or have a history of frequent hospitalizations, jail/detention days or involvement with law enforcement or utilization of crisis services such as detox or FBC. Currently, Medicaid does not permit billing for services in a hospital or jail setting. Trillium has found through review of available data that the majority of members in need of assertive engagement services appear to be new to services and were not engaged in treatment with a provider prior to 1) contact with crisis services such as mobile crisis or assistance for a behavioral health crisis in an emergency department 2) being admitted to an inpatient hospital setting either to a community-based hospital or a state psychiatric hospital, and 3) being admitted to an ADATC or a detox/facility based crisis service or 4) are involved in an event that is a natural disaster or state of emergency. Due to the member's inability to access care or a decision not to pursue recommended after-care treatment or services, it is likely these members will experience re-admissions or to a higher level of care. Assertive Engagement services provide an opportunity to fund providers to work with members to promote engagement and retention as a way of reducing the need for crisis services and stopping the cycle of readmission to higher levels of care.
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)* **x☐ Recommends ☐ Does Not Recommend ☐ Neutral (No CFAC Opinion)** Trillium's CFAC has not reviewed this specific alternative service request. But, has provided ongoing support to the LME/MCOs efforts to engage and to work effectively with this population.
5	**Projected Annual Number of Persons to be Served with State Funds by LME-MCO through this Alternative Service** Up to 4000
6	**Estimated Annual Amount of State Funds to be Expended by LME-MCO for this Alternative Service** Trillium estimates approximately $325,000 for this service annually. We will control and monitor costs through our benefit plan and service design package. In addition, only selected providers of evidence based or best practice services will be utilized to deliver the service. Baseline data will be

	gathered in the first year. 32 units / member X $15.00/ unit = $480.00 $480.00 / member X 4000 members = $1,920,000
7	**Eligible NCTracks Benefit Plan(s) for Alternative Service:** *(Check all that apply)* ***Assessment Only:*** ☐***GAP*** ***Child MH:*** ☒***All*** ☐***CMSED*** ***Adult MH:*** ☒***All*** ☐***AMI*** ***Child DD:*** ☒***CDSN*** ***Adult DD:*** ☒***All*** ☐***ADSN*** ***Child SA:*** ☒***All*** ☐***CSSAD*** ***Adult SA:*** ☒***All*** ☐***ASCDR*** ☐***ASWOM*** ☐***ASTER*** ***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?* **$15.00**
10	**Explanation of LME-MCO Methodology for Determination of Proposed NCTracks Maximum Unit Rate for Service** *(Provide attachment as necessary)* Without direct experience with this service, Trillium adopted the rate setting methodology of other LME/MCOs that have begun using this service, which was to take the average per unit cost of community support and assertive outreach and decreased it by 15%. It was felt that this new service encompasses components of both Community Support and Assertive Outreach. The average rate is applicable to meet this need.
11	**Provider Organization Requirements** Assertive Engagement Services must be delivered by personnel employed by behavioral health provider agencies that: • Meet provider qualification policies, procedures, and standards established by the Division of Health Benefits (DHB); • Meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); • Fulfill the requirements of 10A NCAC 27G Rules For Mental Health, Developmental Disabilities, And Substance Abuse Facilities And Services. • Meet Local Management Entity-Managed Care Organization requirements • Are currently enrolled in the Trillium's provider network; • Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

12	**Staffing Requirements by Age/Disability** *(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)* This service can be provided by licensed clinicians, Qualified Professionals (QP), Associate Professionals (AP), Paraprofessionals (PP) and Certified Peer Support Specialists (CPSS).
13	**Program and Staff Supervision Requirements** The following staff members may provide services according to 10A NCAC 27G .0104 - Staff Definitions: a. Qualified Professional – QP b. Associate Professional - AP c. Paraprofessional - PP Staff providing Assertive Engagement must be supervised by a QP level supervisor.
14	**Requisite Staff Training** Staff providing this service must have knowledge of motivational enhancement techniques or complete such training prior to delivering this service.
15	**Service Type/Setting** Assertive Engagement is intended to be flexible in its approach to meet the needs of members at that moment in time. The place of service will vary depending on the member's circumstances. Assertive Engagement is a direct periodic service that can be provided in a range of community settings. It may be provided in the member's place of residence, community, in an emergency department, or in an office setting, school, shelters, work locations, and hospital emergency rooms.
16	**Program Requirements** Assertive Engagement is designed to be an individual service requiring contact as necessary with identified members in an effort to build/ re-establish a trusting, meaningful relationship to engage or re-engage the member into services and/ or assess for needs. The service is designed to result in one or more of the following outcomes: • Members are linked to appropriate level of services • Members become engaged and involved in active treatment • Members develop and maintain meaningful engagement in services • Member's use of hospital services (inpatient/ ED) is reduced in frequency and duration • Member's use crisis services (mobile crisis/ FBC)less frequently • Members need for detox and ADATC services are reduced • Members medication adherence is increased • Members receive continuity of care regardless of life circumstances or recovery environment • Relapse prevention • Reduction of criminal/ juvenile justice involvement • Reduction of number of days incarcerated or in detention
17	**Entrance Criteria** Members with a MH/ID/DD/SU diagnosis who have a history of erratic or non-engagement in treatment are eligible for this service. They must be identified as in need of active engagement, have experienced a significant therapeutic disconnect with the service provider(s) or have an instance of/situation resulting in inpatient hospitalizations, use of facility based crisis services, emergency departments, detox services, jail days, or involvement with law enforcement.
18	**Entrance Process** Selected providers offering enhanced, high intensity, or best practice services may be able to utilize the service as one strategy to engage and retain members, prevent the repeated use of hospital or other crisis services, and reduce jail/detention utilization. Elements of the assertive engagement process include building trust with the member, assisting members with meeting basic needs for shelter, food, and safety, providing education regarding services and making collateral contacts with

	family and others working with the member. Trillium has developed a process for identifying members with a higher level of non-compliance and numerous hospitalizations, and these members will be prioritized for this service. Trillium will develop a benefit plan outlining the amount and intensity of the service which may be provided based on individual member need and available funding.
19	**Continued Stay Criteria** Not applicable. This is a short term engagement service and is not designed as a long term method of service delivery.
20	**Discharge Criteria** Member is fully engaged in services; OR Member has refused recommended services after reasonable attempts have been made to engage him/her in treatment and no safety issues or concerns are present.
21	**Evaluation of Consumer Outcomes and Perception of Care** Since this is a very short term service, standard outcome measurement instruments such as NCTOPPS, MH/SA Consumer Satisfaction or NCI Surveys are not applicable. In addition to one or more of the following identified outcomes: • Members are linked to appropriate level of services • Members become engaged and involved in active treatment • Members develop and maintain meaningful engagement in services • Member's use of hospital services (inpatient/ ED) is reduced in frequency and duration • Member's use crisis services (mobile crisis/ FBC)less frequently • Members need for detox and ADATC services are reduced • Members medication adherence is increased • Members receive continuity of care regardless of life circumstances or recovery environment • Relapse prevention • Reduction of criminal/ juvenile justice involvement • Reduction of number of days incarcerated or in detention
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 is a daily service note that includes the member's name, date of service, purpose of contact, duration of contact, and the signature and credentials of the person providing the service.
23	**Service Exclusions** There are no service exclusions. Various basic and enhanced services, as appropriate, are allowable. Examples might include medication management/evaluation, SAIOP, SACOT, ACT, CST, etc. Assertive Engagement is not billed on the same day as enhanced services other than assessment and crisis intervention.
24	**Service Limitations** Service is limited to 8 hours per month per member. Maximum per day is 2 hours.
25	**Evidence-Based Support and Cost Efficiency of Proposed Alternative Service** Assertive Engagement is a central component in a comprehensive continuum of community based services. Research has shown a:

	-35% decrease in hospitalization -62% reduction in number of days in hospital -Significant improvement in coping skills and quality of life -Fewer interactions with police www.scmh.org. *"Behavioral health needs also present unique challenges. Mental illness and substance use disorder are stigmatized in our culture and many individuals find it difficult to seek care. Community and individual resistance to clinically appropriate care leads to delays in seeking treatment, which can result in deterioration of an individual's health and well-being. Delays in treatment can also result in individuals having more complex and often more expensive care needs*." Report to the Joint Legislative Oversight Committee on Health and Human Services Joint Legislative Oversight Committee on Medicaid and NC Health Choice and Fiscal Research Division By The North Carolina Department of Health and Human Services; January 31, 2018
26	**LME-MCO Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service** System level (across member served through this proposed alternative service definition): • State hospital and community impatient psychiatric admissions will be reduced • State hospital and community psychiatric bed day utilization will be reduced • Readmissions for facility-based crisis services will be reduced • Crisis services contacts will be reduced • Incarceration rate will be reduced
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_☐_Medicaid waiver_☐_Non-state funds Date:** __/__ __/__ **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**