Vaya Health

Residential Services - Complex Needs

Children and Adults Ages 10 and older with ID/DD and Co-Occurring MH

H0018HA- Child
H0018HB- Adult

Service

Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (I/DD) with co-occurring mental health diagnoses or significant behavioral challenges. The service is intended to act as an alternative to Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs). Members in this service require a multi-disciplinary approach with staff who are trained to treat I/DD, mental health, and severe behaviors. This service is provided in a small group home setting or alternative family living with highly structured supports. The service is delivered 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 provide support for assessment and de-escalation during crisis events. A psychiatrist or other physician with behavioral health expertise within the provider organization shall be available for consultation and coordination with outpatient psychiatric care. Interventions should be individualized based on the unique needs of the member, but behavioral plans shall be developed and implemented for all members. Families/caregivers/guardians shall be actively engaged in treatment, learning strategies and interventions that could be replicated in non-residential settings, such as the members' own homes or family homes at minimum twice per month or more frequently if needed. Comprehensive coordination should occur with other stakeholders such as schools, employers, natural supports, and the primary care provider (PCP). The focus of the service is to conduct strategic planning across the systems, with ongoing development of a strong natural support structure to reduce the need for paid supports.

During therapeutic leave visits, the residential provider staff shall join the member in their home environment for a portion of that time to offer in home supports and training to the caregiver and other family members. In the 30-60 days prior to discharge, the frequency of these visits and coaching should increase. The residential provider also ensures 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.

Through use of a comprehensive team model, members will receive more integrated treatment interventions that ensure all diagnoses, including medical needs, are being fully assessed and treated. At a minimum, providers are required to have access within their own agencies to Qualified Professionals (QPs), licensed clinical staff, psychologists, and medication prescribers. Based on the individual needs of the member's psychiatric services, other services (such as nursing services, Occupational Therapy and Physical Therapy) may also 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 member and adjusted throughout treatment. Routine nursing may be a standard part of the program, if indicated based on the population served.

A key component of this service is to connect members to community activities and interests. The goal is to develop natural supports that can be sustained as the paid services and supports fade. Whenever possible, providers are

required to connect a member to activities that can be maintained as the member transitions back to their home. When the distance between the residential setting and the home community makes this challenging, the residential provider should connect members with similar activities in their local communities prior to discharge to ensure continuity of these supports.

Meeting a member's educational and vocational needs is key to successful outcomes for a member with complex needs. To assist families or other caregivers with navigating systems and accessing support, the residential provider shall work jointly and collaboratively with the school system. In cases where a school transfer does occur due to the location of the residential setting, the provider shall coordinate with both schools to ensure continuity. The residential provider shall assist the family in ensuring that appropriate supports are in place (such as a 504 plan or Individualized Education Program (IEP) plan) and that the behavior plans are used consistently across all settings with modifications as needed. Provider support may involve working directly with the member in the school setting to provide temporary coaching for consistency across settings. The residential provider will assess vocational interests and provide opportunities for the member to engage in employment. Interventions include linkage to formal resources such as Vocational Rehabilitation, Supported Employment, and occupational tracks in school or through informal connections with local community businesses willing to support the member. When necessary, the residential provider assists in transitioning these formal resources or helping with informal resources in the member's home community in preparation for discharge.

Whenever possible, appropriate specific evidenced-based interventions/best practices shall be incorporated into individual treatment plans. These interventions may include, but are not 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.

Treatment Program Philosophy, Goals, and Objectives

Key components of the program include recovery, empowerment, self-determination, person-centered planning, integration, and consumer/family-driven services. The service also provides active engagement in the community to identify community-based opportunities. The goal is for the individual to expand community connections and participate in meaningful day activities outside of service activities. This engagement may involve inclusion in community recreational activities with non-disabled peers and exploration of individual interests.

Providers must complete a Checklist of Adaptive Living Skills (CALS) assessment, functional behavior assessment, and preference assessment on templates provided by Vaya Health, as well as any other needed assessments within the first 30 days of treatment. At a minimum, each assessment will be revisited according to the following schedule:

- CALS assessment: annually
- Preference assessment: every 30 days
- Functional Behavior assessment: when there is no evidence that behavioral progress is occurring (active progress monitoring should occur weekly)
- Other assessments: when clinically appropriate

Goals must be individualized and based on information obtained from the identified assessments. Treatment interventions shall reflect evidence-based practices or best practices as a standard part of the treatment.

At a minimum, Child and Family Treatment teams or treatment teams shall occur monthly and increased as necessary to address incidents, crises, or other concerns. Every effort must be made for these meetings to involve all stakeholders such as schools, employers, and natural supports, in addition to the provider and the family. When other service providers are unable to attend, input should be sought from them prior to the meeting. Meeting outcomes should be

shared with all stakeholders/care team members after the meeting occurs. Providers shall maintain documentation of this communication in their records.

Providers shall work intensively with the member to develop skills to reduce aggressive or inappropriate behaviors and develop supportive strategies that can be utilized in both the treatment and home settings. Providers shall implement a behavior plan and modify as frequently as necessary for effective strategic interventions. The behavior plan shall be shared with all supports that interact with the individual such as the school, therapist, PCP, psychiatrist, and family. Standard outcome measures are utilized at routine treatment intervals, at completion of treatment and during follow up care whenever possible.

Anticipated Outcomes

- Provider accepts no less than 80% of all individuals referred to the provider agency, when demographics inclusive of, but not limited to, age and gender align with other members currently being supported at the identified site
- Member demonstrates a reduction in aggressive, unsafe, or inappropriate behaviors
- Member exhibits improvement in skill development
- Reduction in crisis episodes
- Member demonstrates a reduction of mental health symptoms
- Member can transition back to the family setting or less restrictive setting home within six months
- Objective improvement in school or work as indicated in progress notes, employee reviews, treatment team meetings, etc.
- Coordinated care which includes physical health providers to promote wellness, stability, and whole person care

Concurrent Services

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 may be authorized during the same period as approved by the Utilization Management team but must be included in the plan with coordination occurring.

Outpatient:

- Psychiatric services: Some members may have established psychiatric providers and it may be contraindicated to transfer to a new provider.
- Outpatient therapy: The primary responsibility for therapy provision is within the residential service. However, in individualized cases where specialized therapy is required, an approval may be considered based on the member needs.
- Psychological Testing: If updated psychological testing is necessary, this service maybe billed separately. However, this does not include screenings or the ongoing clinical assessment that is expected as part of the psychologist involvement in the programming.

Crisis Services:

- Mobile Crisis Management: The provider must have licensed clinicians available for first responder functions, including face-to-face assessment. However, if this has occurred and additional assistance is needed, mobile crisis may be utilized to provide additional support to divert a member from inpatient services.
- Inpatient Admission: While it is the overall intent that proactive strategies and planning will reduce the need for formal inpatient treatment, if the member does become an imminent risk to self or others and de-escalation has not been effective, this service may be utilized when medically necessary.

Service Exclusions

Because this service includes a case management component, providers must clearly outline on the member's care plan how they will collaborate with Tailored Care Management to ensure there is no duplication of services. The case management function of this service is to support the treatment being done within the program to ensure progress and decrease the need for a higher level of care for the services.

Service Frequency and Intensity

The service frequency and intensity vary based on the service level and is increased or decreased based on individual needs as documented in the Individual Support Plan (ISP) or care plan. The provider must use direct face-to-face and indirect (e.g., telephone, email, mail, assisted technology) contacts, including collaboration with other providers and the member and their family and team, when delivering this service. Contacts with the member must be at the frequency and intensity outlined in the ISP or care plan.

Provider Requirements:

The provider delivering this service shall meet the following requirements:

- Provider must meet qualification for participation in NC Medicaid and/or NC Health Choice program, be credentialed by the Division of Health Benefits, and be enrolled in NCTracks.
- Provider must be enrolled as a network provider in Vaya Health's Closed Provider Network, in good standing, and contracted to deliver the service.
- Provider must verify employee/independent contractor qualifications at the time employee is hired/contracted. Providers must provide verification of staff qualifications on at least an annual basis.
- Provider must comply with all terms and conditions of the network contract with Vaya Health, other applicable written agreements, and all applicable federal, state, and local laws, rules, and regulations.

Staffing Requirements

Title	Qualifications	Credentialing Process	Clinical Supervisor Requirements	Training
Qualified Professional	Two years of experience with the population served	N/A	Supervises AP/paraprofessional Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.	Training in a standardized program for working with individuals with dual diagnoses is required within six months of operations. Vaya Health will specify the specific training elements, hours required, and accepted training platforms for documentation of training completion.

Associate Professional or Paraprofessional	Two years of experience with the population served	N/A	Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.	Training in a standardized program for working with individuals with dual diagnoses is required within six months of operations. Vaya Health will specify the specific training elements, hours required, and accepted training platforms for documentation of training completion.
Licensed Clinician	Provider agencies with clinical expertise in providing services to individuals who are dually diagnosed	Clinicians associated with the program will be credentialed according to standard process.	Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.	Training in a standardized program for working with individuals with dual diagnoses is required within six months of operations. Vaya Health will specify the specific training elements, hours required, and accepted training platforms for documentation of training completion.
Doctoral Level Psychologist	Provider agencies with clinical expertise in individuals who are dually diagnosed	Clinicians associated with the program will be credentialed according to standard process.	Supervision must be provided according to the requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.	Training in a standardized program for working with individuals with dual diagnoses is required within six months of operations. Vaya Health will specify the specific training elements, hours required, and accepted training platforms for documentation of training completion.

Member Eligibility Requirements

To be eligible for Complex Residential, the member must have NC Medicaid or NC Health Choice based on residence in a county located within Vaya's region and be enrolled in Vaya's Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan, and meet the following criteria:

- Have dual diagnoses (I/DD and MH) with high-level behavioral needs; AND
- Have experienced multiple placements; AND
- Have difficulty functioning in community settings

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards, as verified by Vaya, which will evaluate the request to determine if medical necessity supports more or less intensive services. Medically necessary services are

authorized in the most cost-effective mode, if the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

Prior Approval Requirements:

1. The provider shall obtain prior approval from Vaya Health before delivering Complex Residential
    a. Initial authorization is limited to 1 unit per day for up to ninety (90) days
    b. Reauthorization is limited to 1 unit per day for up to sixty (60) days
2. The provider shall electronically submit the following to Vaya Health's Utilization Management Team for prior approval:
    a. A fully completed Service Authorization Request (SAR);
    b. The most recent Psychological Evaluation for the member. Evaluations must be completed by a psychologist, licensed psychological associate or physician, as defined in N.C.G.S. §122C-3 and as appropriate based on the individual's specific clinical issue. If the presenting issue is an intellectual disability, or a condition closely related to an intellectual disability, a psychologist or licensed psychological associate completes the evaluation. The evaluation includes intellectual testing and adaptive behavior assessment. If the condition is cerebral palsy, epilepsy or a condition closely related to one of these two disabilities, physician records may be submitted in addition to assessments of functional behavior.
    c. A copy of the member's Person-Centered Plan or care plan, developed with the member, along with input from their guardian, family, and team. Relevant diagnostic information must be obtained and included in the care plan. A Master's level behavioral health professional licensed in the state of North Carolina with at least two years of post-master's degree experience with the population served may order this service.
    d. Skills and Preference assessments (required annually)
    e. Comprehensive Clinical Assessment

This service shall be covered when the service is medically necessary and:

- The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not more than the member's needs;
- The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
- The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider; and
- The member meets and continues to meet the eligibility requirements for this service, and treatment goals have not yet been achieved. Services and interventions must be reviewed for effectiveness, and interventions should be modified, if necessary, so that the individual makes greater progress.

Transition or 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 Complex Residential
- 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 Complex Residential

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:

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

EPSDT does not apply to NC Health Choice members.

EPSDT and Prior Approval Requirements

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.

Important additional information about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide and on NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children.

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.

Documentation Requirements

These services shall be properly and contemporaneously documented in accordance with this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya Health.

Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.

Providers shall make all documentation supporting claims for services reimbursed by Vaya Health available to Vaya Health, NCDHHS and CMS upon request.

All clinical evaluations and assessments, including re-assessments, require a written report, completed, and signed by the person who conducted the assessment. When more than one clinician participates in completing an assessment or evaluation, then the signature of each clinician is required on the report, unless stated otherwise in the service definition. Each report should be easily identifiable as such and readily accessible in the service record.

Each individual is required to have a Person-Centered Plan or care plan that is fully complete prior to or on the first date of service. The Person-Centered Plan or care plan must meet all the requirements, including an enhanced crisis plan, as outlined in the NC Person-Centered Plan Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP.

A full service note that meets the requirements per APSM 45-2 is required for each contact or intervention (such as individual session, case management, crisis response) for each date of service. Each service note must include the following information:

- Member's name
- Service record number
- Medicaid identification number (as applicable)
- Name of service provided
- Full date of service
- Place of service
- Type of contact (face to face, telephone call, collateral, etc.)
- Purpose of contact as it relates to the goal(s) on the care plan
- Description of the interventions provided
- Time spent providing interventions (i.e., duration)
- Assessment of effectiveness of intervention and/or the recipient's progress towards the goal(s)
- Signature and credentials of the staff member(s) providing the service

Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with youth, family/caregiver, and child and family team will be documented. A documented discharge plan shall be discussed with the individual and included in the service record.

Claims-Related Information

Providers shall comply with the NCTracks Provider Claims and Billing Assistance Guide, applicable Medicaid bulletins issued by the NC Division of Health Benefits (DHB), applicable NC Medicaid/NCHC Clinical Coverage Policies, this service definition, Vaya Health's fee schedule and other requirements and any other relevant documents for specific coverage and reimbursement for Medicaid and NC Health Choice.

1. **Claim Type:** Professional (CMS-1500/837P transaction) billed through Vaya Health.
2. **International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**
    a. Provider(s) shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description.
    b. A diagnosis of an intellectual disability or a related condition must be present to bill for this service. (See 42 CFR § 435.110)

3. **Codes and Modifiers:** Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
4. **Billing Units:** Providers bill this service on a unit basis. 1 unit = 1 day.
5. **Place of Service:** The service is provided in a group home or an alternative family living home.
6. **Prior Authorization:** Provider must have a prior authorization for the delivery of services to the member approved by Vaya Health prior to submission of claims for payment to Vaya Health.
7. **NCTracks Enrollment:** Providers must be enrolled through NCTracks and ensure valid NPIs, taxonomies, sites, zip code (+4) and all other provider demographic information provided to Vaya Health matches the information in NCTracks to bill Vaya Health and be reimbursed for this service.
8. **Coordination of Benefits:** Providers must file with primary payor(s) prior to submission of claims for payment to Vaya Health, if applicable.
9. **Reimbursement:** Vaya Health reimburses providers for clean claims for services rendered in accordance with this Service Definition.