



## North Carolina Department of Health and Human Services

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### MEMORANDUM

**TO:** Legislative Oversight Committee Members  
Local CFAC Chairs  
NC Council of Community Programs  
County Managers  
State Facility Directors  
LME Board Chairs  
Advocacy Organizations  
MH/DD/SAS Stakeholder Organizations  
Commission for MH/DD/SAS  
State CFAC  
NC Assoc. of County Commissioners  
County Board Chairs  
LME Directors  
DHHS Division Directors  
Provider Organizations  
NC Assoc. of County DSS Directors

**FROM:** Dr. Craigan L. Gray  
Steven Jordan *SS*

**SUBJECT:** Implementation Update #89  
Medicaid Waiver Strategic Plan  
MH/DD/SAS Integrated Care Toolkit  
CABHA Monitoring  
Electronic Submission of Prior Authorization  
Quality of Care Update  
IRIS Updates for FY 2012  
Independent Assessment for CST  
Proposed Changes to Medicaid Policy 8C  
Clarification of NCCI & Enrollment  
Outpatient Billing "Incident To" a Physician  
Perception of Care Surveys  
CAP-MR/DD and MFP Slots  
Press Release on Health Care Fraud

### Medicaid Waiver Strategic Plan

The Department of Health and Human Services (DHHS) will be seeking stakeholder input to develop a draft Medicaid waiver strategic plan. This plan will delineate specific strategies and agency responsibilities for the successful achievement of statewide implementation of the 1915 b/c waiver as identified in House Bill 916.

The North Carolina General Assembly through S.L. 2011-264, House Bill 916 instructed the DHHS to proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915 b/c Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915 b/c Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental

disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. Further, House Bill 916 instructed the DHHS in coordination with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the Division of Medical Assistance (DMA), local management entities (LMEs), PBH and with stakeholder input to submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in the act.

DHHS is grateful for the interest and participation in this process by families, service recipients, advocates, and providers. An initial draft of the waiver strategic plan document will be posted for public comment on both DMH/DD/SAS and DMA waiver web pages by the first part of August. Both Divisions will also reach out to specific State stakeholder advisory groups for input into this strategic plan document.

The Draft Plan is found at: <http://www.ncdhhs.gov/mhddsas/waiver/draftwaiver.htm>. Given the timelines with which we have to work to present the completed plan to the General Assembly by October 1, we request that your feedback to the plan by Monday, August 15. Also, as you read over the Draft, you'll note placeholders for information not yet included there. We hope you'll recognize that this indicates that we do not bring a final version for you to approve or disapprove, but rather that we bring it to you in its formative stages and seek your best thoughts in crafting a worthy report.

Your feedback may be registered by sending it to: [CommentsDraftWaiverStrategic@dhhs.nc.gov](mailto:CommentsDraftWaiverStrategic@dhhs.nc.gov)

### **MH/DD/SA Integrated Care Toolkit**

This toolkit was created to assist MH/DD/SA providers in collaborating with Community Care of North Carolina (CCNC) and primary care providers. (For the purpose of the documents in the toolkit, PCP refers to primary care provider and provider refers to MH/DD/SA providers.) Please refer to the toolkit documents on the DMA website at <http://www.ncdhhs.gov/dma/services/behavhealth.htm>.

### **Overview of the Toolkit**

- 1) **MH/DD/SA Integrated Care Flowchart** – this document details for MH/DD/SA providers how to determine if a Medicaid recipient entering services has a CCNC medical home or other primary care provider and how to gather physical health information (through the Provider Portal/Informatics Center and from the primary care provider) to incorporate into the recipient's assessment and Person-Centered Plan of Care. It also offers guidance on when to contact the primary care providers.
- 2) **Four Quadrant Care Management Model Responsibilities** – using the Four Quadrant Model framework, this document defines the expectations for collaboration between MH/DD/SA providers and primary care providers in conjunction with Local Management Entities/Managed Care Organizations and Community Care of North Carolina networks.
- 3) **Sample questions** – this document offers sample questions for MH/DD/SA providers to ask recipients to determine their level of involvement with primary care and potential physical health needs.
- 4) **Benefits of CCNC** – this document, from the Department of Social Service (DSS) manual, explains the benefits of a CCNC medical home. This form, along with a Spanish version can be found on the DMA website <http://info.dhhs.state.nc.us/olm/forms/forms.aspx?dc=dma>. The forms are DMA-9016 and DMA-9016sp. Only DSS can enroll Medicaid recipients into CCNC medical homes.
- 5) **Information from the Provider Portal/Informatics Center** – this document is an example of information that can be accessed (via CCNC or the LMEs) from the Provider Portal/Informatics Center – this includes a Patient Care Team Summary, Visit History, Medication Regimen, and any applicable care alerts.

### **Critical Access Behavioral Health Agency Monitoring**

The temporary CABHA Rules require that the CABHAs (Critical Access Behavioral Health Agencies) certified prior to January 1, 2011 be allowed a period of six (6) months of operation as a CABHA to come into compliance with the Medical Service and Certification and Staffing Requirements of the rules. Given the date of January 1, 2011 as the official start date for CABHA-only services going into effect, DHHS will begin CABHA monitoring during the last week of August, 2011. A sample of approximately 75 CABHAs statewide will be monitored by teams led by the DMH/DD/SAS Accountability Team and include staff from DMA and the LMEs. The sample is about 95% random, supplemented by provider agencies referred to the DHHS due to significant issues of concern.

The overall monitoring process will include the following four (4) components:

1. Data review completed at the DHHS level
2. Onsite review by LME staff
3. Onsite review by DHHS staff
4. Off site telephone contact by LME staff to individuals receiving services from the CABHAs

The process will involve utilizing separate monitoring tools developed for LME and DHHS staff. The LMEs will review items related to service records, while DHHS staff will review administrative/infrastructure requirements. Data elements to be reviewed off-site by DHHS staff address outcomes specific to access, safety, service and treatment success, and cost control. Training for LME monitoring staff will be presented by webinar in mid August. Training for DHHS monitoring staff will also occur in August.

All reviews will take place at the offices of each CABHA at their certified CABHA site. Information letters will be posted or sent by mid-August. The monitoring tools and data elements will also be posted on the web prior to the start of monitoring. Follow-up letters with identification of service records needed for review will be sent to each CABHA to be monitored one week prior to scheduled review dates. Reports of the results of each monitoring will be generated once the process is complete.

This monitoring process has been informed by participation of consumer and family advocates, providers, LME and State staff – both DMH/DD/SAS and DMA staff. It combines fact-gathering components for the purpose of gathering baseline information, rule-based components, and personal outcome measures. Every attempt has been made to both gather as much data as possible from available resources such as paid claims, and to not duplicate other monitoring efforts. All results and feedback will be used to improve and streamline the monitoring process going forward.

### **Mandatory Electronic Submission of Authorization Requests**

Effective October 1, 2011, the Appropriations Act of 2011 (House Bill 200) mandates that providers submit authorization requests electronically via the vendor's website. For purposes of submitting mental health, substance abuse, and developmental disability requests to the appropriate Utilization Review vendor, please note the following information for submission:

#### **ValueOptions**

ValueOptions continues to offer live webinar training on ProviderConnect submission. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *Provider Training Opportunities* section to view webinar details and access additional ProviderConnect resource documents such as the ProviderConnect User Guide, Quick Reference Guide, and Frequently Asked Questions (FAQ) document:

[http://www.valueoptions.com/providers/Network/North\\_Carolina\\_Medicaid.htm](http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm)

#### **Eastpointe Providers**

For purposes of submitting mental health, substance abuse, intellectual and other developmental disability requests electronically to Eastpointe, providers should utilize the LME ProviderConnect web portal at <http://carelink.caretasp.com/EastpointePC/>.

Eastpointe providers can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the bottom of the page and see the section labeled *Webinars*. Providers can also view additional

Medicaid utilization review materials from this page:  
<http://www.eastpointe.net/providers/MedicaidUR/mur.aspx>

### **The Durham Center Providers**

For purposes of submitting mental health, substance abuse, IDD and CAP I/DD requests electronically to The Durham Center, providers should utilize the ProviderConnect web portal:  
<https://carelink.carenetasp.com/DurhamPC/>

The Durham Center will be providing several live webinars in the coming months. Please visit the Durham Center's training/events calendar located on their website or use the following link to get directly to the calendar: <http://www.durhamcenter.org/index.php/provider/calendar>. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *ProviderConnect* section to access a recorded webinar and to access the Durham Center ProviderConnect User Manual. The webinar and user manual will provide information regarding obtaining a ProviderConnect user name and password: <http://www.durhamcenter.org/index.php/provider/docs/service>

### **Pathways LME Providers**

For the purpose of submitting CAP I/DD requests electronically to Pathways LME, providers should utilize the following link and select "CAP MR/DD Authorization Request": <http://www.pathwayslme.org/capur/>

The "CAP MR/DD Authorization Request" link is under construction at this time. Please visit Pathways LME website for updates on electronic submissions and trainings they will be providing.

### **Crossroads Behavioral Healthcare Providers**

For the purpose of submitting CAP I/DD requests electronically to Crossroads Behavioral Healthcare, providers should utilize the following ProviderConnect web portal: <https://carelink.carenetasp.com/crossroadspc/login.asp>.

Crossroads providers can access a ProviderConnect presentation at the link below and select "CAP MR/DD UR" and scroll down to Provider Training Presentations: <http://crossroadsbhc.org/>. To obtain a login and/or individualized training on Provider Connect, you can contact Pat Draughn at [pdraughn@crossroadsbhc.org](mailto:pdraughn@crossroadsbhc.org)

### **Quality of Care Update**

The DMH/DD/SAS and DMA have updated the Quality of Care process to assist in promoting quality of care provided to consumers. Quality of care refers to the health and safety of the consumer as well as to the clinically appropriate service(s) at the clinically indicated frequency and duration.

DMH/DD/SAS and DMA collaborated, with input from various stakeholders, to create a plan incorporating guidelines for two complementary processes: quality of care oversight and independent assessments. As part of this process, recipients who have been in a service for an extensive length of time may be referred for an Independent Assessment in order to ensure appropriate service delivery continues and all identified needs are met. The utilization review vendors (ValueOptions, Eastpointe, The Durham Center, Crossroads and Pathways) identify concerns for follow up by the LME and the DMA/DMHDDSAS Quality of Care Committee.

The Quality of Care Guidelines and related documents can be found on the DMH/DD/SAS website at: <http://www.ncdhhs.gov/mhddsas/statspublications/presentations.htm> and the DMA website at: <http://www.ncdhhs.gov/dma/services/behavhealth.htm>.

### **Incident Response Improvement System Updates for FY2012**

Incident Response Improvement System (IRIS), the web-based incident reporting system, was updated in July in preparation for the fiscal year 2011-2012.

### **Service Combinations**

In order to provide clarity for providers and to obtain accurate data, the following services have been combined (Note: All prior data has been maintained within the system):

- Therapeutic Leave and Room and Board services are considered part of residential services so therapeutic leave and room and board are now inactive services. Providers will only need to check the appropriate residential service.
- The majority of Supervised Living (.5600) homes are licensed through the Division of Health Service Regulation (DHSR). The DHSR license will specify the type of home and if the home is licensed as a .5600 A, B, C, D, E or F. Providers should now select the appropriate type of supervised living based upon their license. If the supervised living home is unlicensed, providers should select unlicensed supervised living services.
- If the individual being served is also receiving IPRS Supported Living, Family Living or Group Living in a licensed or unlicensed Supervised Living home, the appropriate IPRS service type should also be checked in addition to the appropriate Supervised Living home category.
- Since IRIS is obtaining only information about the services being provided, each service contains a listing of the applicable billing codes. Providers will now only need to check the appropriate service. The following services contained several billing codes: Behavioral Health Counseling and Treatment, Community Respite, and Supported Employment.

**Note: The billing codes referenced in the bullets above remain the same for billing purposes and have been combined only in IRIS for data collection.**

### **Reporting of Medication Errors in IRIS**

Due to recent changes within our system, the medication error reporting process had to be updated.

Any time that a provider learns that a consumer did not take or was not given medication as prescribed, the provider should contact the physician or pharmacist as required by 10A NCAC 27G .0209(h) to determine if this is a threat to health and safety and for directions for care of the person (including next medication). All medical issues as well as the provider's contact with the physician should be documented in the individual's chart (medication administration record (MAR) and/or notes as applicable). When a consumer is not taking medication, or not taking it as prescribed, it is a treatment issue and should be discussed with their doctor and appropriate clinical staff.

Each agency should inform the consumer's physician upon learning of any medication issue. If the physician or pharmacist indicates that the medication error does not threaten the consumer's health or safety, the error should be documented as specified by the agency's policies and procedures. Level I medication error incidents (including self-administration and medication refusals) are to be documented and reported by providers who are directly responsible for administering or overseeing that the medication was taken by the consumer. (Examples of providers who are directly responsible for medications include: opioid treatment services, detoxification services, facility based crisis services, residential services, day treatment). Providers who are directly responsible must document as a Level I error and should submit summary numbers through the Provider Quarterly Report to the Host LME. Providers who are not directly responsible for administering or overseeing that the medication was taken by the consumer (i.e., medication management and outpatient providers) must document based on agency policy but are not required to submit the Provider Quarterly Report of Level I incidents.

Level II and III medication errors should be reported through IRIS by all Category A and B providers.

Providers should report Level II or III errors in IRIS within 72 hours of learning of the incident.

### **Implementation of Independent Assessments for Community Support Team**

The final revised policy for Community Support Team (CST) will be posted in early August 2011. Although the policy had stated that there was a six-month per year hard limit for CST, the revision allows for exceptions to this limit when medical necessity is shown. The revisions states:

*Any request for an exception to this six month limit must be accompanied by a comprehensive clinical assessment completed by an independent licensed professional and an updated person centered plan (PCP) with*

*new service order signed by a medical doctor ( MD), licensed psychologist, nurse practitioner (NP) or physician assistant(PA). The clinical assessment must meet the requirements as specified in Implementation Update #36 and clearly document medical necessity as defined in the continued stay criteria in this policy. The independent licensed mental health professional must meet the criteria included in 10A NCAC 27G .0104 and must not be employed by the agency providing the Community Support Team service or have any financial or other interest in the agency providing the Community Support Team service.*

Beginning on and after October 1, 2011, all requests for concurrent authorizations that extend the authorization beyond a six month period for that consumer per that year, must be accompanied by an independent assessment indicating that CST continues to be medically necessary as well as an updated PCP as noted above and in the policy. The independent assessment must have been completed within 60 days of the new authorization request. The six months per calendar year are cumulative and include any time during that calendar year when the consumer received CST services. If there has been a gap in services, and an initial authorization is requested that would lead to an individual receiving six or more months of CST that year, those initial requests must be accompanied by an independent assessment and PCP as noted above. Requests that do not include this documentation will be sent back as incomplete.

### **Proposed Changes to Medicaid Clinical Coverage Policy 8C**

Outpatient Behavioral Health Services Provided by Direct-Enrolled Provider, have been posted for 45 days of public comment. The policy with proposed changes can be found on the DMA website at <http://www.ncdhhs.gov/dma/mpproposed/index.htm>.

### **Clarification of National Correct Coding Initiative and Enrollment Guidelines for Outpatient Behavioral Health Providers in Integrated Care Practices**

As a reminder, per 8C policy (<http://www.ncdhhs.gov/dma/mp/8C.pdf>) all licensed professionals listed (i.e. LCSW, LMFT, LPC, LPA, PhD) must be enrolled with Medicaid. All components of this policy (*8C Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*) must be followed by any licensed Outpatient Behavioral Health Provider listed in the policy, regardless of practice setting. Outpatient Behavioral Health Providers can only provide and bill the psychiatric CPT codes listed in 8C, even if practicing "incident to" under the current policy.

Please note that under the proposed revisions to Clinical Policy 8C, licensed professionals will not be allowed to bill incident to a physician, but will need to enroll and submit claims under their own attending NPI number. To enroll as an independent Outpatient Behavioral Health Provider with NC Medicaid, the provider must fill out the Individual, In-State/Border Application found at NC Tracks <http://www.nctracks.nc.gov/>.

Recently, we have had many questions about the impact of the National Correct Coding Initiative (NCCI) on integrated care practices. Per NCCI, only one office code (E&M or psych CPT code) can be billed for the attending provider, per recipient, per date of service. In order to ensure that both the medical office visit and the behavioral health CPT code both pay on the same date of service, the claim must be submitted with different attending provider National Provider Identifiers (NPIs).

In order to accomplish this, licensed, enrolled behavioral health providers (listed in 8C) operating in integrated care practices must also enroll as an Outpatient Behavioral Health Group, which may be mapped to the tax ID number of the physician group practice. All enrolled, licensed Outpatient Behavioral Health Providers in the integrated care practice would enroll as part of the Outpatient Behavioral Health Group practice. The integrated care practice must have at least 1 active, enrolled licensed Outpatient Behavioral Health Provider in order to apply for the Outpatient Behavioral Health Group number. The Physician Group enrollment is a separate enrollment from the Outpatient Behavioral Health Group enrollment, although both may be mapped to the same tax ID number for billing purposes.

To enroll as an Outpatient Behavioral Health Group with NC Medicaid, providers must fill out the Organization In-State/ Border Application found at NC Tracks <http://www.nctracks.nc.gov/>. Please see pages 18 through 23 of the *Provider Qualifications and Requirements Checklist* for full information on Outpatient Behavioral Health Provider enrollment.

The Medicaid provider enrollment process includes the completion of the Internal Revenue Service's (IRS) W-9 form. The N.C. Medicaid Program must collect this information in order to correctly report income paid to the provider. The W-9 form is retained by the N.C. Medicaid Program and is not sent to the IRS. The instructions that the IRS provides with the W-9 form explain that payments you receive may be subject to backup withholding if you do not report your correct tax identification number (TIN). The instructions further explain that the TIN provided must match the name given on Line 1. Failure to provide your correct TIN may result in a penalty. (The W-9 form and instructions for completing the form are available at <http://www.irs.gov>.)

Provider earnings reported on the 1099 form are based on the provider number associated with the National Provider Identifier entered on the claim form. If incorrect earnings are reported it may be because claims are incorrectly filed without the group number, which results in income being reported to the individual (attending) provider number entered on the claim. Incorrect earnings are **NOT** reported based on the W-9. It is important that all providers carefully review the Financial Section of their Remittance and Status Report (RA) to verify that the claim is submitted properly and income is reported to the correct TIN. Please see the July 2009 Bulletin for additional information.

Please note that ALL behavioral health services should be billed under the Outpatient Behavioral Health Group Billing NPI and the Outpatient Behavioral Health Individual Attending NPI, including both unmanaged and managed visits. Unmanaged visits should NOT be billed "incident to" a physician if the attending provider can bill independently. Outpatient Behavioral Health Providers are encouraged to read the July 2009 and the March, April, and June 2011 Medicaid Bulletins which give helpful guidance on prior authorization, NCCI, and unmanaged/managed visits.

As a reminder, please contact DMA directly at (919) 855-4290 with any questions regarding NC enrollment or billing questions in order to ensure accurate receipt of information.

#### **Outpatient Behavioral Health Providers Billing "Incident to" a Physician**

As noted above, the revisions to Clinical Policy 8C, when implemented, will explicitly prohibit "incident to" for licensed professionals billing services under a physician's number. While the current policy has not disallowed this billing "Incident to" the physician, it does **not** allow a licensed professional listed in Clinical Policy 8C to bill incident to any other licensed professional. The licensed professionals listed in Clinical Policy 8C must be the only ones providing services through their own Medicaid Provider Number (MPN) and NPI. **Allowing anyone else to use your Medicaid MPN/NPI is considered fraud and individuals doing so may run the risk of losing his or her license in addition to losing the ability to provide Medicaid services.**

Outpatient Behavioral Health Providers are encouraged to read the July 2009 and the March, April, and June 2011 Medicaid Bulletins which give helpful guidance on prior authorization, NCCI, and unmanaged/managed visits.

As a reminder, please contact Medicaid directly at (919) 855-4290 with any questions regarding NC enrollment or billing questions in order to ensure accurate receipt of information.

#### **Perception of Care Surveys**

The DMH/DD/SAS administers the Perception of Care (POC) survey annually to individuals with mental health and substance use problems who receive a publicly-funded service (including an admission) from a provider during a designated two-week period. DMH/DD/SAS uses three types of surveys:

- (1) The adult survey completed by those 18 and older.
- (2) The Youth Services Survey (YSS) completed by youth aged 12 through 17.
- (3) The Youth Services Survey - Family (YSS-F) completed by the parents or guardians of those 11 and under.

The surveys are designed to collect information on five indicators related to services and outcomes (functioning, social connectedness, positive outcomes, accessibility of services, quality of services, and satisfaction with services). The surveys are required by the Community Mental Health Services Block Grant that use the POC indicators as part of the National Outcomes Measures that compare states with each other. LMEs will be distributing the surveys to providers to be completed in August.

### **CAP-MR/DD and Money Follows the Person Slots**

We have received questions regarding the budget and its impact on CAP-MR/DD slots as well as potential expansion of Money Follow the Person (MFP) slots. Information regarding CAP-MR/DD and MFP slots will be forthcoming.

### **Excerpt from PRESS RELEASE: WINSTON-SALEM COUPLE SENTENCED**

Medicaid fraud can take on a variety of appearances and have serious consequences.

### **Health Care Fraud and Tax Offenses Draw 24 Month Sentences**

GREENSBORO, N.C. – United States Attorney Ripley Rand announced that Ruben D. McLain, age 40, and Michelle Judge McLain, age 38, both of Winston-Salem, North Carolina, were sentenced yesterday in federal court. The McLains were each sentenced to 24 months incarceration and three years of supervised release. They were also ordered to pay restitution of \$1,313,671.14 jointly and severally to the Internal Revenue Service.

The McLains were initially charged in a multi-count Indictment filed September 27, 2010. On January 24, 2011, the McLains entered pleas of guilty to Count One, conspiracy to defraud the United States, Count Nine, failure to pay over withholding taxes, Count Twelve, health care fraud, and Count Twenty-Five, tax evasion. In addition, Michelle Judge McLain entered a plea of guilty to Count Eight, false entries involving a health care benefit program.

The McLains did business in Winston-Salem as Universal Services, Inc., Reynolds Home Care, and Triage Behavioral Health Systems. The factual basis filed at the time of the plea indicated that the McLains established a bank account for Universal Services, Inc., using a false tax identification number. The factual basis further revealed that the defendants used business bank accounts to purchase personal items for their home, to pay school tuition for their children, and to purchase jewelry. The McLains also pleaded guilty to charges that, from 2004 through 2007, they either failed to file tax returns or filed false tax returns that did not declare their true income.

The McLain companies provided personal care and mental health services to qualified recipients, paid for by the Medicaid program. The McLains pleaded guilty to submitting a false enrollment application to the North Carolina Division of Medical Assistance that concealed their involvement in the companies through the use of a nominee and a fictitious person.

The McLains also pleaded guilty to withholding income, social security, and Medicare taxes from their employees' wages without paying over those withholdings to the Internal Revenue Service.

The case was investigated by Special Agents of the Internal Revenue Service Criminal Investigation Division, the Department of Health and Human Services Office of Inspector General, and the North Carolina Medicaid Fraud Unit. The case was prosecuted by Assistant United States Attorney Robert Hamilton.

Contact: Lynne Klauer, Assistant United States Attorney, Press Officer (336) 333-5351.

Unless noted otherwise, please email any questions related to this Implementation Update to [ContactDMH@dhhs.nc.gov](mailto:ContactDMH@dhhs.nc.gov).

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