Alternative or "in Lieu of" Service Description Template

1. **Service Name and Description:** Practitioners Rendering treatment in place (TIP) - Comprehensive Clinical Support Services (CCS)
   Service Name: TIP **-** Comprehensive Clinical Support (CCS)

   Procedure Code: G2021-CR

   License: N/A

Description: The service includes activities with and/or on behalf of a member of with Mental Health (MH), Intellectual/ Development disabilities (IDD) and Substance Use Disorder (SUD) diagnoses. This service will provide a comprehensive set of supports to members when the typical services (usually those delivered in a group environment) are not able to be provided. Interventions include strategies and actions for the purposes of treatment continuity allowing for flexibility of the intensity and combinations of treatment interventions best able to meet and individual's needs. These services may be needed when individuals are not able to attend their typical site-based services, or when other enhanced services are not able to be provided due to the extenuating circumstances being experienced in the current pandemic. Such services are performed by an individual employed by a provider agency for members that do not have other services in place and that can provide this type of clinical support or have had services temporarily suspended due to extenuating circumstances.

This service is designed to meet some of the broad healthcare, educational, vocational, residential, financial, social and other non-treatment needs of the member and may include the arrangement, linkage or integration of multiple service and providers involved in the member's care. Examples of such activities include making referrals to other service providers if this becomes necessary and following up to ensure services are initiated. Provision of supportive contacts, skill reinforcement, skill development through telephonic or other technology means, and face-to-face when it remains appropriate to do so.

Comprehensive Clinical Support interventions will include but are not limited to:

- Qualified Professionals will utilize virtual/telehealth visits for communication at the same frequency of contacts per week the service would typically be provided. Because services may not be able to be provided in a group setting, daily hours may vary from what would be typically provided. For any service dates where, services were not provided the record should reflect the reason the service did not occur.
- In the event of a crisis, the provider will have a plan in place to proactively take steps to avoid sending a member to an Emergency Department or hospital unless absolutely necessary, including telephone triage, virtual visits, face to face telehealth visits, and in person visits when safe and clinically indicated, in order to protect members from the increased risk of exposure to the virus that causes COVID-19 in facility settings. In the

rare event that there is no other way to stabilize outside of a crisis facility setting, it is expected that providers contact the hospital, emergency department, or crisis facility ahead of time to provide advance communication of the specific details of the situation, including risk of member and other pertinent clinical information.

- Where activities align with evidenced based practices and can be provided in written formats to the families/members to work on in the home they will be sent via email or electronic communication methods or packets that can be dropped off at the member's residence to be worked on independently and with appropriate coaching from staff.
- Therapy services with licensed clinicians at a frequency/ session length that is clinically indicated for the member. Some members may require more frequent therapy sessions but for shorter time periods (multiple 30-minunte sessions vs. one 60-minute sessions) and some may require more individual sessions than family.
- Parent training on developing a schedule, behavior plans, behavior de-escalation, etc. for services being delivered to children in homes with parents or alternative care givers.
- Implementation of standardized measurement tools to measure symptom increase/decrease with adjustment to intensity of treatment and/or modifications to the treatment plan
- In the event a member goes into crisis:
    - Staff from the provider agency are on call 24/7/365 to support the member and family and typically the Qualified Professional would provide the initial contact to assess the member's needs
    - First line support would be telephonic or telehealth
    - Appropriate staff would go out to the home if needed unless travel becomes restricted for essential personal
    - Would utilize the other professionals such as therapist/psychiatrist/psychologist via secure telehealth to address the crisis while on-site
- If parents/family are showing symptoms of behavioral conditions or medical conditions or need assistance with crisis situations, the agency delivering CCS can provider linkage and coordination to appropriate providers
- Provider staff such as QPs will be responsible for linking to necessary resources as the situation continue to develop with COVID-19. Providers will assist members/families with obtaining internet during this crisis where possible, so they can utilize telehealth. Providers can address any social factors that represent a current need or may arise during this pandemic.
- All members would have access to medication management directly through the provider agency providing CCS or in cases where the provider agency does not have an available psychiatric resource, they must have an established relationship with a provider than can provide this access to care as necessary for psychiatric evaluation and medication management.

2. Information About Population to be Served:

Population	Age Ranges	Projected Numbers	Characteristics
Children and adolescents, and Adults with MH, SUD, and IDD or any combination of the above	3+	Unable to give a valid estimate due to the uncertainties of the pandemic	The member is eligible for this service when: A. There is a DSM-5 (or subsequent editions) diagnosis present, or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a). **AND** B. Level of Care Criteria, LOCUS/CALOCUS, ASAM, or SNAP/SIS deemed eligible for services based on a documented developmental delay or disability. **AND** C. The member is receiving an enhanced facility/group-based service that cannot be delivered due to pandemic circumstances

3. **Treatment Program Philosophy, Goals and Objectives:**
   The program is expected to help maintain members in the community and reduce the need for crisis intervention or higher levels of care. This will be utilized in lieu of services such as Child and Adolescent Day treatment, Substance Abuse Intensive Outpatient Program (SAIOP) when these are not able to be provided in group or direct contact settings and will allow for a reimbursement methodology when providers are still working to meet the comprehensive needs of the members but through different treatment structure or methodology than would typically be provided. The service is expected to be delivered in a flexible manner to be able to meet the identified needs of the members. Objectives for each member will be individualized but may include maintenance activities when they are not able to participate in their typical facility-based programs, linkage to appropriate services in members need to transition to alternative treatment. The overall objective to maintain continuity of care for members in a flexible manner and provide supports needed to help maintain in community settings in the least restrictive environment possible. The provider will also be available as a first responder to enrolled members 24/7 as needed during the special circumstances.

Expected Outcomes:

a. Decrease in the frequency/ need for crisis intervention (use of ED, Mobile Crisis, and Facility Based Crisis)
b. Connection to supports that are able to assist in meeting the identified needs which may be beyond the MH/IDD/SUD treatment system such as food, shelter, and supplies
c. Maintenance of skills that have been developed through more intensive treatment programs.
d. Connection to benefits such as Medicaid, Unemployment, or other necessary resources

4. **Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:**

Staff Qualifications:
Staff providing these services will meet the same qualifications of those of the service this is being used in lieu of.

Training:
Staff will have the same training as the service this is being utilized in lieu of, allowing for any flexibility that is given for training modifications through Federal or State guidance resulting from the pandemic.

Supervision:
Supervision should be provided at the intensity required based on the level of staff providing the treatment and intervention, following the providers established policies for supervision of staff, and staff written supervision plans where these are required.

5. **Unit of Service:** 1 unit = per diem

6. **Anticipated Units of Service per Person:** 15 to 75 units per person - this is a broad estimate as it is currently unknown as to the length of time members will not have access to the typical service array due to the pandemic

7. **Targeted Length of Service:** 2 to 3 months (this may be longer based on the length of the pandemic)

9. **Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**

Cardinal Innovations' members are in need services that can replace those facility based, group services, or face-to-face services that are unable to be delivered due to special circumstances such as the current pandemic. This service was developed to be extremely flexible so that individualized support can be provided to members through a variety of methods, to best support them. This is not designed to provide for a per diem payment to a provider that includes all the clinical and supportive services that they would typically deliver in a facility or group setting, until there are fully established alternative treatment methods for service delivery during these unique circumstances. This is particularly needed when it may be difficult for members to be able to be active in the community and may need to be homebound due to the extenuating circumstances being experienced.

10. **Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.**

Cost Neutrality/Cost Effectiveness Comparison

Service	**Procedure Code**	**Unit Definition**	**Units of Service**	**Cost of Service**
Day Treatment	H2022	1 unit per hour	30 units week per member	$4071.24 (per month)
SAIOP	H0015	1 unit per diem	3 units per week	$1697.12 (per month)

While the utilization is difficult to predict given the special circumstances it is anticipated that it will be utilized at a less intensity than the services that it will be a temporary replacement as

alternative means of service delivery need to be utilized. The goal is to continue to have a method of connection/support to members that will reduce avoidable inpatient and Emergency room visits which will also assist in maintaining cost-effectiveness and allowing for providers to continue to operate their businesses.

Average expected utilization (will vary based on the service it is being used in lieu of) –
5 units per week * $188.46 * 4.3 weeks per month = $4051.89 (using Day Treatment as comparison)
3 units per week *$131.56 *4.3 weeks per month = $1697.12 (using SAIOP as comparison)

Cost Effectiveness Summary:

These services will be utilized to ensure members still are connected to care and to allow providers flexibility and creativity when they cannot delivery their typical office/facility-based services or face-to-face services in the community. Without some additional supports in places for these members it is anticipated that more ED or crisis episode will occur. Especially during a pandemic or other special circumstance, it is important to minimize unavoidable crisis events as much as possible.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.):
Providers will submit 1 unit per daily use, under the code of G2021-CR. Post-services reviews will be connected as necessary, and frequency of utilization monitoring to identify any patterns of over utilization. Providers will maintain a minimum standard of a service note for each contact, service event, or intervention.

Description of Monitoring Activities:

The LME/MCO will review claims monthly to monitor patterns and trends in utilization of this service.

The LME/MCO will monitor service utilization through prior authorizations, utilization management, and utilization reviews.

Documentation Requirements

A full service note for each contact or intervention (such as individual session, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service will contain the following information: recipients name, service record number, Medicaid identification number if applicable, service provided, date of service, place of service, type of contact (face to face, telephone call, collateral), purpose of contact, providers interventions, time spent providing interventions, description of effectiveness of intervention, and 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.

Records should support the intensity of contacts needed, and the appropriateness of treatment delivery method. Ex. If all contact is done via phone, are there limitations to tele-health service provision, etc.