

# PROVIDER NEWS

## Endorsement Update

Agencies that are preparing for endorsement should go to the announcement page of DHHS website and download the checklists for the services that your agency intends to provide. This will prepare you for your agency's site/service specific endorsement review.

Even though the Division has not announced when the new service definitions will take effect, the LME has been directed to proceed with the endorsement process. This initial endorsement of new services will be considered *conditional*, with a second review to follow within six months.

Seven phase one checklists are

available at the DHHS website for community support for adults; community support for children and adolescents; community support team; diagnostic assessment; intensive in-home; mobile crisis; and multi-systemic therapy.

To access these documents go to <http://www.dhhs.state.nc.us/mhddsas/announce/index.htm>, look on the right side of the page under State Plan Communication Bulletins, find Bulletin #044, and download the excel file named "Service Specific Check Sheets."

If you have questions regarding endorsement, please contact Linda Jones at 513-4222.



## ADS Gets SDFS Grant

ADS was been awarded a Safe and Drug Free Schools and Community Grant by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

This grant will provide additional substance abuse prevention services to selective and indicated youth in Alamance County. Middle

and high school aged kids are involved with law enforcement, experiencing difficulty in the school setting, involved with social services; experimenting with addictive substances; or are the children of substance abusers.

Funding is for two and a half years, starting in January 2005.

# Cash, Paybacks and Mergers

There are a lot of rumors about DMHDDSAS cash flow problems, Medicaid paybacks, and forced mergers. According to Chris Phillips of the Advocacy and Customer Service Section, these are the facts:

The Division is experiencing some cash flow issues, but is working to address them. Some are fairly typical, such as increased costs in the institutions. The Division intends to make sure that all LMEs and providers get cash, if their payments were delayed. The Division does not expect to have to withhold payments.

In addition, the system is experiencing a shortfall in funding that covers LME Systems Management Payments. When the Cost Model was implemented, a transfer of approximately \$25 million from the DMA budget was anticipated to support the payments. Those funds were anticipated to come from savings in the Medicaid budget by reducing service rates by the old 13% area program administration add-on. With the growth in the cost of the Medicaid program, those funds have had to cover the cost of other services and are not available for transfer. Without that transfer and with the additional LME funding requests, we are approximately \$28 million short.

To address this shortfall, the Secretary asked DMHDDSAS to develop some cost-saving proposals. The Division considered hiring a single statewide vendor to perform all Utilization Review (UR) and Screening & Referral functions, reducing service payments, or imposing across-the-board cuts to all LMEs. The Division does

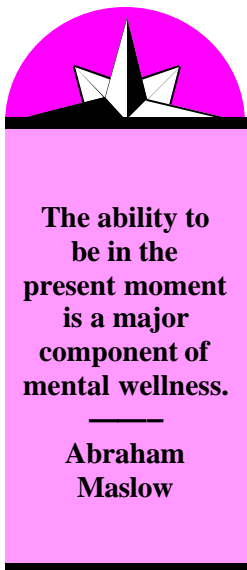
not believe that reducing service payments is a viable option and thinks that an across-the-board reduction would “starve” LMEs for funding. Keeping UR and Screening in the public sector has been one of the primary goals of the LMEs, so the Division argued against that alternative.

Instead, the Division proposed that the state be grouped into 10 regions with one LME per region to perform all UR and after-hours Screening & Referral functions for that region. The remaining LMEs would continue provider endorsement, provider monitoring, initial approval of Person Centered Plans, Monday-Friday walk-in Screening & Referral, etc.

DHHS would choose regional LMEs based upon LME’s proposals. Under this proposal, DMA would still contract with a statewide vendor to do inpatient IR and PRTF services and to perform quality assurance reviews on LME UR decisions.

The Secretary outlined this proposal to representatives of the NC Council of Community Programs and the NC Association of County Commissioners. She asked for feedback on the proposal and indicated a willingness to make adjustments in the proposal based upon that feedback. A final decision is expected in early October.

Finally, there is not a \$25 million payback to Medicaid, and the Division is not “forcing mergers.” This proposal regionalizes 2 LME functions that can be done more uniformly and more cost effectively at a regional level, rather than replicating them 30 different times.



# Consumer Information Cards

The Consumer and Family Advisory Committee (CFAC) has developed a wallet-sized card for consumers that lists their contact information, medications, physicians, and other pertinent information. Cards will be printed in early October and given to local providers. Providers are asked to fill out each consumer's card, give it to the consumer, and update the information as needed. These cards are optional for consumers to carry.

The CFAC Jail Diversion Subcom-



mittee recommended these cards in an effort to assist consumers who encounter law enforcement officers. The cards can notify the officers that the person's behavior may be related to a mental illness. In addition, if the person were placed in jail, law enforcement would have information about medication and diagnosis that would be helpful in caring for that consumer.

For information, contact Karen Webb, CFAC Relations Manager, at 513-4221 or [kwebb@acmhdds.org](mailto:kwebb@acmhdds.org).

# Consumers, Not Clients

As we shift service delivery roles from area programs to community providers, more focus is being placed on satisfaction, outcomes and rights. Consumer-centered services are an important part of the system reform process and consumer advocacy is one of the building blocks of this new system.

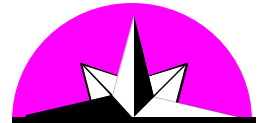
In this new world, we speak of *consumers*, not *clients*. *Human* rights, not *client* rights. While using politically correct words is important, the action we take is more important.

An important part of service delivery is advocating for and protecting the rights of consumers. We build stronger services for our consumers when we protect their rights. Consumers have the same rights as other citizens; how-



ever, when they receive MHDDSA services, they have additional rights governed by federal and state laws, statutes and rules.

By establishing a human rights committee, consumer rights are protected and monitored in a structured and organized way. The committee consists of an impartial body, not members of an agency's staff. The committee gives oversight to the service provider's treatment of consumers and is a safeguard for the protection of their rights. The human rights committee monitors incidents and restrictive interventions, hears complaints, approves behavior plans, reviews investigations, provides training, and implements new policies/procedures/rules related to human rights. — *Jane Peters, QI/QA*



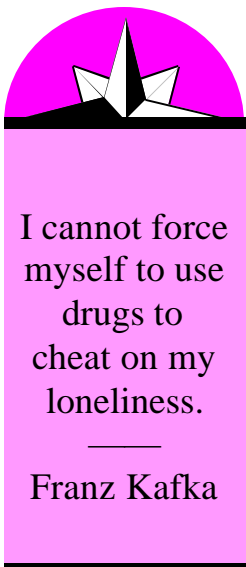
**Through our willingness to help others we can learn to be happy rather than depressed.**

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**Gerald Jampolsky**

## Request of Services by Current Procedural Terminology (CPT) , Healthcare Common Procedure Coding (H-codes) , and State Codes

As we continue to transition into a managed care environment we want to ensure accuracy as well as timeliness of services being authorized. To help us move toward this you will soon be asked to request **all** services by using the CPT, H-code , or State Code. The Outpatient Treatment Request (OTR) is also being revised to assist us in getting the information that we need. Keep your eyes open for the Communication bulletin that will give you further instructions about implementation dates and a copy of the revised OTR.

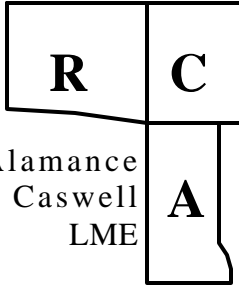


### Provider Satisfaction Survey Results

Thank you to the twenty-two Providers who took the time to complete the Provider Satisfaction Survey sent out by the QI department in early September. Your input is important to the LME and is being used to develop strategies for improvement. For those who missed the opportunity to participate, the next survey will be sent to providers in March 2006. The following are results of this survey, which were presented to the LME's QI committee in September:

1. 59% of respondents indicated that the authorization process was completed in a timely manner.
2. 87% of respondents indicated that billing and reimbursement disputes were settled quickly.
3. 80% of respondents indicated that claims were paid within 30 days of being submitted.
4. 80% of respondents indicated that complaints are addressed in a timely and professional manner.
5. 86% of respondents indicated that LME staff was professional and courteous.
6. 80% of respondents indicated that needed clinical information was provided in a timely manner.
7. 68% of respondents rated their overall satisfaction with the LME at 95% or more.
8. 86% of respondents indicated that phone calls were returned within 24 hours.
9. 95% of respondents indicated that training and orientation was adequate.
10. 80% of respondents indicated that the web site was useful and helpful.





Alamance  
Caswell  
LME

Alamance-Caswell LME  
Consumer & Provider Relations  
Human Services Building, Suite A  
319 N. Graham-Hopedale Road  
Burlington, NC 27217  
Phone: 336-513-4200  
Agency Website: [www.acmhdds.org](http://www.acmhdds.org)  
Provider website: [www.acmhdds.net](http://www.acmhdds.net)

**Upcoming Trainings  
November 2005**

2005 NC Providers Council Conference  
November 2-3, 2005  
Sheraton, Chapel Hill, NC  
Registration: 919-836-9686

Community Support/Targeted Case  
Management Conference  
November 8-10 2005  
Adam's Mark Plaza Hotel, Charlotte, NC  
Registration: 336-713-7701



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## Alamance-Caswell LME Fax Numbers

**513-4449**

Access, Medical Records,  
Utilization/Management

**513-4203**

ACT Team, Crisis Team,  
Psychiatry Services,  
Quality Improvement

**513-4379**

Accounting, Contracts,  
Information Systems

**694-7325**

Caswell ACT Team

**513-4319**

Community Relations,  
Consumer Affairs,  
Resource Development

**513-4422**

Human Resources,  
Provider Relations