



Clinical Design Plan

CenterPoint Human Services Managed Care Organization

Clinical Design Plan

May 2012

The CenterPoint Human Services Managed Care Organization (MCO) Clinical Design Plan serves to guide the clinical services under the 1915 (b) and the Innovations (c) Waiver. The services are designed to meet the needs of enrollees with mental illness, substance use disorders and developmental disabilities effectively and efficiently with awareness of the unique personal and cultural needs of each enrollee. The Clinical Design Plan guides the coordination and strategic implementation of public resources including Federal, State and County funds to achieve optimal outcomes for enrollees served by the MCO and our partner providers. Continuous quality improvement with actively managed feedback from enrollees, providers and internal process monitoring is integrally woven into the Clinical Design Plan. The management strategies provide the structure and tools to continually re-evaluate and improve services to achieve the goals of the Clinical Design Plan.

Clinical Design Plan Goals:

1. To establish a clinical model based on person centered thinking which guides all functions of the MCO's services and activities. The Clinical Design Plan clarifies the purpose and focus of each MCO function to demonstrate effective, responsive and consistent management of services in an environment of continuous quality improvement. These functions include Customer Services (including the screening, triage and referral function), Enrollee Education, Care Coordination, Utilization Management (UM), Provider Network Management, Community and Provider collaboration with the MCO, the oversight of the provision of crisis services, stakeholder input, and coordination with the Community Care Network.
2. To establish a network of clinical partners who actively collaborate with the MCO to provide culturally competent services, implement evidence-based practice models and employ clinical care guidelines with proven beneficial outcomes. The selection and training of a qualified comprehensive network of providers that is increasingly able to self manage by implementing the model of continuous feedback and quality improvement will be central to achieving the desired outcomes for each enrollee.
3. To establish the recovery model for MH/SA as a core expectation for the positive outcome of the treatment of the disabilities served and to provide the foundation for the goals of enrollee education and self management in the least restrictive context possible.
4. To ensure the principles of cultural competency, recovery models and person-centered care are provided with equitable access and responsiveness for the population served.
5. To establish funding guidelines that assures the provision of services guided by these principles.

6. To involve enrollees and their families as partners and collaborators in the evaluation and improvement of services that lead to recovery.
7. To employ data to assist the process of continuous quality improvement and demonstrate accountability in the process of needs assessments, cultural competency, delivery of services and outcome evaluation and establishing targets for needed service modifications and quality improvement.

Mental Health and Substance Abuse Service Delivery:

Recovery Focused

According to the National Consensus Statement on Mental Health, recovery is the single most important goal for the mental health service delivery system. In the past, many thought that a diagnosis of serious mental illness meant a lifetime of disability. Research continues to show this long held belief is false. Since the mid-1980s, much of the literature regarding mental health recovery from the perspective of the enrollee, the family member, as well as the mental health professional, has evolved and become the focus of research.

Recovery Definition

SAMHSA defines recovery as a process of change through which individuals work to improve their own health and well being, live a self-directed life, and strive to achieve their full potential (SAMHSA December 2011).

Hope

The belief that recovery is real provides the essential and motivating message of a better future (SAMHSA, August 2011). Having a sense of hope is the foundation for ongoing recovery from mental illness and substance abuse. Even the smallest belief that one can get better, as others have, can fuel the recovery process. Early in the recovery process, it is possible for a treatment provider, friend, and/or family member to foster hope for an enrollee. At some point, however, enrollees must develop and internalize their own sense of hope.

Empowerment

Empowerment is the belief that one has power and control in their life including the management of their illness. Individuals exercise their autonomy and self determination by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience (SAMSHA August 2011). Empowerment involves taking responsibility for self, as well as advocating for self and others. As enrollees grow in their recovery they gain a greater sense of empowerment in their lives.

Support

Support from peers, family, friends, and health care professionals is essential to recovery. This not only reduces an individual's sense of isolation but also increases activity in the community. In addition to support from individuals, participation in support groups is an important tool in

recovery. Enrollees report that being able to interact with others who understand their feelings and experiences is one of the most important components in their recovery.

Knowledge/Self Help

In order to optimize recovery, it is important to learn as much as possible about illnesses, medications, best treatment practices, and available tools and resources. It is also important to learn about individual needs including learning to identify symptoms and taking action to manage them, speaking with health care professionals, reading relevant materials and skill building resources and learning about an illness and its treatment. In addition to learning and applying coping skills, often attending support groups and developing a support system to rely on when necessary will be helpful in illness management.

Culturally-based and Influenced

Culture and cultural background in all of its diverse representations – including values, traditions, and beliefs – are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, addictions and mental illness treatment, services and supports, primary healthcare, dental care, complementary and alternative services, spirituality, creativity, social networks, recreation, and community participation. The array of services and supports available should be integrated and coordinated.

Intellectual and Developmental Disabilities Service Delivery:

People with intellectual and developmental disabilities have historically not had the opportunity nor the needed support to control choices and decisions about important aspects of their lives. Many have been overprotected and involuntarily segregated. Others have not had the opportunity to learn the skills or to have the experiences which encourage them to exercise personal control and make informed choices (AAIDD and The ARC, *Joint Position Statement of Self-Determination*, 2008). People with intellectual and developmental disabilities have the same right to a self-directed and self-determined life as all people.

Self determination challenges institutional and other facility based models of care by supporting individuals with intellectual and developmental disabilities to partner with natural and paid supports. It also encourages individuals to participate actively, to the best of their abilities, and

to live meaningful lives in communities of their choice. The Clinical Design Plan for people with intellectual and developmental disabilities considers the medical needs of the person as well as possible cognitive and adaptive challenges, while also promoting the values of self-determination. These include:

Freedom

The opportunity for people with disabilities, along with freely chosen family and friends, to plan their own lives, with necessary support, rather than to purchase a program. They will be able to control resources through individual budgets, make decisions about kinds of support they receive and the people who will provide that support, and alter the configuration of their supports as their life situations change or as they gain more experience in making choices.

Support

The arranging of resources and personnel, both formal and informal, that will assist a person with a disability to live a life in the community that is rich in relationships and contribution. People with disabilities will have the assistance they need to plan and live their lives. Much of that assistance should come from an informal network of family and friends. People with disabilities should receive the help they need to develop informal relationships and thereby increase their participation in the social, economic, cultural, and spiritual dimensions of their community. People who provide support must have an attitude of “whatever it takes”, that nothing is impossible. “No” is replaced with “How can this be done.”

Authority

The ability of a person with a disability to control a certain sum of dollars in order to purchase his/her supports. When people with disabilities need assistance in controlling dollars and planning their lives, they themselves will decide who will provide that assistance. Anyone helping someone plan their life will be ever mindful of the need to ascertain the real desires and aspirations of the person who chose them to assist.

Responsibility

The acceptance of a valued role in a person’s community through competitive employment, organizational affiliations, spiritual development and general caring for others in the community, as well as accountability for spending public dollars in ways that are life enhancing for persons with disabilities. People should not be seen and treated as dependent and incapable of being contributing members of our communities. People in support roles have a responsibility to insure that the risks taken by someone with a disability are reasonable, safe, and will lead to further growth.

Additional materials which may help to understand Self –Determination

- Joint position statement of AAIDD and The Arc 2008. (http://www.aamr.org/content_163.cfm?navID=49)
- Wehmeyer, M. L. and Garner, N. W. (2003), The Impact of Personal Characteristics of People with Intellectual and Developmental Disability on Self-determination and

Autonomous Functioning. *Journal of Applied Research in Intellectual Disabilities*, 16: 255–265. doi: 10.1046/j.1468-3148.2003.00161.x

- Hamner, D, Timmons, J. and Bose, Jennifer (2002), A Continuum of Services: Guided and Self Directed Approaches to Service Delivery. *Journal of Disability Policy Studies*, Fall 2002, vol. 13, pp 105-113.

Network of Providers: Self Managed and Collaborative

The Clinical Design Plan is intended to be a working document to promote the development of a self-managed system of care for enrollees in the MCO catchment area of Forsyth, Stokes, Davie and Rockingham Counties. To function effectively the system must rely on educated providers who understand and operate in tandem with the MCO's clinical objectives as described in the Clinical Design Plan. Ideally, this is a system where the structure, requirements and expectations are so well known, that extensive management and intervention are not required. Providers are involved in the management of the system with the MCO and share in strategies to meet performance objectives, review system performance, and commit to problem solving. Venues available to providers to participate with the MCO include the CenterPoint Area Provider Council, the Clinical Advisory Committee, the Global Continuous Quality Improvement Committee and the DD Advisory Committee. The MCO's overarching goal for the self-managed system is to assure reliable broad access to appropriate, high quality services that are culturally appropriate, cost effective, and provided in the least restrictive environment. .

The quality of the providers in the MCO network is measured through the interdependent relationship of the Quality Management Program Description/ Plan (QMPD/Plan) and the Network Development Plan. The Network Development Plan will be developed and continuously updated based on the MCO Needs Assessment that will include software to help determine geographical gaps in service. Network Development plan specifies and lays out the process for the implementation of the overall Network structure to maintain a self managed system. The QMPD/Plan specifies the process by which the quality of systems operation is reviewed and maintained.

The Clinical Plan

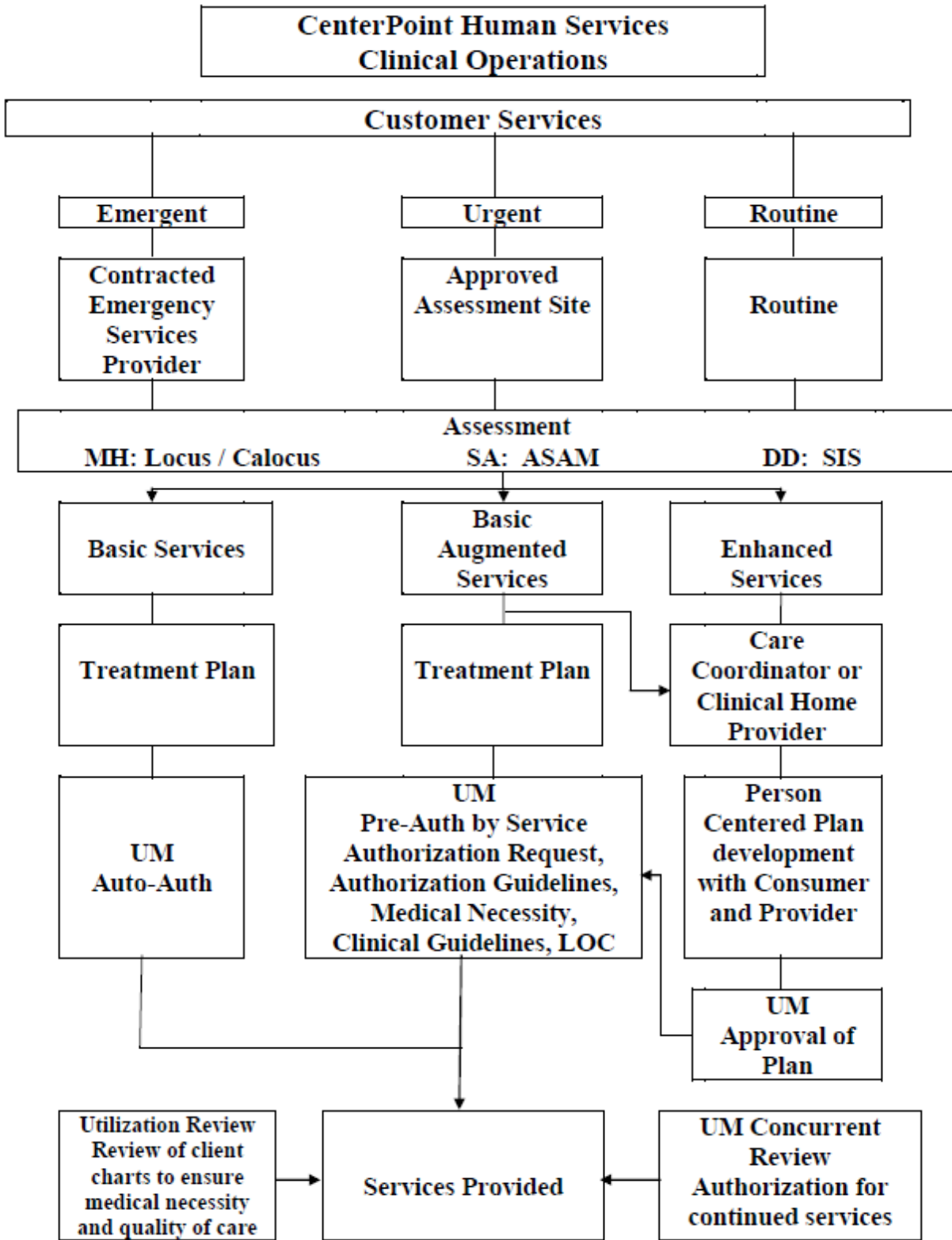
This plan consists of two parts: the MCO Clinical Operations, and the System of Services.

- I. MCO Clinical Operations: The systems and structures that the MCO has in place to provide all eligible enrollees access to services and to manage the system of care.
- II. System of Services: A highly organized array of services and supports operated by a network of providers. This continuum of services is accessed by enrollees at the most appropriate point relative to their individual needs. Service access is guided by clinical and cultural assessment information which is then correlated with specific levels of care.

I. MCO Clinical Operations

MCO Clinical Operations	
Component	Method
Customer Services/ACCESS	At the point of access the urgency of the person's need is determined. Access points are culturally and linguistically enabled. Emergent: face to face assessment within 2 hours Urgent: face to face assessment within 48 hours Routine: face to face assessment within 14 calendar days
Standardized Functional Assessment Tools	The standardized functional assessment tools inform Medical Necessity determination and identify Levels of Care. Required Tools: State's Screening, Triage, and Referral form MH: LOCUS and CALOCUS SA: ASAM levels DD: Supports Intensity Scale (SIS)/Support Needs Matrix. Until implementation of the SIS, the NC-SNAP will be utilized.
Level of Care	Services are Grouped into the following Levels of Care according to services intensity and frequency. Basic Basic Augmented Enhanced
Treatment Planning	The enrollee's "Clinical Home" (lead clinical agency) is responsible for the treatment planning process. For those individuals who do not have a clinical home and who have special health care needs or are categorized as High Cost/High Risk, the MCO's care coordination staff develops the treatment plan. The treatment plan is a document that reflects the goals of the person receiving services and the strategies that will be implemented to reach those goals. For persons receiving Enhanced Services, a Person Centered Plan (PCP) is developed using the person centered planning concept and is grounded in cultural and recovery based principles. The planning reflects life priorities and supports/services needed to achieve life goals. For basic and basic augmented services a standard treatment plan may be developed in lieu of a complete Person Centered Plan. However, person centered principles are always utilized in plan development.
Utilization Management:	Basic Services have an unmanaged period. Adults are eligible for 8 visits before prior authorization. Children are eligible for 16 visits under the Basic Services Benefit prior to authorization.

Prior authorization And Post-Service Authorization, Concurrent Authorization (continued stay), Discharge	Basic Augmented (non-enhanced services beyond the Basic Service benefit limits) and all Enhanced services must be pre-authorized. Prior Authorization, Concurrent, and Post-Service authorizations are requested through the following: Service Authorization Request form: Request includes diagnosis, current status/symptoms, standardized assessment results, risk assessment, treatment history, progress toward goals (for re-authorization), current medications/psychiatric intervention. The information submitted in the request is compared to the service definition criteria for Admission, Continuation, and Discharge for each service
Clinical Guidelines	Evidence Based (research based) practices that have been proven to consistently produce specific, intended outcomes.
Utilization Review	Concurrent and Retrospective review of treatment plans and service documentation to insure care was provided as authorized and medically necessary. A secondary review is done to determine points of disparate utilization and progression through the identified Levels of Care. Secondary data will be used to develop strategies for service improvement to effected populations.



Customer Services:

The MCO staffs the Customer Services Center 24 hours per day, 7 days per week. All Customer Services clinicians who are involved in clinical decision making are Master's level and licensed. Some qualified professionals handle routine calls but a clinician is always available for backup. The MCO responds to emergency calls, complaints, requests for information and appeal requests as well as completing the screening, triage and referral function. Requests for services fall into the following categories:

Emergent Need: For Mental Health/Behavioral Health Emergencies-- A life threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs or inability to care for self. A face to face assessment must be arranged within 2 hours from the point of call.

Emergent Need: For Substance Abuse Emergencies--A life threatening condition in which use of alcohol or other drugs results in suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance abuse or dependence. As above, a face to face assessment is arranged within 2 hours from the point of call.

Urgent Need: For Mental Health/Behavioral Health--while not actively suicidal or homicidal, and without a lethal plan, means or intent for suicide or homicide, but the enrollee reports feelings of hopelessness, helplessness, or rage and has the potential to become actively suicidal or homicidal without immediate intervention, or displays a condition which could rapidly deteriorate without immediate intervention, and/or without diversion and intervention will progress to the need for *emergent* services and care. Requirement is for a face to face assessment within 48 hours from the point of call.

Urgent Need: For Enrollees who have Substance Abuse issues- while not imminently at risk of harm to self or others or unable to adequately care for self, the enrollee is using substances and is in need of prompt assistance to avoid further deterioration in condition which could escalate to an *emergent* situation. Requirement is for a face to face assessment within 48 hours from the point of call.

Routine Need: Mental Health/Behavioral Health- The caller describes signs and symptoms which result in impairment and functioning of life tasks, impacts ability to participate in daily life, and/or have markedly decreased quality of life. Appointments will be scheduled within 14 calendar days from the point of call.

Routine Need: Substance Abuse Conditions- the caller presents signs and symptoms consistent with substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder. All Enrollees presenting with a potential substance-related problem should be considered **Urgent** and referred for substance abuse assessment and treatment accordingly so that every effort can be made to intervene when the enrollee expresses any interest in assistance.

Emergent Need: Developmental Disabilities – the caller, or the caregiver for the person with an intellectual/developmental disability presents information which may result in self-harm or harm to others for which the individual or primary caregiver is unable to provide the level of support necessary to meet needs. As noted above, a face to face assessment should be arranged within 2 hours from the point of call.

Non-Emergent Need: Developmental Disabilities – the caller, or the caregiver for the person with an intellectual/developmental presents with needs that are not emergent. The STR is completed, and a

referral is made to an appropriate assessor to determine eligibility. The initial assessment should occur within 14 days from the point of call.

Enrollment:

Enrollment is the process of obtaining required demographic and clinical information about the person seeking services. Enrollment can be achieved by calling the Customer Services Center. Network Providers may also enroll enrollees through a secure internet connection.

Administrative Enrollment: This process includes the basic demographic information about an enrollee such as name, address, date of birth, marital status, race, ethnicity, etc.

Clinical Enrollment: This process includes information about the person's diagnosis and clinical needs. The information for the clinical enrollment is usually obtained during the clinical assessment. A provider must submit the clinical enrollment information prior to payment for services.

Culturally Competent Assessment:

An accurate and complete assessment makes a significant contribution to the recovery process for the enrollee. It identifies areas where clinical intervention is needed. Accurate assessment information, including diagnosis, is critical for the MCO to authorize and monitor care and outcomes. In the context of Person Centered Planning and the achievement of recovery, assessments must consider the cultural background and context of the enrollee's symptoms and needs. In those areas where the efficacy of selected measures and practices have not been established across cultural and/or ethnic groups, care will be given to assure that assessments, services, and reviews are conducted within a culturally competent paradigm. The 2001 Surgeon General's report, *Mental Health: Culture, Race and Ethnicity*, highlighted disparities in behavioral health services for racial and ethnic populations. The report identified differences in cultural conceptualizations of illness and health, in help-seeking, language and communication patterns as some of the barriers to services. Culturally appropriate assessments can help identify these conceptual, linguistic, and communication barriers. Also, the 2003 *President's New Freedom Commission Report achieving the Promise: Transforming Mental Health Care in America* considered cultural competence to be essential to assure quality of care, responsiveness to services, and renewed hope for recovery among ethnically and racially diverse populations. Culturally appropriate assessments and/or assessment processes are essential tools of culturally competent service provision.

Functional Assessment:

In order to standardize the information that we receive from providers about the people served through our network, assessment tools that are standardized, valid and reliable, and can be consistently used across the providers in our network are critical. These tools structure the reporting of information from the clinical assessment so that this information can be used strategically by the MCO in authorizing and monitoring care and services. Accurate clinical information, including the diagnosis, is important in monitoring services to enrollees to ensure that they receive appropriate care and is an essential part of our Utilization Management Plan as well as our UR process and the forecasting of utilization trends. The following standardized functional assessment tools will be utilized for each disability group.

Mental Health:

Adult-Level of Care Utilization System (LOCUS)

Child- Child Adolescent Level of Care Utilization System (CALOCUS)

Substance Abuse:

American Society for Addiction Medicine (ASAM) Placement Criteria. ASAM levels are required.

Developmental Disabilities:

Supports Intensity Scale (SIS™) and Support Needs Matrix
(Until implementation of the SIS, we will continue to use the NC-SNAP)

Use of a standardized functional assessment tool is a structured way of gathering information and is only a part of a diagnostic assessment or clinical evaluation. The diagnostic assessment should address:

Diagnostic profile (diagnoses, IQ)
Current symptoms/problems/needs
Adaptive Functional skills
Symptoms
Chronicity
Risk
Progress toward goals if person is receiving treatment
Cultural and linguistic preferences/needs

Providers will be trained and/or certified to conduct standardized assessments. It is expected that Licensed Professionals, appropriately credentialed by their agency or by the MCO, will conduct or supervise completion of the standardized functional assessment tools. Qualified Professionals (QPs) may complete the actual functional assessment tools. Licensed Professionals must conduct clinical assessments. Clinical assessments provide a diagnosis and are used to inform one of the approved standardized functional assessment tools.

A Comprehensive Clinical Assessment should be completed during the first visit with a network provider. Obtaining an initial diagnosis and updating this if it changes is critical for accurate reporting and provision of services. It is important that the diagnosis is appropriate for the type of service received and is reflected on the claim submitted by the provider. This will be audited as a part of the UR process.

Treatment Planning:

Treatment Plans reflect clinically and individually identified strengths and needs of the person served as well as goals and strategies to address these needs. The plans include timelines for completion, and the responsibilities of the enrollee, the provider(s), and the Clinical Home Provider in achieving these goals.

Basic and Basic Augmented Treatment Plans:

These treatment plans reflect the needs that are to be addressed by the treating provider only.

Person Centered Plans (PCPs):

PCPs follow a comprehensive assessment process that reviews the person's holistic life situation, strengths and supports the person has in place, as well as services and supports needed to achieve the identified long term goals. This is an overarching plan that addresses all aspects of the person's life, and may involve multiple providers.

Each provider is expected to develop specific goals and strategies that are related to the services or supports assigned to the provider in the plan document. Services are coordinated and monitored by the Clinical Home Provider, if several providers are involved in care.

Care Coordination:

The function of Care Coordination is not to provide Targeted Case Management (TCM), and may not be available to all enrollees who previously received TCM. It is specifically for those enrollees who belong to a special healthcare need population or who are classified as high cost/high risk. Care Coordination's purpose is to empower, support, and educate enrollees and their families. Care Coordinators must be proficient in the application of cultural, linguistic, and recovery principles. They help the enrollee manage the treatment and support services identified in their treatment plan. Their role is to work in collaboration with other clinical professionals and to seek appropriate clinical input and assistance when needed to assist the enrollee with his/her challenges in reaching individual goals. Staff also provides front line monitoring to assure the health and safety of the enrollee, satisfaction with care and services, and to ensure services are delivered as specified in the plan.

The Care Coordinator monitors services and plans for the individual and works to adjust these over time as necessary in order to achieve positive enrollee outcomes. Examples of Care Coordination activities include the provision of follow up on high-risk individuals who do not appear for scheduled appointments, for people whom a crisis service is provided as the first service, to manage and follow those who are hospitalized until they are connected with a Clinical Home, and to intervene in the care of people who frequent the emergency room. The Care Coordinator monitors individuals across the MCO system and with external systems including the medical and primary health care systems. The Care Coordinator may also make referrals and appointments for enrollees as well as follow up to see that the person received the needed care. Care Coordinators research outlier cases to assess whether the person is receiving the right mix of services, to identify gaps in care, or needs the person may have that are not being adequately addressed. These outliers often include individuals who disengage or do not respond due to specific cultural, linguistic needs, or individual preferences that may have been overlooked, or inappropriately or insufficiently addressed. Care Coordinators also follow up on cases identified through the UM process as potentially needing different or additional services (under-treated, or not appropriately treated).

Utilization Management

Medically Necessary Treatment:

Medically necessary treatment is defined as those procedures, products and services that are provided to enrollees that are necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health, substance abuse or developmental disability. Treatment must be consistent with evidence based standards, North Carolina DHHS standards, or verified by clinical experts. Care should be provided in the most cost effective, least restrictive environment that is consistent with the clinical standards of care. Treatment/supports provided solely for the convenience of the recipient, recipient's family, custodian or provider is not medically necessary. Treatment/supports will not be experimental, investigational, unproven or solely for cosmetic purposes. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose. Interventions must be provided by appropriately credentialed and trained staff. All care must be reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

As part of the UM process, the MCO embraces the philosophy of Care Management. This philosophy will be evident in the actions of UM that go beyond standard UM expectations for medical necessity and

promote the most effective, efficient care possible, mitigating substandard care and ensuring individuals meet their goals.

Authorization:

Services in the Basic Benefit do not require pre-authorization, as long as these do not go over the limits (Adults 8 sessions, Children, 16 sessions). Basic Augmented and Enhanced Levels of Care must be pre-authorized. MCO, through its UR process, will establish timeframes for re-authorization that meet URAC standards and State guidelines. Each service has entrance, continued stay, and discharge criteria. These criteria are used when a request for services is received. The request could be an initial or prospective request, a concurrent request (reauthorization) or a retrospective request (after service provision). The clinical information about the person's disability, diagnosis and needs will be compared to the entrance, continued stay or discharge criteria for the service requested in order to approve or deny the request. All services provided must meet Medical Necessity Criteria. The MCO authorization process includes some basic unmanaged services, "standard care" authorization with minimal review, and some services requiring rigorous review prior to authorization.

- **Basic Benefit Services:** In cases where the appropriate care is individual therapy with a Licensed Independent practitioner, the provider establishes the medical necessity for the service, not the MCO. The provider must follow the admission and continued stay criteria for the service. The MCO audits basic services to ensure that these services are both Medically Necessary and appropriately provided. Basic augmented, those services above the limits of 8 sessions for Adults and 16 sessions for Children, require authorization.
- **Enhanced Services:** For enhanced services, prior authorization is required. The MCO establishes Medical Necessity prior to service provision. The provider submits assessment and other clinical information along with the service recommended on a Service Authorization Request. The clinical information about the person's diagnosis and needs are then compared to the Medical Necessity Criteria for the service requested. The MCO determines whether the service is Medically Necessary and issues an authorization or denial.

As the MCO gains experience in waiver management and builds baseline data related to specific network providers, decisions will be made regarding which services require authorization and the length of authorizations that will be issued for specific services and/or specific providers. The objective is to strategically utilize the Utilization Review staff resources by identifying outlier utilization, unusual patterns and other indicators for review and not in routine activities.

Appeals of Clinical Decisions:

An appeal is a request for review of a UM action. An action is a denial, reduction, suspension, or termination of a previously authorized service. There are strict requirements for notification of enrollees when a request is denied, or a service is reduced, suspended or terminated. This allows the enrollee to request a review before the action is taken. There are five conditions that must be met in order to determine if the service must continue to be provided until the review of the decision is completed. They are: 1) The appeal is filed timely; 2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; 3) The services were ordered by an authorized provider; 4) The authorization period has not expired; and 5) The Enrollee requests extension of benefits. The appeal occurs first at the MCO level. This is called a Request for Reconsideration. If the enrollee is not satisfied, an appeal can be made to the Division of Medical Assistance for Medicaid Enrollees or to the state for non-Medicaid enrollees.

Utilization Management and Review:

Utilization management is the process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria. Utilization Management includes activities such as ongoing evaluation of timeliness to care, as well as analysis of utilization patterns to monitor for both under and over utilization, gaps in care, and use of restrictive services. Recommendations for Care Coordination may be made by UM staff based on their review of clinical data and as they follow high cost, high volume and high risk cases through the system.

Utilization Review includes an audit process that involves a review of a sample of services that have been provided. Information from the enrollee's record (assessment information, treatment plan and progress notes) is evaluated against Medical Necessity Criteria. This is done concurrently (during re-authorization) and retrospectively (after the service has been provided). The outcome of this review can indicate areas where provider training is needed, services that were provided that did not meet Medical Necessity, and situations where the enrollee did not receive appropriate services or care that was needed. Indicators will be identified to select cases for review, such as high utilization of service, or frequent hospital admissions, as well as random sampling of other events.

Through the UR process or through analysis of population data, cases may be identified that are appropriate for referral to Care Coordination. Through proactive identification and intervention with high risk/high cost individuals, the Care Coordinator may intervene with the person and providers serving the person to assure that a plan is developed that will lead to improvement in the person's status and which will help assure that the pattern of resource utilization is appropriate.

Clinical Guidelines

The MCO in collaboration with the providers will review and if needed will develop clinical guidelines to be utilized in the MCO network. These will be posted on the MCO website. Clinical Guidelines are based on national research, but are developed and recommended by the Clinical Advisory Committee with the support of the Clinical Operations Team. The Clinical Advisory Committee (CAC) will be chaired by the CCO and will be comprised of the COO, an external psychiatrist and representatives from network providers, CFAC, enrollee/family member(s) and advocacy representation. The CAC will advise the MCO on Clinical Decision Support tools, will make recommendations on the Benefit Plan, and review evidence-based/best practices. This team establishes the community standard of practice. Clinical Guidelines are important guides for providers because they describe best practices in various areas of treatment. These will help establish quality standards of practice and will be reviewed every year to determine if each guideline remains current and clinically useful. The MCO is actively engaging the MCO CenterPoint Area Provider Council and the Clinical Advisory Committee in the process of identifying guidelines and in the process of educating providers concerning the use of guidelines. The guidelines identify clinical expectations to Network Providers as well as providing information to assist enrollees and families in making choices of services and providers. In those areas where the efficacy of selected assessments and practice have not been established across cultural and/or ethnic groups, care will be taken to assure that assessments, services, and reviews are conducted within a culturally competent paradigm.

Resources for guidelines include the NC Division of Medical Assistance medical necessity and clinical coverage guidelines, the American Psychiatric Association, the American Association of Addiction Medicine, the Texas Medication Algorithm Project, the Veterans Administration Guidelines, and other national organizations.

Standard Care Guidelines will be used for Utilization Review/Management and Care Coordination. These guidelines will be referenced when clinical care is felt to be outside of the standard of practice for a given course of treatment for a given illness. Utilization Review will use the Clinical Guidelines to measure appropriateness of care and for review of individual providers and to assess a course of treatment. These guidelines will be posted on the MCO web site where the purpose of each of the guidelines is explained. The Clinical Guidelines are intended for both providers and enrollees.

Evidence Based Practices (EBPs) that have been proven to consistently produce specific, intended outcomes are an integral part of the provision of enhanced services through CABHAs and are useful in a wide variety of contexts. The MCO is actively promoting the implementation of evidence based practices. Please see Attachment A for a list of current EBPs contracted in the MCO service area. MCO is working with contracted CABHAs, with the support of our two partner Community Care Networks, Northwest Community Care Network and Partnership for Health Management Community Care Network, to promote the evaluation and implementation of EBPs. There are a variety of state and national resources to support the objective selection, implementation and fidelity monitoring of EBPs. Some of the resources include the following:

- DHHS: <http://www.ncpic.net/>
- NC Council of Community Programs: www.nc-council.org
- CCNC Behavioral Health Integration:
<http://www.communitycarenc.org/population-management/behavioral-health-integration/>
- CCNC Mental Health Integration Project:
<http://www.communitycarenc.com/MH%20Integration.htm>
- The NC Center of Excellence for Integrated Care (ICare): <http://www.icarenc.org/>
- The NC Evidence Based Practices Center, housed at the Southern Regional (Fayetteville) AHEC
<http://www.ncebpcenter.org/>
- SBIRT: Substance Abuse Screening, Brief Intervention, and Referral to Treatment:
<http://www.sbirtnc.org/>
- The UNC Center for Excellence in Community Mental Health: <http://www.unccmh.org/>
- Duke AHEC Program:
<http://dukeahec.mc.duke.edu/index.html>
- SAMHSA: NREPP National Registry of Evidence-based Practices and Procedures:
<http://nrepp.samhsa.gov/Search.aspx>

Information Systems Infrastructure

Data Driven System: Timely, accurate data is essential in managing a complex system. Data reflects the health and performance of the system. Key performance indicators will be identified and data on the performance monitored in order to understand utilization and to identify early warning signals for trends that may result in financial problems. Target populations must be identified and utilization patterns monitored so that results of services can be measured, gaps in services or capacity can be identified and risk can be managed.

A Risk Management Plan will be developed that will specifically address performance risk factors and strategies to address them. Data on service utilization, in aggregate, by disability, age, ethnicity, by individual, by providers, and groups of providers will be collected and continually evaluated in order to identify areas which need intervention. This will include review of services provided, gaps in care, over-under utilization, patterns of service provision outside the normal range (outliers), and the provision of educational opportunities to help providers understand the clinical framework or performance requirements. Data will be used to inform the Financial Management, Care Coordination, UM, and the Quality Management systems of the MCO Health Plan. This review will be based on multiple data sources (including AlphaCM) and will utilize Business Intelligence software so that massive amounts of data may be easily manipulated.

II. System of Services

The System of Services in place through the MCO Health Plan is based, whenever possible, on evidenced-based practices. Evidence-based practices will be incorporated into Clinical Guidelines implemented by the MCO Clinical Advisory Committee in collaboration with the Provider Council and supported by the Clinical Operations Team. It is important that prior to implementation of a new service, that the clinical model is identified, associated with a Clinical Guideline and the expectations made known to the providers. A plan to monitor the implementation, outcomes and service delivery of any new service should be in place prior to initiation of a new service in order to assure consistency in implementation and attainment of expected outcomes.

The System of Services reflects a range of services and supports from the least restrictive, and least costly, to the most restrictive and most costly services. Along the continuum, enrollees must be directed to the most appropriate services to address the needs identified during the assessment and urgency reflected during the Customer Services process. Services are grouped into Basic, Basic Augmented and Enhanced Services. Within the continuum services are arranged along tracks reflecting disability specific needs and associated evidenced based practices:

1. Mental Health Adult/Substance Abuse Adult
2. Mental Health Child/Substance Abuse Child
3. Developmental Disabilities Adult/Child
4. Innovations

Medicaid vs. State Benefit Packages

Medicaid recipients and State funded recipients will have access to a similar service array; however the State Funded Benefit is not as robust as the Medicaid benefit as services are subject to the availability of State funds as set forth in the North Carolina State Plan. If State funds are depleted, The MCO has a procedure for creating waitlists for specific services until additional state funds are identified. A waiting list for services may be necessary when the demand for services exceeds available resources (Non-

Medicaid Funds Only) or when service capacity is reached as evidenced by no available provider for the service needed.

Standardized monitoring reports will be available from the Quality Management and Management Information System (MIS) indicating level of funding available daily by service category and for specific identified services lines, or groupings of service lines. Reports will be monitored by the Quality Operations Team, and by the Care Management CFT. Should funding levels reach a pre-determined percentage of obligated/projected, the Utilization Management staff will be notified. Based on review of service patterns and trends, Clinical Operations will determine which clinical services require the development of a wait list process.

If a Medicaid funded service is needed by a Medicaid recipient, and there is no capacity within the network to provide this service or an alternative agreeable to the enrollee, the service will be sought from an out of network provider.

Identification of Service Needs and Network System Gaps

Gaps in the MCO system of care and specific service needs are identified in several ways. These methodologies include:

- Via enrollee requests through Customer Services
- Through review and authorization of services in the UM and Care Coordination processes
- Through case staffing in the UR process
- Through Cross Functional Team processes
- Through a Needs Assessment completed by the MCO (Provider Network Operations will rely on the Needs Assessment to understand service need in relationship to existing capacity as an objective measure to inform specific development in needed capacity.)
- Through Geo-mapping to identify service area gaps

Upon identification of these potential needs, Network Operations will be notified of the request for additional capacity in specific services or service continuums to take to the Network Operations CFT. This CFT consist of the Provider Network Director, Waiver Contract Manager, Quality Management Director, Care Coordination Director, Community Operations Director, Accounting Manager, Credentialing Specialist, and Corporate Compliance Specialist-Fraud and Abuse. This design maximizes information exchange, and assures the information is shared with each department that has responsibility in the development of our system of services. Each department is then responsible for developing and implementing their part of the process in coordination with other departments.

Correlation of the Assessment to the Level of Care and Service Provision:

Another aspect of the MCO System of Services is the correlation of assessment information to the Levels of Care. Initially scores from standardized assessments will be grouped into the two tiers of care (Basic and Enhanced). This information will be used as a guide along with other information provided on the Service Authorization Request, such as the person's living situation, the availability of natural supports, recent hospitalizations, etc., to assign an appropriate level of care. Licensed Professionals well versed in their area of expertise and trained in the principles of recovery and cultural competence will conduct reviews of the service authorization requests.

Service Categories:

Each service is assigned to one of twelve major categories according to the type of program typically associated with the service. The Service Categories include:

1. Inpatient
2. Community Support
3. BH Long-term residential
4. PRTF
5. Partial Hospitalization/Day Treatment
6. Outpatient: periodic clinical services
7. MST/IIH
8. Psychosocial Rehab
9. ACTT
10. Crisis Services
11. ICF: Intermediate Care Facility
12. Innovations: Services included in the Innovations Waiver

Crisis Services System

The MCO is committed to ensuring that there is a comprehensive Crisis Continuum available in all MCO counties. The MCO focuses on providing easy and open access to services. The goal of the Crisis Continuum is to both prevent escalation in crisis events and to assure appropriate intervention in crisis situations. Urgent and emergent care is always available. Enrollees can access the right amount of care when they most need it. The crisis continuum of services is intended to reduce the number of enrollees seeking care in Emergency Departments in local hospitals. Well trained clinical intervention is important in responding to both enrollee and community needs.

Authority to authorize and manage inpatient care, both locally and at State hospitals and facilities is essential in managing the Crisis Continuum. Discharge and linkage to community services is easier when enrollees are served locally. Also, significant others in the enrollee's support network are more likely to be involved in treatment if it occurs close to home. Studies have shown greater sustained improvement when families and other support networks are involved in the treatment process.

Any caller can receive crisis services by accessing any of the following services. Each service leads directly to evaluation and treatment:

- 1-888 call to MCO (1-888-581-9988)
- Mobile Crisis Management Response
- First Responder
- NC Start
- Critical Access Behavioral Health Agencies (CABHAs)

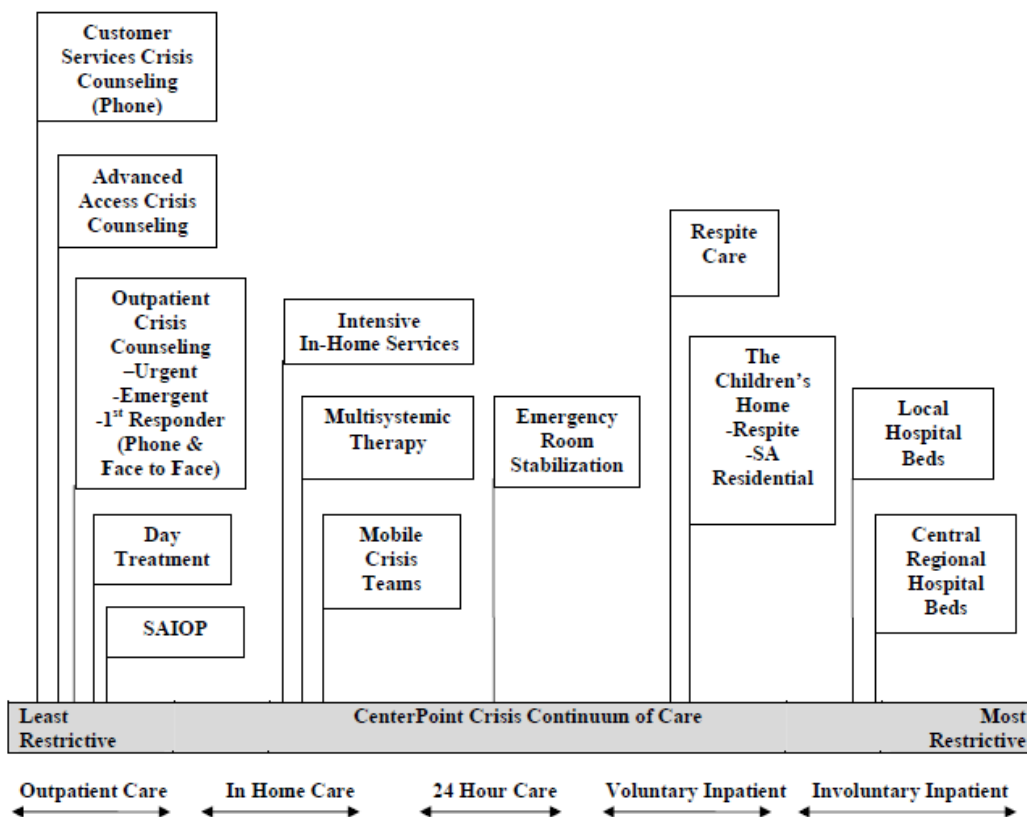
We work to assure that all callers receive appropriate emergency intervention based on individual needs and that they are assisted in re-entering the service system, if necessary.

First Responders:

Most of the state's Medicaid enhanced service definitions have a First Responder component. There is an expectation of readiness for providers delivering Enhanced Services. Personnel of the provider agency

designated as the Clinical Home in the PCP will have access to the enrollee's crisis plan at all times and be knowledgeable of the local crisis response system as well as the MCO crisis continuum. Clinical Home providers are responsible for responding to enrollees they serve directly. The goal is to prevent escalation and to intervene in the person's crisis situation, or assist in getting the person to a site for evaluation by appropriate professionals. If the crisis situation exceeds the capacity of the First Responder, the primary provider should contact the MCO Customer Services line for formal instruction to assure the enrollee's safety and well-being. The Customer Services Clinicians initiate action for enrollees whose Clinical Home provider is not able to manage the situation effectively, as well as any new people entering the system through crisis. In order to facilitate appropriate response to crisis situations for known enrollees, providers will conduct risk assessments as part of the person centered planning process for all enrollees receiving Enhanced Services, ensure that crisis plans are developed, and assist enrollees with Advanced Directives. MCO will have access to all Crisis Plans that are part of the treatment plan for enrollees already in care.

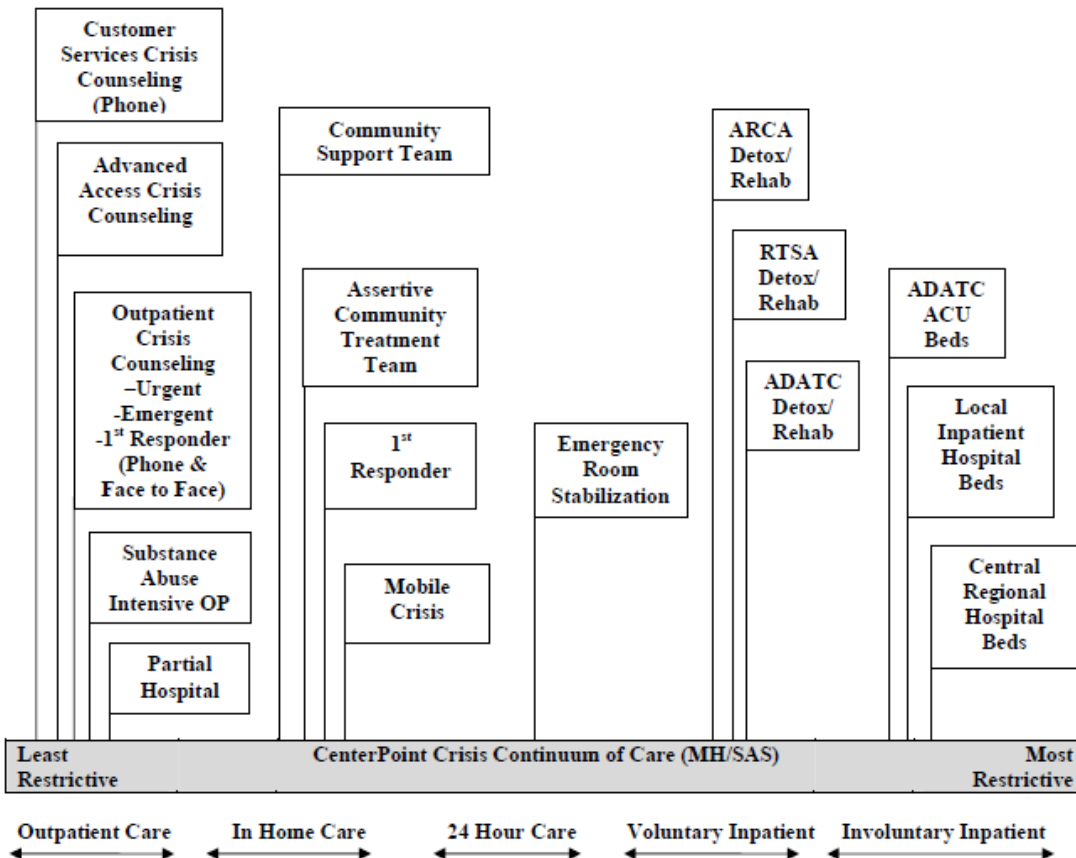
Child Mental Health/Substance Abuse System of Care: Child/Adolescent



1. The MCO Care Coordination and Utilization Management functions are available to all four CenterPoint area counties. The MCO collaborates with public partner agencies (DSS, DJJDP, School systems) to discuss children who are in need of care and to assure that children are identified as early as possible to begin intervention. The objective is to connect families to services as early as possible to prevent the need for residential placement.
2. Child and Family Teams are made up of professionals, children and their families, and other paid and natural supports. This team develops the individualized treatment plan. This is an essential component of all treatment models for children. Plans must be developed in the context of the family's culture and be based on strengths, values, norms and preferences of the child, family, and their community.
3. The MCO works for increased collaboration with school systems to assist in supporting children at school.
4. Whenever possible, the MCO works with network providers to stabilize children quickly, with rapid reunification with their family and engagement in treatment. Returning children to their home setting quickly with support services is important in reducing the need for future out of home placement.
5. Intensive In-home support for families will be provided so that Licensed Professionals and Qualified Professionals work with the family in their home environment to address the family-child dynamics that are contributing to the child's problems. Professionals also serve as models for parents in how to effectively manage behavioral health issues their children may have. The service involves wrap-around strategies that bring in supports and services as needed from the community at large, as well as other agencies charged with the well being of children and their families. Multi-Systemic Treatment (MST) is also a model with research support for working with children with aggressive and/or other anti-social behaviors.
6. If residential placement is medically necessary, the MCO will encourage a child or youth placement in residential services within the four county areas, or close by, in order to make family involvement as easy as possible. Family involvement will be strongly encouraged and facilitated.
 - a. When a child is placed in a residential setting, the placement will be intensively monitored:
 - i. A thorough clinical assessment will be required prior to authorization (if an emergency, as soon as possible after placement).
 - ii. A treatment plan must be developed and monitored by a Licensed Clinician.
 - iii. The MCO as well as the Clinical Home Provider will monitor the child's progress and remain involved throughout placement and at discharge. Once discharged, both the MCO and the Clinical Home Provider will provide intensive follow up to assure that treatment needs are met, that appropriate treatment resources are in place, and all community stakeholders contribute to assure the family receives needed support upon the child's return home.

Adult Mental Health/Substance Abuse System of Care:

Adult



Addictions and Substance Abuse:

The Substance Abuse Continuum for adults includes local detoxification capacity, residential and outpatient treatment. The continuum also includes care that focuses on the needs of women, and women with children. Enrollees reporting a substance abuse problem who do not need emergent assessment for detoxification are viewed as urgent, and will be referred to the appropriate level of care. Easy entry to the system has been made possible through the Critical Access Behavioral Health provider agencies (CABHAs) who may then link to Addiction Recovery Care Association (ARCA), Residential Services of Alamance (RTSA) or ADATC if residential treatment is needed. .

Early and appropriate intervention is important in preventing other social and medical problems that will impact the public system at a later point in time. Prevention programming is available to actively at risk children and youth as well as their families.

The following services are active within our Substance Abuse continuum:

1. Outpatient Services
2. Intensive Outpatient (IOP)
3. Comprehensive Outpatient Treatment (SACOT)
4. CASP funded programs including Opioid Maintenance Therapy
5. Halfway House (REMMSCO)
6. Residential Treatment (ARCA, RTSA, ADATC)
7. Detoxification, non-medical (ARCA, RTSA)
8. Detoxification, medical, hospital based (FMC, OVBH)

Substance Abuse Treatment Services for children include:

1. Outpatient Services
2. Intensive Outpatient (IOP)
3. Residential Treatment (The Children's Home)
4. Multi-systemic Therapy (MST)

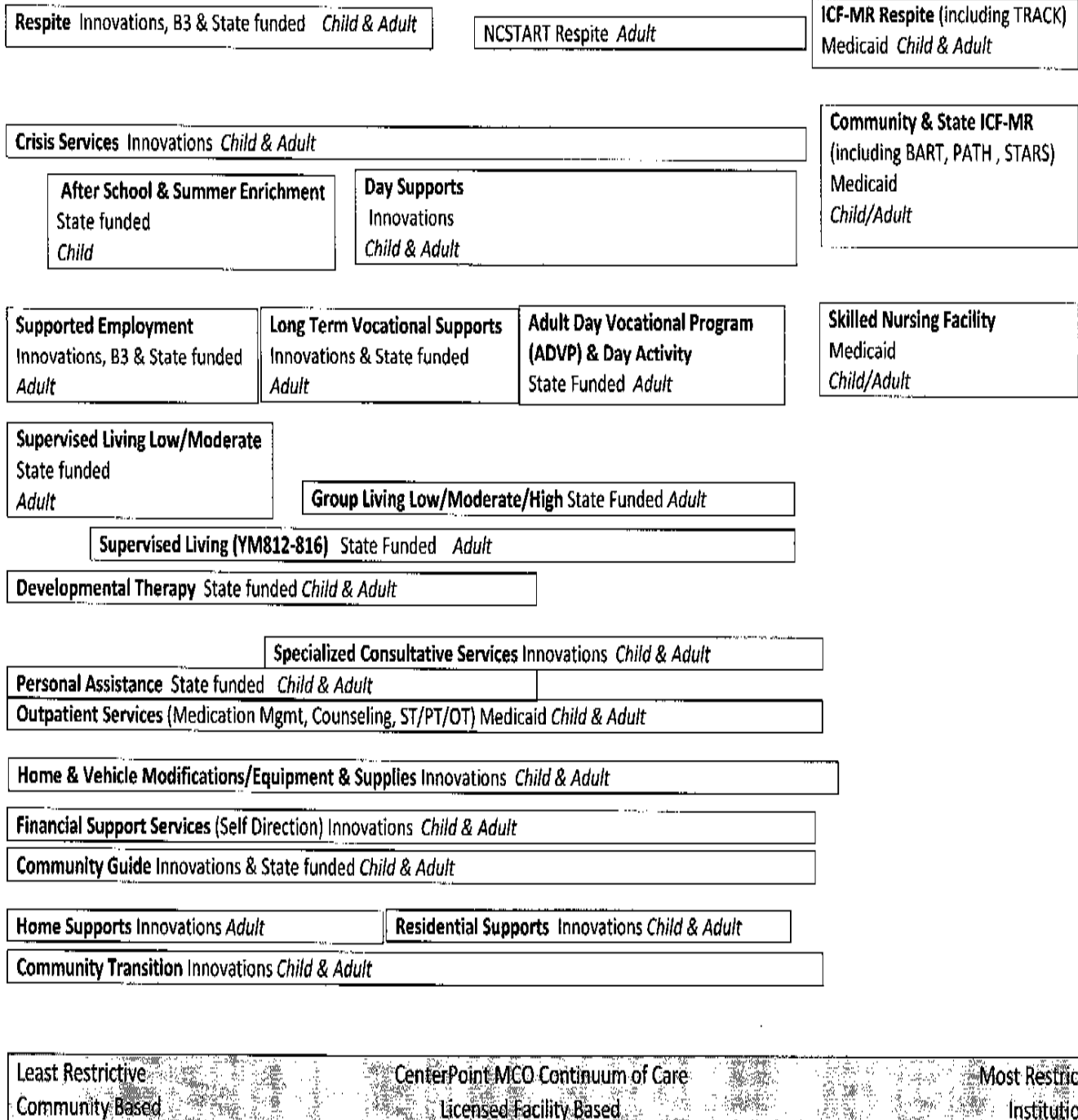
Adult Mental Health:

The MCO network has a broad array of providers who are credentialed to provide Mental Health treatment services to adults. The array of services provided includes the following:

1. Outpatient Services
2. Best Practice Specialty Group services (group/individual treatment)
3. Community Support Team (CST)
4. Assertive Community Treatment Team (ACTT)
5. Psycho-Social Rehabilitation (PSR)
6. Partial Hospitalization
7. Local Inpatient Hospitalization
8. State Hospitalization

Adult/Child Intellectual/Developmental Disabilities System of Care:

I/DD Services Continuum



Intellectual/Developmental Disabilities:

The service/support continuum for individuals with Intellectual and/or Developmental Disabilities (I/DD) begins and is accessed following a thorough assessment process. This assessment process includes objective measures of cognitive and adaptive functioning completed by licensed professionals in private practice. These professionally conducted assessments are used in determination of eligibility for services for I/DD.

Upon determination of eligibility, additional assessments of functionality and risk are conducted, at a minimum annually, to inform development of the Treatment Plan and authorization of services/supports to address identified needs. Functionality and risk issues related to I/DD typically require lifelong support. Despite lifelong need, the individual specific service/supports needed to promote optimal independence vary greatly. Due to this variance, regular assessment of functionality is needed to insure that individuals receive the needed amount of service/support at the needed time. Assumptions that an individual will always need a service/support at the same intensity are an affront to the dignity of the individual with I/DD.

There is almost always a greater need in the community for individual specific services/supports than can be met by available funding. With these limitations in mind, the following service/support options are available within the I/DD continuum:

1. Education
 - a) Care Coordination is provided to all individuals functionally eligible for services for I/DD
 - b) Community Guide is provided to all individuals when the need for education exists regarding natural and community supports
2. Vocational and Day Supports
 - a) Existing programs will be expected to develop individualized programming that promotes optimal independence through employment
 - b) State funded periodic services
3. Residential Services
 - a) Group living settings are available
 - b) Efforts will be made to expand independent living options
4. Home and Community Based Services (HCBS)
 - a) NC Innovations 1915(c) Waiver
 - b) State funded periodic services
5. Intermediate Care Facilities for Intellectual Disabilities (ICF-ID)
 - a) The opportunity to increase the use of HCBS exists through managed care because the NC Innovations Waiver and ICF-IDs are consolidated under one management entity
 - b) The MCO will begin this process in the third year of managed care
6. Self-Direction
 - a) NC Innovations offers two models of self direction, Individual and Family Directed Supports
 - b) Agency with Choice model
 - i. Only model that will be available for the first three years of managed care
 - c) Employer of Record
 - i. The MCO will educate family members and providers in the use of this model in the third year of managed care
 - ii. The MCO will offer this model at the beginning of the fourth year of managed care

Additional Services Based on the B-3 Section of the 1915 B Waiver:

With savings from the efficient operation of the 1915 B and C waivers, the MCO may offer services under section B.3 of the 1915 (b) Waiver, e.g. Peer Support, Community Guide and respite.

Benefit plans will be posted at www.cphs.org once they are formally approved and adopted.