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Executive Summary

Cardinal Innovations Healthcare clinical leadership continuously evaluates the organization and quality of the behavioral health system of care in our catchment areas. This process includes biannual review, at minimum, of the following tasks:

- Defining the core principles that guide clinical strategy and implementation of the clinical program;
- Defining the core evidence-based practices, clinical outcomes and clinical management tools that permeate the clinical system;
- Clarifying the intended population, targeted best practices and outcomes, and clinical management strategy for each Medicaid service;
- Developing advanced clinical management strategies for clinical operations, quality and network management;
- Developing data-based methods for identifying at-risk and high-cost members or member populations and matching those populations with sophisticated care management and care coordination interventions;
- Identifying gaps in the system of care and outlining clinical initiatives to address those gaps; and,
- Defining and standardizing clinically-relevant expectations for regional and local interactions with stakeholders, particularly focusing on areas that promote community integration for our members. Such areas include housing, employment, education, the legal system, and veterans affairs.

The Cardinal Innovations Clinical Design Plan is the result of this process. This document outlines the guiding principles for our clinical system of care and details how that system works to meet the varying needs of our members.

Additionally, the purpose of the Clinical Design Plan is to increase transparency with both Cardinal Innovations’ members and stakeholders. Ultimately, Cardinal Innovations seeks to develop a self-managed system in which providers and members are fluent in our expectations and are engaged and empowered to implement those expectations. We want members and providers to understand our structure, approach to care, and expectations.
Introduction

Cardinal Innovations Healthcare develops, implements, and updates a broad Clinical Design Plan, outlining our approach to developing and maintaining high quality and highly accessible behavioral health services for our members. This document provides the clinical design structure for the NC MH/DD/SAS Health Plan and NC Innovations Waiver, our philosophical priorities, and the quality assurance tools with which we manage our network of providers and the services they provide. Our dedication to the holistic wellbeing of our members will be apparent throughout this design.

Cardinal Innovations is a managed care organization (MCO) currently covering more than 850,000 individuals with complex needs in North Carolina. Cardinal Innovations manages Medicaid, as well as other federal, state, and designated local funding for mental health, intellectual disability/developmental disability, and substance use/addiction services in our covered areas. Cardinal Innovations pioneered this unique managed care model in North Carolina, which relies on strong community partnerships with providers and stakeholders to provide person-centered care.

Cardinal Innovations provides access to high quality services through a comprehensive network of over 900 of the best providers across the state. We are a community-focused organization with a history of sustained partnerships with members, local stakeholders, and elected officials designed to create quality solutions for special populations who rely on the public system for care.

Cardinal Innovations has over 40 years of experience in managing community services for people with mental health disorders, intellectual disabilities/developmental disabilities, and substance use disorders. We are proud to have had over a decade of proven success in the operation of a Medicaid Managed Care Waiver. We have redefined managed care through our hands-on and compassionate approach. Our track record includes significant savings to taxpayers, positive member outcomes, and reinvestment in additional services for the people and the communities that we serve. The North Carolina General Assembly endorsed our model as the basis for the statewide expansion of the Medicaid Managed Care Waiver in 2013.

Our Purpose: Improve the health and wellness of special populations

Our Mission: We create innovative, community-based managed care solutions for special populations

Our Vision: We are the healthcare leader in integrated managed care for special populations

Our Core Values:
We are:

- Individually accountable
- Community focused
- Innovative
- Focused on quality outcomes
Description of the Medicaid Waivers

Cardinal Innovations provides access to Medicaid behavioral health and intellectual disabilities/developmental disabilities services through 1915(b) and 1915(c) waivers. Sections 1915(b) and 1915(c) of the Social Security Act authorize the use of waivers to give states increased flexibility in operating their Medicaid programs. States apply to the Centers for Medicare and Medicaid Services (CMS) for waiver approval through written applications that describe in detail how waivers will operate.

The 1915(b) waiver is used to implement mandatory enrollment of Medicaid beneficiaries in managed care through entities such as prepaid health plans, health maintenance organizations (HMO), and primary care case management programs. The requirements of the Social Security Act pertaining to Medicaid that are typically waived to implement 1915(b) waivers are noted below.

- Freedom of Choice – Medicaid beneficiaries may be required to receive services through specific types of managed care plans. In addition, the number of plans may be limited through selective contracting, and the number of providers may be limited by the plans.
- Statewideness – The waiver may be limited to specific geographic areas of the state.
- Comparability of Services – Additional benefits (such as care management and health education) that are not available to other Medicaid beneficiaries may be provided. In addition, any savings generated may be used to create and fund innovative and cost effective services, known as 1915(b)(3) services, for waiver participants.

States that implement 1915(b) waivers comply with the federal regulations that govern managed care delivery systems regarding quality assurance and performance improvement, reasonable access to providers, grievance and appeal rights, and cost effectiveness. Cost effectiveness is achieved if the waiver does not increase Medicaid costs. Actual waiver expenditures are tracked and reported to CMS on a quarterly basis.

The 1915(c) waiver allows for the provision of long-term services and supports in an individual’s home and community instead of an institution. In order to qualify for the waiver, a Medicaid beneficiary must meet ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) level of care criteria as follows.

- The member must be diagnosed with an intellectual disability prior to the age of 18
- OR
- The member must be diagnosed with a related condition prior to the age of 22 that is likely to continue indefinitely (such as a developmental disability or a traumatic brain injury) AND have substantial limitations in three of six major life activity areas (self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living) and require active
treatment to enable the member to function as independently as possible and prevent or delay loss of optimal functional status.¹

The requirements of the Social Security Act pertaining to Medicaid that may be waived through 1915(c) waivers are noted below.

- Statewideness – The waiver may be limited to specific geographic areas of the state.
- Comparability of Services – An array of home- and community-based services geared toward the waiver target population is developed and available only to waiver participants.
- Income and Resources – Medicaid eligibility for children is determined under different criteria.

Performance measurement and quality improvement strategies are required components of 1915(c) waivers. Findings and remediation activities are reported to CMS on a regular basis. The 1915(c) waivers also must be budget neutral. The average per capita cost of Medicaid-funded services for waiver participants cannot exceed the average per capita cost of Medicaid services if the individual were in an institution.

Concurrent operation of 1915(b)/(c) waivers provide for a managed care delivery system that covers both Medicaid state plan services and long-term services/supports created under the 1915(c) waiver. Cardinal Innovations and the state Medicaid agency worked together to develop and implement concurrent 1915(b)/(c) waivers for behavioral health and intellectual disabilities/developmental disabilities services in 2005. The waivers were implemented as a demonstration in Cardinal Innovations’ original five counties. Significant savings and increased quality of care were achieved during the demonstration, and the waiver program was expanded statewide in 2013.

**State-funded and Locally-funded Services**

While Medicaid is Cardinal Innovations’ primary payer, the company also oversees the expenditures of state funds to serve members within its catchment. The company receives such funds through state allocations, determined annually by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This division of the North Carolina Department of Health and Human Services works closely with North Carolina’s state Medicaid agency as an important partner to Cardinal Innovations. Cardinal Innovations also receives service-specific allocations and grants. The company receives these funds from the state and from various counties in support of specific initiatives. While the primary focus of the Clinical Design Plan is the Cardinal Innovations Medicaid system of care and member management, references to some state-funded and locally-funded services are included throughout this document.

Cardinal Innovations
Clinical Governing Principles

Cardinal Innovations bases its entire clinical design on several governing principles. Some principles are important for the entire system of care, while others are important for specific disability groups.

Principles for the entire clinical system include the following:

- Quality and Accountability
- Innovation and Specialization
- Cultural and Linguistic Competence
- Recovery and Community Integration
- Person Centeredness/Quality of Life
- Safety and Wellbeing

Each principle is defined below.

**Quality and Accountability**

Cardinal Innovations believes that the services we fund should be evaluated based on whether they yield improvements in the lives of members. Services should accomplish the following goals, in light of a member’s preferences (Substance Abuse and Mental Health Services Administration National Outcomes Measures):

- Ease of accessibility
- Member participation, retention, and satisfaction with services
- Symptom improvement and morbidity reduction
- Reduction in use of more restrictive levels of care (including the criminal justice system)
- Increased access to stable community-based housing and employment
- Meaningful community and social involvement

In order to promote these goals, outcomes must be measured individually and systemically. This process requires the development of tailored metrics and analytics tools that truly measure service quality through claims analysis and highly sophisticated utilization review, going beyond the traditional tools of compliance monitoring, medical necessity determination, and grievance/incident investigation.

Not only do we believe that the service providers we fund should be accountable for outcomes, Cardinal Innovations also believes that we must be accountable to our major partners, which include the state of North Carolina and its taxpayers, our members, and our network of providers. It is our duty to efficiently use funds dedicated for services, in full compliance with all relevant regulations, to ensure these services are cost effective, high-quality, and delivered to those for whom services are entitled. Further, it is our
duty to incentivize the providers who deliver these services to provide high quality care. To our members, we are committed to advocating first for their health and safety, followed closely by their satisfaction and life success. To our providers, we are committed to removing barriers to offering good care and rewarding excellence.

**Innovation and Specialization**

While it is important to set standards of accountability that apply broadly throughout our network of care, it is also important to ensure specialized and innovative care is available for specific population subsets. Cardinal Innovations is proud of our successes in bringing innovation to Medicaid managed care for special populations. Effective behavioral health interventions are often not “one-size-fits-all.” Access to specialized interventions is vital for high-risk and/or high-cost populations. Some examples of these population groups include the following:

- Members transitioning from high to lower levels of care (e.g., inpatient to outpatient or residential to community)
- Members with complex comorbidities (e.g., dual diagnoses or complex medical problems)
- Members with unstable, high-risk behavioral health conditions (e.g., sexually reactive youth, significant legal involvement due to illness, or youth at high risk of out-of-home placement)

Specialized care may include enhancing existing services by adding service team members with expertise in high-risk conditions, or may require the development of specialized services not currently available within existing benefits. It may also include allowing for bundling multiple services together which otherwise are typically excluded under standard benefit limitations. Such high-risk and high-cost members are detected through a number of means, including standard authorization reviews, retrospective utilization reviews, routine care coordination activities, data monitoring, incident monitoring, grievance resolution activities, and provider/advocate referrals.

**Cultural and Linguistic Competence**

Cultural and linguistic competence refers to the importance of culture and language as integrated into service development and delivery. Culture is an inclusive term. Everyone has a unique culture which encompasses their socio-emotional makeup. Cultural competence encourages professionals and staff to be culturally aware and respond in culturally appropriate ways when working with diverse populations. It incorporates a rich knowledge of diversity, culture, and language in our interactions with others. How we communicate, both through written and oral forms, is essential in providing and receiving the right services at the right time clinically. Not only should service delivery be responsive, it should be respectful of the culture of the member and his or her family members.

Cardinal Innovations strives to embrace this philosophy as a critical piece of the design of our clinical process. Culture is considered throughout the entire process – beginning with staff onboarding and training; through the initial contact with a member or family member; and the assessment, treatment, and discharge phases of care. Mental health, substance use disorders, and intellectual and developmental disabilities have many connotations in various cultures, which may affect help-seeking behavior.
Our clinical process is designed to provide equal access to services for diverse communities. This affects service development and delivery. Developing a skill set to design and deliver culturally and linguistically competent care benefits the members and their families. Understanding how culture and language affect treatment modalities and best practices sets the environment for better cultural understandings and member outcomes.

In 2013, The Office of Minority Health, U.S. Department of Health & Human Services, released a revised version of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare. This blueprint provides a foundation for implementing cultural and linguistic competence throughout a program, system, or organization. Cardinal Innovations embraces these standards and strives to work toward consistent adaptation and implementation throughout our organization and our provider network.

As demographic shifts occur over the next 30 years, integrating cultural and linguistic competence into the clinical design of our organization becomes not just a philosophy to embrace, it becomes an essential part of the business design for the development and delivery of mental health, intellectual disabilities/developmental disabilities, and substance use disorder services.

**Recovery and Community Integration**

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” It is a journey for most, as it is a gradual process that may start at any point in a person’s illness and continues throughout his/her life.²

The elements of recovery as defined by SAMHSA are

- **Health**: overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love, and hope.

The unique opportunities available through Cardinal Innovations’ service array foster the strength of natural support networks which enable members to maximize their independence and/or community integration. Services are designed to value and support members to be fully functioning participants in their communities. The service array is intended to facilitate each member’s ability to live and work in the most integrated setting desired. Opportunities for community integration through work, life-long learning,

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² Substance Abuse and Mental Health Services Administration (SAMHSA). *SAMHSA’s Working Definition of Recovery* [PDF document]. Retrieved from SAMHSA website: [https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf](https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf)
recreation, and socialization are encouraged with a service array designed to leverage both natural and community supports.

Having adequate support is an essential element for both recovery and community integration. The goal of many recovery-oriented services is to reduce dependence on professionals while assisting the member in building/rebuilding natural supports and becoming more integrated in their communities. Natural supports reduce vulnerability, dependence, and loneliness. Research findings suggest that the approach to integration should follow a balanced direction, whereby professional and natural supports are accepted as complementary rather than substitutes.

**Person-Centeredness and Quality of Life**

Critical elements of a person-centered approach include members directing their treatment and/or support plan development along with their chosen communities/families. The planning process should reflect the perspectives and preferences of the member and identify goals with outcomes measured to reflect the eight quality of life values. Fundamental elements of quality of life include the following:

- Emotional well-being
- Interpersonal relations
- Material well-being
- Personal development
- Physical well-being
- Self-determination
- Social inclusion
- Rights

A person-centered approach is designed to focus on the perspectives and preferences of the member, rather than the perspectives and preferences of the community, family, guardian, or provider. Support for individuals with intellectual disabilities/developmental disabilities is anticipated to continue throughout the lifespan, but the type of services and intensity of services evolve to reflect their unique, changing needs and goals. To assure person-centered planning and services, it is important to balance between a quality of care approach and a quality of life approach.

Members have a right to express and live according to their preferences, and our duty is to respect their autonomy to the greatest extent possible. Doing so demonstrates respect and helps to maintain the trust in the therapeutic relationship. In addition, members can learn from their decisions and feel more control over their lives. We encourage our members to play a primary role in determining the types of treatment in which they want to participate, as well as consider developing Psychiatric Advanced Directives (PADs), should their illness ever prevent them from meaningfully participating in making decisions about their treatment. Additional information on PADs can be found online at [http://www.nrc-pad.org](http://www.nrc-pad.org).

Members must be able to rely on the information provided to them by professionals about treatment. Understanding a treatment’s nature, benefits and risks are the foundation of informed consent. In order for their consent to be valid, members must have a clear understanding of the treatments being recommended and the opportunity to choose treatment/service options. Informed consent requires honesty from the professional sharing the information, which is tailored to fit the member’s level of
understanding. It also reflects the member’s wishes, as autonomy should always be respected and treated as the most important ethical consideration underlying informed consent.

Services offer support to facilitate opportunities for each member to explore and enhance their quality of life by maximizing self-determination, self-advocacy, and self-sufficiency. Services are intended to support members to live in homes of their choice, have employment or engage in purposeful daytime activities of their choice, achieve their life goals and provide an opportunity to direct their services to the extent they choose. It is important to note that waiver services are designed to provide the necessary support that families with children need to keep their children in the home setting.

**Safety and Wellbeing**

An important component of waiver services is to achieve the delicate balance between “dignity of risk” with safety and wellbeing for the member. This balance is unique for each person. Balancing “dignity of risk” with safety and wellbeing includes understanding and respecting the individual’s preferences, challenges, habits, desires, and dreams rather than following a “cookie cutter” approach focused exclusively on safety. Individuals with intellectual disabilities/developmental disabilities are vulnerable to coercion, exploitation, neglect, and abuse. To assist with securing safety and wellbeing, members must be encouraged to communicate when they are upset, hurt, scared, or want something to stop. These messages are essential to communicate. They can occur in a nonverbal or verbal manner and must be respected by natural supports and paid staff in order to help empower and protect the member.

Many people with mental illness and/or substance use disorders have limited choices in where they live and with whom they live. Many individuals live in substandard housing and/or inappropriate placements such as nursing homes. This issue has become apparent in North Carolina with the recent lawsuit settlement with the Department of Justice, where North Carolina is to move individuals out of adult care homes that have more than 50 percent of residents with primary diagnoses of mental illness. Further, 30 percent of chronically homeless people have SPMI.

Individuals with mental illness and substance use disorders also may become involved with the legal system. In 2006, 25 percent of inmates who had been incarcerated suffered from a mental illness. People who are diagnosed with serious and persistent mental illnesses (SPMI) are also at elevated risk for being the victims of violence. In a paper in Psychiatry Services, it was found that individuals with SPMI were two-

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and-a-half times more likely than the general public to be violently perpetrated.⁷ Lastly, many individuals with SPMI either receive substandard or no health care. Many of these individuals have no health insurance and are relegated to free clinics or no health care at all. Many only receive their care through emergency rooms where they cannot be turned away. Individuals with schizophrenia have a truncated life span of approximately 20 years less when compared to the general population.⁸ Even though there is a high rate of suicide in the schizophrenic population, the main causes of death are the same as for the rest of Americans (heart disease, cancer, etc.).

Cardinal Innovations strives to address these issues of exploitation, abuse, inadequate housing, incarceration and physical health through a comprehensive approach, which takes into account the whole person, not just a diagnosis.


Managed Care and Quality Tools

Cardinal Innovations manages a high functioning clinical system by using management tools such as cross-functional oversight teams, as well as designated operational units. Each of these teams and units reports directly to executive leadership. Our goal is to ensure a high-quality, financially viable network that provides services needed by our members in the least restrictive, clinically appropriate setting. We continually monitor and assess the performance of our network and expect high quality results from the perspective of our members, providers, stakeholders and regulators. For members with specialized and intensive needs, we utilize high-intensity, data-driven management strategies to increase the likelihood of positive clinical outcomes and reduce the likelihood of institutionalization. Cardinal Innovations recognizes that effective care may vary by member in accordance with local community resources and has strategies for ensuring localized solutions for member needs.

Specifically, we use the following cross functional teams and operational units to ensure a high-quality, highly accessible system of care.

Cross Functional Teams

Clinical Advisory Committee (CAC)

Led by the Chief Medical Officer (CMO), the CAC is comprised of clinical staff representing various disciplines and disabilities from Cardinal Innovations, network providers and practitioners, and members and family members. Responsibilities include direct reporting to the Care Management Team, reviewing and adopting clinical practice guidelines, reviewing evidence-based practices, identifying training needs, evaluating utilization in relation to clinical practice guidelines, and assisting with the development of community standards of care. Additional responsibilities include identifying prevention concerns in the community and making recommendations on identified accessibility issues, service gaps in the service continuum, diversity and cultural issues impacting clinical approach to treatment and training needs pertaining to best practice.

Continuous Quality Improvement (CQI) Committee

Led by the CMO, the CQI Committee is responsible for establishing clear expectations for member safety; allocating adequate resources for measuring, assessing, improving and sustaining Cardinal Innovations’ performance; and enhancing the efficiency and delivery of quality care through quality improvement activities. Additionally, the CQI Committee monitors performance trends against targets, quality of care metrics and provider performance, the Quality Improvement work plan, clinical operations metrics, quality improvement activities (QIAs), and performance improvement projects (PIPs).
Care Management Team (CMT)

Led by the CMO, the CMT reports to the Corporate CQI Committee and provides oversight for the management of member care, including access to and utilization of both clinical and support services. This oversight includes utilization, demographics, and overall penetration by identified target populations. The Care Management Team develops the Clinical Design Plan. Additional responsibilities include:

- Researching evidence-based practices
- Developing new services and managing other clinical initiatives
- Working with the Clinical Advisory Committee to develop clinical guidelines
- Monitoring timeliness of access to care, member demographics, and utilization trends and patterns
- Reviewing authorizations and adverse determinations, appeals and resolutions, and disability waitlists for non-Medicaid services.

Network Operations Cross Functional Team (NOCFT)

Led by Network Operations, the NOCFT reviews the Network Capacity Study and approves the resulting Network Development Plan in accordance with priorities identified in the Clinical Design Plan. The NOCFT monitors provider performance on quality and utilization reviews. The team may take corrective action in cases of poor performance, failure to meet regulatory standards, or in the case of serious incidents. The NOCFT is also tasked with reviewing service gap-related information to identify the needed capacity in specific service or geographic areas, and to identify the providers that will be needed to implement new services and/or increase availability of best practice services when gaps are identified.

Operational Units

Access Call Center

Cardinal Innovations maintains a 24/7/365 “Access” Call Center (1-800-939-5911) through which members, families, community stakeholders and others can speak directly with a qualified staff person to inquire about services; be connected to services (emergently, urgently, or routinely); and inquire about community resources. Appointments with many of our providers can be made anytime, day or night, through this access line. Cardinal Innovations contracts with providers within our service regions to ensure emergent access for individuals within two hours, urgent access within two calendar days, and routine access within 10 business/14 calendar days. In addition, Cardinal Innovations contracts with Comprehensive Community Clinics (see below) to offer same-day access to assessments during business days each week. Access also supports a web-based “live chat” function for all visitors to www.cardinalinnovations.org to answer customer service relations inquiries.

Network Management

The 1915(b) Waiver allows Cardinal Innovations to use a closed network of providers, allowing us to specifically tailor the service system to fit the unique needs of each community in which we are the payer. Cardinal Innovations selects high performing providers, as evidenced by close monitoring and evaluation described in the Quality Management (QM) and Network Development Plans. Our monitoring includes review of grievances against providers, as well as concerns recorded in our electronic Provider Concerns Module by our internal staff. In addition to the management of our provider network, we also have a
Development unit within Network Operations. The focus of this unit is to identify providers which are needed to address gaps throughout the network.

Our company selects providers in a way that accounts for high-quality service accessibility and financial viability adapted for each local or regional service area. New providers are not added without demonstrated need and evidence of appropriate qualifications. We understand that providers are only able to provide high quality, evidence-based services if they are financially viable. Therefore, we complete a yearly Community Needs Assessment of the adequacy of our network of providers. Additionally, we use selective rate setting to promote greater availability of least restrictive, evidence-based practices and services.

Cardinal Innovations verifies the credentials of each licensed provider prior to permitting them to provide services. Doing so ensures each provider has the proper education, experience, and licensure for the services provided. Additionally, once credentialed, practitioner licensure boards are monitored on a monthly basis for any actions by the boards that would require review by Cardinal Innovations of credentials previously granted. As well, federal databases are queried on a monthly basis to ascertain whether a practitioner has been excluded from federal programs, including Medicaid. Finally, the Network Compliance Unit issues a semi-annual report to the Cardinal Innovations Credentialing Committee of actions taken against practitioner credentials in the six (6) months preceding the report.

**Utilization Management**

Cardinal Innovations uses several clinical tools to assure that high-quality services are utilized according to medical necessity and best practice standards. These tools include high risk member monitoring, prior authorization (PA), tracking of under/over utilization, application of clinical practice guidelines, and both quantitative and qualitative measurements of clinical quality. Additionally, the Utilization Management (UM) Department, along with the Medical Department, provides senior clinical oversight for innovative clinical initiatives. It is vital that Cardinal Innovations’ members receive care that is medically necessary, in the right amount, for the right duration, and in the least restrictive setting appropriate. The UM Department is the focal point for managing member care. Each year, Cardinal Innovations develops a Utilization Management Plan, approved by the Care Management Team, which outlines UM goals.

Utilization Management Care Managers are responsible for the majority of member care management activities and for initiating the use of additional tools (such as Care Coordination) when necessary to ensure high quality care and positive member outcomes. The UM Department must look at aggregate data as well as individual data to complete its functions. The following UM monitoring and management tools help ensure these goals are met:

**High Risk Member Monitoring**

Care Managers review cases with in-house experts and consultant experts (physicians, pharmacists, and doctoral-level clinicians) based upon Cardinal specific criteria in order to address complex conditions. There is often coordination between the UM Care Managers and Care Coordinators in these cases.
Prior Authorization

Prior authorization (PA) means that Cardinal Innovations requires submission of a Treatment Authorization Request (TAR) before a service is provided, so that medical necessity can be adequately assessed. PA is required in the following kinds of instances:

1. High-cost and/or highly-restrictive services (e.g., enhanced, residential and inpatient levels of care)
2. Low-cost, minimally-restrictive services used in amounts that are greater than community norms (e.g., outpatient therapy above the unmanaged sessions which for Medicaid are 24 per fiscal year)
3. Non-entitlement services (state-funded services) where funding sources are limited

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

All requests for Medicaid services for children under 21 are considered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria when standard clinical coverage policy criteria is not met or when the request is for a non-covered service. Federal Medicaid law at 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to apply EPSDT for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina Medicaid State Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. All submitted treatment authorization requests are considered under this criteria whether this is formally requested or not. If EPSDT criteria are determined to be met, medically necessary services will be authorized even when this may exceed the standard service limitations. EPSDT does not apply to (b)(3) services. Additional information on EPSDT can be found at: https://www.cardinalinnovations.org/consumer-families/services/what-is-epsdt

Over/Under Utilization Tracking

Cardinal Innovations reviews claims data and compares them to expected norms. The goal is to identify instances when services are used too little to be effective or too often compared to best practice standards. These indicators reflect the need for a different level of care or to identify situations in which low-quality care has been provided. Also, Cardinal Innovations reviews coding to ensure providers are not over- or under-coding for specific services. Examples of over/under utilization data include the following:

1. Length of stay
2. Units/sessions used per unit of time (compared to peer benchmarks or best practices)
3. Member engagement in services (units/sessions used toward the beginning of a service)
4. Utilization of authorized units (percent of units used compared to those that were authorized)

Quantitative Clinical Data Monitoring

Quantitative claims, authorizations, and other data can be proxy indicators of clinical quality. Cardinal Innovations reviews certain types of data to assess provider quality and member safety. These types of data include the following:

1. Rates of crisis system use
2. Readmission rates to specific services at various time intervals
3. Prescribing practices
4. Total cost of care (Medicaid only)
5. Level of care (e.g., LOCUS, CALOCUS, ASAM) measures match with level of care requested/provided

**Qualitative Clinical Data Monitoring**

1. Quality Management monitoring can be performed on a routine or problem-focused basis. From a clinical standpoint, QM reviews quality of care standards and compliance with the following:
   a. Medicaid/State service definition and Clinical Coverage Policy requirements
   b. Effective coordination of care and communication with other providers and/or invested parties
   c. Appropriate discharge planning and referrals
   d. Use of and fidelity to evidence-based practices/best practices and adopted clinical guidelines
   e. Measurement/evaluation of progress (e.g., use of measurement-based care tools, and monitoring of progress toward treatment goals)
   f. Adequacy of informed consent and respect for member rights

2. Utilization Management audits are called Utilization Reviews (URs). Utilization Reviews are used to evaluate certain aspects of clinical quality related to funded services. Utilization Reviews can be routine, in which providers meeting specific clinical criteria are reviewed. Utilization Reviews also may be focused, in which a specific provider is reviewed due to concerns about quality of care. While each review requires service-specific questions, most URs evaluate clinical quality by reviewing the following aspects of care:
   a. Diagnostic integrity (comprehensiveness of symptom evaluation and diagnostic accuracy)
   b. Medical necessity
   c. Treatment goals related to diagnosis, adaptive functioning, and/or level of risk
   d. Use of adopted clinical guidelines

**Medical Department**

Cardinal Innovations’ Medical Department, under the direction of the Chief Medical Officer, provides clinical and medical oversight to internal business operations to reinforce member access to quality of care. This involves active oversight and collaboration with UM, Access, Network Operations, Care Coordination and Quality Management Departments. The Medical Department leads a number of functional teams including Care Management Team (CMT), Continuous Quality Improvement (CQI), Clinical Advisory Committee (CAC), as well as carries out a leadership role on clinical initiatives and Clinical Design Plan. The scope of the department responsibilities includes direct oversight and input on outlier case management, quality of care reviews, pharmacist consultation, provider credentialing, incident reviews, internal consultation on complex cases for Utilization Management and Care Coordination, as well as provision of educational activities such as Grand Rounds. Clinical practice guidance is also provided to Cardinal Innovations’ provider network, as well as other key external stakeholders at the state, regional, and local levels. Medical Department leaders are responsible for assigned geographic regions of responsibility, which supports our community operations model.
Regional Medical Directors partner with Community Operations, Quality Management, and Network Operations staff to address community-specific clinical needs and interface with local community stakeholders, such as provider medical directors and other staff, Community Care of North Carolina, school systems, legal systems and law enforcement, social services, and elected officials.

**Care Coordination**

Cardinal Innovations has qualified professionals (licensed clinicians for MH/SUD populations and both licensed and unlicensed staff for ID/DD populations) who serve as Care Coordinators. Care Coordinators are assigned to members who meet criteria for special populations deemed to be high priority or high risk. For children and adolescents, Cardinal Innovations follows the System of Care model, which integrates a comprehensive network of community-based services to meet the needs of families who are involved with multiple child service agencies (child welfare, mental health, schools, juvenile justice, and health care). The Care Coordination Department is comprised of four major divisions to support the specialty populations served by Cardinal Innovations. Those divisions are Mental Health and Substance Use Disorder Care Coordination inclusive of the Child and Adult spectrum of support and the System of Care team, Intellectual and Developmental Disability Care Coordination, Transitions to Community Living Care Coordination, and Population Health Management. Each division is assisted by the Systems Operations team that monitors quality of care and additional supportive functions to ensure the success of our model.

**Intellectual and Developmental Disability (IDD) Care Coordination**

Intellectual and Developmental Disability (IDD) Care Coordinators are qualified professionals who support high risk members, most of whom are NC Innovations Waiver participants, to achieve their life goals through education and person-centered planning. The IDD Continuum of Care Team includes:

- **Community Care Coordinators** work with the Cardinal Innovations member, the member’s natural supports and the member’s treatment team to ensure that individuals receive the support needed to be successful.
- **Monitoring Specialists** monitor the quality of care received by individuals residing in group homes, Alternative Family Living homes, and supported living settings.
- **Clinical Support Specialists** provide technical assistance internally to Care Coordination as well as externally to members, families and providers.
- **Olmstead Specialists** work collaboratively with intermediate care facility providers, including state developmental centers, members and members’ natural supports to identify members who are appropriate for and express interest in community placement.

**Mental Health and Substance Use Care Coordination**

Mental Health and Substance Use Disorder Care Coordinators are trained Master’s level licensed clinicians and Registered Nurses who coordinate, manage and monitor care and transitions across the continuum of health services, in various settings, and in conjunction with individuals, providers and others to connect components of the healthcare team and improve outcomes for the individual including member self-management and positive treatment engagement. The MH/SUD Continua of Care Team includes:

- **Acute Transitional Care Coordinators (ATCC)** are Registered Nurses who initiate Care Coordination with members in emergency rooms and inpatient behavioral health units. This team is founded on
the evidence-based Coleman Care Transitions Intervention model. In collaboration with their treatment team and collaterals, ATCCs support identified members in developing a safe discharge plan, facilitating self-management goals and building connectivity to professional and community resources to encourage successful transition from facility to next level of care and/or home. ATCCs complete medication reconciliation for members following discharge from emergency room and inpatient care and additionally provide community-based follow up for these members for thirty days following their discharge. This specialty team utilizes medical based assessment skills to evaluate integrated health needs, including physical and behavioral diagnoses. The goal of this program is supporting members in increasing engagement with outpatient professional and community supports to decrease behavioral health crises. ATCCs support hospital to home transitions in specific hospital facilities across the Cardinal Innovations catchment area.

- **Community Care Coordinators** work with the Cardinal Innovations member, the member’s natural supports and the member’s treatment team to ensure that individuals receive the support needed to be successful. The focus of this program is to promote engagement in community-based resources and treatment.
- **Complex Integrated Care Coordinators** focus interventions on the medical and behavioral health multisystem needs of our most high risk and vulnerable members.
- **Child Residential Care Coordinators** support our members who are currently authorized for services at psychiatric residential facilities.
- **Residential Treatment Specialists** support our collective Care Coordination team in facilitating the residential treatment process for our members in need of these levels of care.
- **State Hospital Care Coordinators** support Cardinal members who are receiving treatment in targeted state inpatient facilities.

**Population Health**

Population Health is a Care Coordination initiative designed to preventatively target members who may be at risk for readmission back into Care Coordination post discharge. The goal of Population Health outreach efforts is to support individuals in preventing behavioral health crises. Specialists provide telephonic support for individuals identified as potentially benefiting from preventative care initiatives to encourage outpatient treatment engagement, self-management plan utilization and medication adherence. The focus for this program is on populations who have completed Care Coordination services and individuals who have been identified by predictive modeling as at risk of behavioral health crisis.

**Transitions to Community Living (TCL) Program**

The Transition to Community Living (TCL) Team is a diverse team of masters licensed clinicians, Peer Support Specialists and Qualified Professionals who work collaboratively to support the State of North Carolina in regards to the settlement that DOJ instituted based on a disproportionate number of individuals with mental illness who were residing in Adult Care Homes. Many of these individuals can live independently successfully. The focus for this team is to identify and secure community-based, independent housing for adults residing in Adult Care Homes who have a severe and persistent mental illness. Though each team has an area of specialization, all teams focus on helping high risk individuals secure services and supports needed to promote healthy, independent living. Apart from other Care Coordination teams, the TCL team pursues housing on behalf of the member receiving care coordination;
members are monitored indefinitely following transition to community living. This function is unique to the Transition to Community Living Team.

**Systems Operations Team**

In 2016, the Care Coordination Department at Cardinal Innovations implemented the Systems Operations team to assist Care Coordination by providing the supportive functions needed to be successful. The areas of focus for this team include enhancing the quality and impact of Care Coordination and ensuring a data-driven approach to successful outcomes, providing training and on-boarding to Care Coordination staff, as well as ensuring consistency and scalability within the department. This division emphasizes fidelity to national standards of care and compliance with accreditation standards.

**System of Care**

System of Care is a comprehensive network of community-based services and support that are organized to meet the needs of families who are involved with multiple child service agencies (e.g., child welfare, mental health, schools, juvenile justice, and health care). Families and youth work in partnership with public and private organizations to ensure that supports are effective and built on the strengths and needs of individuals. Creating a sustainable System of Care requires reshaping and redefining the approach the system takes in working collaboratively and in partnership with each other and with youth and families receiving supports. It requires positive engagement, dedication, and commitment that will result in how we make behavioral changes on both an individual and community level.

The System of Care and wrap-around planning are not services or programs — they are practical ways of partnering with youth, families, and each other to achieve the outcomes that are identified as important. System of Care occurs within all levels of a community. The comprehensive support that youth and families who have complex challenges need requires that the community come together. Professionals across the system work collaboratively with families and the community in a reciprocal manner.

In order for each Child and Family Team to be successful, community leaders and agency decision-makers must work together to support them. The needs of youth and families within the community drive all activities of System of Care. Below are some of the team structures that support System of Care within our communities:

- **Community Collaborative (System of Care partners):** Within our System of Care, the community collaborative serves as the overarching leadership structure. The community collaborative holds the vision and strategic plan that outlines the work needed to support Child and Family Teams within the community. In addition, the community collaborative identifies, advances, and role models standards associated with System of Care.

- **Juvenile Justice, Substance Abuse, Mental Health Partnership (JJSAMHP):** The Juvenile Justice Substance Abuse, Mental Health Partnerships (JJSAMHP) are local teams across our community that work together to deliver effective, family-centered services and supports for juvenile justice-involved youth with substance use and/or mental health challenges. The guiding principles of the System of Care are embedded within the partnerships.

- **Child and Family Teams (CFT):** Child and Family Teams, on a practice level, is where the rubber meets the road. System of Care is actively implemented to promote positive outcomes for youth and families. The Child and Family Team is built around the family to make sure that each family's
strengths are promoted and that their needs are met. Team members work together with the family to write an individualized plan based on what the child/youth and family wants and needs. They also decide on Child and Family Team membership and the frequency of meetings.

- **Care Review Teams:** Care Review Teams are a resource for Child and Family Teams of high risk youth with serious mental health, substance use disorder or intellectual disabilities/developmental disabilities. The Care Review Team is a cross-systemic community group that supports the work of the community collaborative. The care review process is intended to reflect System of Care principles and values that are also role modeled by all Care Review Team members.

**Quality Management and Performance Monitoring**

In addition to reviewing individual members’ care through care management, Cardinal Innovations assesses the function of our clinical system more globally through the following tools:

**Development of Quality Assurance/Performance Improvement Plan:** This plan outlines Cardinal Innovations’ quality improvement activities on an annual basis. This plan is the guiding principles for continuous quality improvement. This plan describes activities to support member safety and the quality of behavioral health services.

**Member and Provider Satisfaction Surveys:** A critical component of our external quality program is to obtain both member and provider feedback on our performance. Annual surveys are used to obtain, compile and analyze information, identifying opportunities for improvement in service, timeliness, communication and other key areas.

**Incident Monitoring:** Information is received from providers about incidents that have occurred, such as but not limited to falls, medication administration, reports of abuse, neglect, exploitation, injuries and deaths. This information is tracked and trended to identify opportunities to minimize the recurrence of these events. Recommendations for system changes are made, and implementation of the recommendations is monitored by the Quality Management Department (QM) and reported by QM to the Continuous Quality Improvement Committee.

Quality Management staff receive incidents and perform the appropriate screening and review using an algorithm to determine which cases are referred to the Medical Department for an additional clinical review.

**Grievance Resolution:** Equally important is the grievance process, which allows members, families and stakeholders to communicate their dissatisfaction about any matter other an action. An action is defined as, the denial or limited authorization of a requested service, including the type or level of service. The grievance management system is a centralized process managed through the Quality Management Department.

**Measures of Performance:** Organizations such as Agency of Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), Healthcare Effectiveness Data and Information Set (HEDIS), Substance Abuse and Mental Health Services Administration (SAMHSA), Division of Mental Health (DMH), Division of Medical Assistance (DMA) and several others are working to achieve consensus on indicators that define best practice standards. Although the development and measurement of behavioral indicators are in the
early stages compared to physical healthcare, measures that guide the delivery of high-quality care and service are critical to the success of our quality management program.

- **Our quality performance dashboard** is a valuable tool used to assist us in measuring our performance against targets and benchmarks in order to prioritize our opportunities for improvement. Comprised of both internal and external indicators, it is designed to capture and communicate our performance in the areas of clinical care, service, coordination and timeliness/access to care.

- Cardinal Innovations has also developed a set of core clinical performance measures called **Key Performance Indicators (KPIs)**. KPI results are reported routinely to the Care Management Team. Clinical KPI data is used to evaluate the effectiveness of care management activities and processes, as well as achievement of established program goals. The KPIs that have CMT oversight are as follows:
  - Accessibility of behavioral health care services for urgent and routine needs
  - Follow-up after discharge from acute inpatient stay within seven days
  - Timeliness and outcome measures for initial clinical review and appeals process
  - Provider and member satisfaction survey responses related to the UM program
  - Screening, Triage, and Referral (STR) response and follow up timeliness
  - Access Call Center reporting, call abandonment (number of callers who hang up after 30 seconds) and call monitoring
  - MH/SUD and ID/DD Utilization reporting including discharge, admission, average length of stay, readmission, population demographics and other contractual reporting requirements
  - Timely initiation and engagement
  - Quality Indicators identified for the NC Innovations Waiver

- **Provider Monitoring**: Cardinal Innovations monitors its providers through various methods. Current monitoring processes are noted below.

- **On-site Health and Safety Reviews** – Initial on-site review assessments occur when a new provider enters the network or when an existing provider adds a new site. Reviews are conducted to ensure that the service delivery sites meet the required guidelines for safety, accessibility and quality of care.

- **Clinical Quality Provider Reviews** – measures the quality of service delivery, assesses the effective use of evidence-based practices and measures member outcomes.

- **NC DHHS Provider Monitoring Process** – Providers are reviewed in accordance with the DHHS Provider Monitoring Process to assess compliance with state standards and billing practices.

- **Justified Cause Audits** – Audits are conducted when a credible allegation of fraud or a medical record documentation concern is identified. A justified cause audit can be identified during any monitoring
review through the concern line/grievance process, or can be recommended by any Cardinal Innovations committee.

- **Focused Post Payment Reviews** – Focused reviews typically occur when concerns arise regarding adherence to service definitions, service delivery, or the addition of a new service definition/Clinical Coverage Policy adherence.

- **Investigations** – Investigations are typically conducted when there is a quality of care or service delivery allegation. Investigations are performed as issues are identified.

- **Home and Community Based Service (HCBS) Reviews** – In 2014, the Centers for Medicare and Medicaid Services (CMS) published new regulations for Medicaid Home and Community-Based Services (HCBS). These rules apply primarily to the Innovations Waiver and are designed to maximize opportunities for people with disabilities to have access to the benefits of community living in the most integrated settings.

Quality Improvement Activities (QIAs) and Performance Improvement Projects (PIPs) represent a requirement by the National Committee for Quality Assurance (NCQA), Cardinal Innovations’ accrediting body, and DHHS to identify clinical areas of improvement and service or non-clinical opportunities. Our CQI committee selects the QIAs from review and prioritization of identified areas of opportunity and monitors incremental improvement to achieve better outcomes.

**Community Operations**

The Community Operations Department engages community advisory boards, county leaders, elected officials and other key stakeholders to ensure Cardinal Innovations is involved and present within the communities we serve. Community Operations staff educate members and their families on the resources available through Cardinal Innovations and within their communities, and assist in the navigation of those systems and supports. In addition to members, families and elected officials, staff strategically engage key community stakeholders such as representatives from schools, social services, and the legal system and law enforcement.

Community Operations is comprised of three distinct units: Community Relations, Community Engagement and Member Engagement.

**Community Relations**, through our Senior Community Executives (formerly Community Office Directors), provides an executive-level link between Cardinal Innovations and local leaders, elected officials and other key stakeholders who represent the interests of the communities we serve.

**Community Engagement** engages key community partners, such as law enforcement agencies, school systems and non-profit organizations, through outreach, education and training to promote awareness of Cardinal Innovations, the special populations we serve and their unique needs.

**Member Engagement** assists Cardinal Innovations’ members and their families in navigating Medicaid benefits, Cardinal Innovations and community resources and supports. This unit also provides education and programming designed to promote self-advocacy, health awareness and wellness among members and their families.
These staff members provide numerous community stakeholder trainings including (but not limited to) the following topics and evidence-based programs:

- Behavioral Health Overview
- Cardinal Innovations Overview of services available for members and stakeholders
- Disabilities Overview: Intellectual and Developmental Disabilities
- Guardianship and Alternatives for ID/DD and MH
- Mental Health First Aid (for Adults, Youth, Veterans)
- Peer Support
- Person Centered Thinking/Planning
- Prime for Life with a focus on substance use prevention
- Stigma
- Suicide Prevention Training (QPR – Question, Persuade, and Refer)
- Trauma-Informed Care
- Whole Health Action Management (WHAM) self-management of chronic physical health conditions, mental illnesses and addictions
- Wellness Recovery Action Planning (WRAP)

Community Operations’ staff are located throughout our geographic coverage areas and demonstrate the commitment and partnership between Cardinal Innovations and the communities we serve. Cardinal Innovations’ Community Operations team strives to achieve optimal customer satisfaction from the community at large.

Data Science and Business Analytics

The Data Science and Business Analytics (DSBA) team was officially established in May 2015 to further develop and improve the corporate capability for managing and analyzing multiple data sources and leading Cardinal Innovations’ journey toward predictive and optimized healthcare analytics. The DSBA team will lead efforts toward the following improved outcomes and future state:

1. Identifying high-risk and high-cost members and potential impact
2. Providing more specific and timely identification of member care intervention opportunities
3. Increasing visibility into population health conditions at individual and whole population levels
4. Improved decisions for operational efficiency
5. Making better use of current data inventory to improve clinical outcomes and expanding external data sources to support analytics goals
6. More closely correlating population health outcomes to cost models
7. Improving current baseline reporting and forecasting capabilities
8. Increasing Cardinal Innovations’ organizational awareness of improving business outcomes through analytical capabilities

Special Population Management

All of the above departments, in part through cross functional teams, work collaboratively to address the needs of our members. Members who have specialized, high-intensity needs, require highly coordinated approaches including rapid identification of member needs and the development of individually-tailored
interventions to increase the likelihood of positive member-centered outcomes. These members may be identified by any of Cardinal Innovations’ clinicians based upon established triggers or through special population reporting and predictive analytics tools. At various points these members may have direct interface with Cardinal Innovations staff including Access Clinicians, Care Coordinators, and/or Member Engagement Specialists. These staff are further supported through the efforts of Utilization Management Care Managers, Clinical Support staff, as well as physicians and psychologists available for specialty consultation.

Many members with specialized needs will qualify for Care Coordination interventions. These interventions are individualized within a framework of four levels of intensity: Levels I-III constitute different intensities of Community Care Coordination; Level IV is complex, integrated Care Coordination. Once identified as needing Care Coordination, the Care Level Stratification System is used to guide the frequency/intensity of Care Coordination intervention needed.

Management strategies for special population members are focused on ensuring the following:

- Accurate assessments based upon available clinical history and presentation;
- Identifying and including relevant community stakeholders and maintaining complex multisystem coordination through regular and as needed conference calls and/or Child and Family Team meetings;
- Regular member contact, including face-to-face contacts;
- Member-centered goal setting;
- Linkage and engagement with effective, best practice treatment interventions;
- Any barriers to treatment engagement are addressed and minimized;
- Monitoring of treatment engagement, efficacy and outcomes.

The special needs populations targeted by Cardinal Innovations include those specified in the NC 1915(b)/(c) Waivers, as well as others identified to be at high-risk. These populations include, but are not limited to, the following:

**At-Risk-for-Crisis Members**
- Individuals who do not appear for scheduled appointments and are at risk for inpatient or emergency treatment; or
- Individuals for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; or
- Individuals discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility, or Facility-Based Crisis or general hospital unit following admission for a behavioral health (BH) or I/DD condition.

**Intellectual Developmental/Developmental Disabilities**
- Individuals participating in the North Carolina Innovations Waiver or (b)(3) Deinstitutionalization Service array
- Individuals who are functionally eligible for, but not enrolled in, the NC Innovations Waiver, and who are not residing in a ICF/IID facility
• Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the North Carolina Department of Public Safety, Division of Adult Correction, or the Department of Juvenile Justice

Child Mental Health
• Children who have a range of mental health diagnoses AND current CALOCUS Level of VI (with or without co-occurring substance abuse or intellectual and developmental disability diagnosis).
• Additional populations include youth with mental health diagnoses who meet one or more of the following criteria:
  o Currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the North Carolina Department of Public Safety, Division of Adult Correction, or Department of Juvenile Justice
  o Have experienced frequent crisis services use
  o Identified as needing or authorized to receive Psychiatric Residential Treatment Facility

Adult Mental Health
• Adults with a serious and persistent mental illness (SPMI) diagnosis (with or without co-occurring substance use or intellectual and developmental disability diagnosis) with a LOCUS Level of VI.
• Additional populations include adults with mental health diagnoses who have required frequent crisis services use.

Substance Use
• Child or adult with substance use disorder diagnosis with ASAM Levels of 3.7 or 2.2 or higher.
• Additional populations include adults with substance use diagnoses who meet one or more of the following criteria:
  o Have required frequent crisis services use
  o Individuals with substance dependence diagnosis who have significant health and safety risks that require enhanced clinical coordination to meet needs
  o Individuals who have an Opioid dependence diagnosis and have reported using drugs by injection within the past 30 days

Department of Justice Participants
• Adults with serious mental illness (SMI) or SPMI diagnoses who currently reside in Adult Care Homes
• Adults with SPMI who have been inpatient at a state psychiatric hospital for more than 90 days and are homeless/at risk of homelessness
• Adults with SMI/SPMI diverted from entry into adult care homes pursuant to the pre-admission screening and diversion provisions under the North Carolina Department of Justice settlement
Co-occurring Diagnoses

- Individuals with both mental illness and substance use diagnoses AND current LOCUS/CALOCUS of V or higher OR current ASAM Level 3.5 or higher.
- Individuals with both mental illness and intellectual disability/developmental disability diagnoses AND current LOCUS/CALOCUS of IV or higher.
- Individuals with both an intellectual disability/developmental disability and substance use diagnoses AND current ASAM Level 3.3 or higher.
The Cardinal Innovations Continua of Care

Cardinal Innovations contracts with providers who offer services that collectively form a continua of care specific to each of the following age/disability groups:

- Adult Mental Health (AMH)
- Adult Substance Abuse (ASA)
- Child Mental Health (CMH)
- Child Substance Abuse (CSA)
- Adult Intellectual Disability and Developmental Disability (AID/DD)
- Child Intellectual Disability and Developmental Disability (CID/DD)

Cardinal Innovations has several tools available for ensuring a wide array of services are available to our members in each of these age/disability groups. In addition to what is provided as part of the North Carolina Medicaid State Plan, Cardinal Innovations also can develop new services to enhance our service array and fill needed gaps in the care system. Options for adding new services include (b)(3) services and Alternative/In Lieu of services.

Section 1915(b)(3) of the Social Security Act allows states to use savings generated from a managed care delivery system to provide new services, called (b)(3) services to eligible Medicaid recipients. These services are an entitlement, but only to the extent that funds exist. Funds are replenished on a yearly basis. Cardinal Innovations offers (b)(3) services to support individuals with intellectual disabilities/developmental disabilities, mental health diagnoses, and substance use disorders who have Medicaid. Providers who offer (b)(3) services must provide comparable services to all populations covered under the 1915(b) waiver. Cardinal Innovations and North Carolina DMA believe that 1915(b)(3) services improve member outcomes and potentially reduce overall costs of care. These services are added to the existing service array a member may be receiving: basic, enhanced and/or residential.

Cardinal Innovations also may develop and reimburse services that are cost-effective alternatives to existing Medicaid-funded and state-funded services. These services, called Alternative/In Lieu of Services, are provided voluntarily by entities like Cardinal Innovations and may be MCO-specific. An Alternative/In Lieu of Service is not just a minor modification to an existing Medicaid-funded or state-funded service, but represents a substantial or radical change to a service or a completely new service. Alternative/In Lieu of Services must not contradict the Medicaid-funded or state-funded service arrays. The cost of the Alternative/In Lieu of Service must be less than the cost of the Medicaid-funded or state-funded service that it is replacing.
Core Best Practices across ID/DD and MH/SUD Services

For any of our funded services, Cardinal Innovations expects that certain core best practices, as well as member and process outcomes, will be common throughout the service system, regardless of age and disability group. There are a number of best practices that span all age and disability spectrums. These principles have been found beneficial throughout medical and behavioral health fields and are essential to quality care.

Measurement-Based Care

How do we objectively know members are better unless we measure their target symptoms? Are they improving or getting worse? Has progress stalled? Have they achieved remission? For those members where progress is not expected, is quality of life being assessed and are their personal goals being addressed?

There are many measurement tools that can assist providers in improving members’ lives, and suggest when it is time to alter or enhance treatment modalities. Cardinal Innovations’ adopted clinical guidelines (http://www.cardinalinnovations.org/guidelines/guideline_articles.asp) each have a number of suggested measurement tools. Clinical judgment is essential in selecting the right tool for each individual. That said, for all individuals in services, it is essential to measure their progress so treatment can be adjusted to their needs.

Coordination of Care

Health care and social services systems are complex. Specialty systems often operate in silos and may not effectively communicate with other providers and social welfare systems. This isolation often leads to inefficient, duplicative and confusing care for individuals.

Cardinal Innovations expects and monitors that providers will coordinate care and services with other current physical and behavioral health providers; collect relevant information from past providers (e.g., hospitals/facilities, therapists, physicians); and work collaboratively with relevant community social service workers (e.g., departments of social services, juvenile justice, parole officers). The goal is to ensure a seamless system of care, giving members the best chance for positive outcomes.

Use of Clinical Guidelines

Clinical Practice Guidelines are road maps for the care of disease states in medicine. Guidelines are usually produced by experts in their respective fields after much research and consensus gathering. Most of Cardinal Innovations’ adopted guidelines are produced by national organizations such as the American Psychiatric Association or the Veterans Health Care System.

Some disease states have no national guidelines and, in those cases, Cardinal Innovations has gathered groups of their own experts to develop guidelines.

Clinical practice guidelines are intended to assist providers with clinical decision-making and to improve care. They also document evidence available to determine appropriate care. Guidelines are not meant to dictate all clinical practice but are evidence-based and provide guidance in the care of mental disorders. One needs to keep in mind that each person is an individual and that each provider has his/her own
approach to delivering care. Good clinical judgment should be used in all situations and at times will supersede practice guidelines.

Clinical guidelines, by diagnosis, are adopted as recommended by the Cardinal Innovations Clinical Advisory Committee (CAC), which is comprised of clinical practitioners from our provider network, the local community, and recipients of services. Cardinal Innovations maintains dozens of clinical guidelines for mental health conditions, conditions specific to children and adolescents, substance use disorders, and intellectual disabilities/developmental disabilities. These guidelines are reviewed no less than every two years. The adopted guidelines are intended to inform community standards of practice. Providers are expected to be familiar with the guidelines and use them to inform their behavioral healthcare activities. Adopted clinical guidelines are available online (https://www.cardinalinnovations.org/resources/clinical/practice-guidelines).

Cardinal Innovations monitors providers' fidelity to the clinical guidelines during authorization management and utilization review processes. At times, there is clinical rationale for deviating from adopted standards of care, which are considered during these reviews. In order to ensure that clinical guidelines are being used across the service delivery system, annual measurement of at least two aspects of three guidelines are formally measured. This may be done through formal Quality Improvement Activities, Utilization Reviews, or provider data collection and reporting.

Core Expected Outcomes across ID/DD and MH/SUD

Certain outcomes are universal throughout the behavioral health system service array and are evidence of quality care.

Improvement of Symptoms/Behaviors/Skills

- **Symptoms:** Mental health and substance use disorder symptoms should be monitored and measured, through standardized measurement tools when available and appropriate. Symptoms should show improvement, or the treatment being offered should be enhanced or changed. Remission from the acute illness is the goal, along with recovery of previous levels of functioning when possible. Standardized measures of remission are specific to the measurement tool being used.

- **Behaviors:** For ID/DD, often the function of challenging behavior is related to trauma responses, communication difficulties, skill deficits, medical conditions, access to some desirable attention, escape, sensory input, or pain relief. Challenging behaviors are subject to improvement when interventions reflect best practices. In addition, the intervention must correspond with the function of the behavior in order for the individual to achieve optimal outcomes. For MH/SUD, behavior improvement may include improvements in abilities to:
  - Engage in pro-social, age-appropriate functioning in home and community
  - Regularly participate in treatment services or positively respond to treatment engagement efforts
  - Keep stable employment or actively participate in supports/services to improve employability
- Maintain a stable living environment
- Establish and maintain relatively healthy interpersonal relationships

- **Skill Acquisition:** Best practices for individuals with intellectual disabilities and developmental disabilities include following a person-centered approach to attain skills that will maximize opportunities for community integration and enhance quality of life for the individual. To reflect a person-centered approach, the identification of skills to be developed should be based on the preference, skill repertoire, age, short-term changes, long-term changes, medical situation, and other factors affecting the individual.

**Improvement in Quality of Life**

Quality of life can be measured using various quality of life scales as well as through demonstrating specific quality of life gains, which include successful housing, education, employment, relationships, civic activities, and social involvement. Quality of life should be measured and improved as a result of any behavioral health service.

**Reduced Use of Higher Levels of Care**

- **Setting:** Services should yield increasingly less restrictive and more highly community-integrated living settings to the greatest extent possible.
- **Crisis:** Services should yield a reduction in the use of emergency rooms, inpatient hospitalizations and 911 calls.
- **Legal:** Services should yield a reduction, and ideally complete elimination, of legal system interaction due to activities/behaviors by the individual.

**Reduction in Total Cost of Care**

Effective services ultimately lead to a reduction in the cost of care to society as a whole. Reduced emergencies, medical and psychiatric hospitalizations, use of social services, and use of the legal system, as well as increased civic contributions are the anticipated benefits when the right services are received at the right time and in the right setting. At times, this may mean a higher cost of behavioral health interventions to lower the total cost of care to society or intensive intervention to stabilize a mental health crisis and assist an individual in moving towards recovery; however, early treatment and appropriate intervention can lead to long term positive outcomes for members.

Ultimately, our goal is to ensure our members receive the evidence-based, high-quality services they need. This goal has precedence over other considerations such as cost of services. Our aim is to take the right action for each member.
Mental Health and Substance Use Disorder Continua of Care

The mental health and substance use disorder (MH/SUD) continua of care begin with the goals of easy access and service engagement as well as high-quality evidence-based care. To ensure these goals are met, Cardinal Innovations develops and maintains the following levels of care for both youth and adults, which serve to augment what is provided through primary care offices, community natural supports and prevention activities:

1. Basic services include comprehensive clinical assessments; outpatient individual, group and family psychotherapies; psychiatric medication management; and psychological testing.
2. Enhanced community-based services typically consist of team-based interventions, which assertively treat members with more complex needs in their community setting.
3. Residential services are non-crisis placements in individualized or congregate settings where intensive services are provided for members with highly complex needs who require 24 hours per day supports with either awake or asleep staff overnight.
4. Crisis services are intended to provide 24/7 response for members experiencing a behavioral health crisis, but who do not require a 911 response from Emergency Medical Services (EMS).

Primary Care and other Medical Setting Integration

Cardinal Innovations manages a carve-out behavioral system of care, where funding for behavioral health conditions are managed separate from funds for services in non-behavioral health medical settings. While our main focus is the development and maintenance of specialty behavioral health services for special populations, we recognize that many of our members may not require these services and will be treated in primary care settings, just as members with hypertension and diabetes may not require referral to a cardiologist or endocrinologist. Moreover, primary care settings are the most common location for screening, detection and basic treatment of behavioral health conditions. To assist Primary Care Physicians (PCPs) with evidence-based management of behavioral health diagnoses, we provide 24/7/365 telephonic access through our Access Call Center. PCPs can refer their members to be linked with a licensed provider who will perform a Comprehensive Clinical Assessment and further connect the member to medically necessary services.

Cardinal Innovations also employs a Holistic Health Consultant. This role is designed to enhance our efforts in our approach to whole- person care. This position is a Registered Nurse who collaborates with Care Coordination (MH/SUD, IDD, TCL, and Population Health) to provide medical consultation and resources. The Holistic Health Consultant assists with staffing complex dually-diagnosed medical and behavioral health cases to ensure a seamless integrated method to care. Additionally, this position collaborates with
other healthcare disciplines and attends home visits to provide clinical consultations with members and families. The role partners with medical facilities including our high volume hospitals in the Cardinal Innovations catchment area to increase integrated health support to our members. Providing a valuable medical lens to operations, the Holistic Health Consultant is also critical in program development as well as our Population Health initiative.

**Comprehensive Clinical Assessments and Level of Care Determinations**

Most members entering care through non-emergency settings first receive a Comprehensive Clinical Assessment (CCA), which is a thorough face-to-face evaluation by a licensed clinician assessing the following areas:

- presenting and associated problem(s)
- behavioral and physical health treatment histories
- current medications and past medication trials
- family and social histories
- review of biological, psychological, familial, social, environmental and developmental dimensions
- a biopsychosocial formulation or interpretation of the information gathered
- diagnoses
- treatment recommendations

The purpose of the CCA is to ensure that medically necessary, least restrictive and evidence-based treatment recommendations are made and that referrals are successfully completed for all of our members.

It is recommended that these assessments use standardized behavioral health screening tools as indicated to identify potential dual diagnoses. These tools are based on research and scientific evidence of their effectiveness. Cardinal Innovations makes information on these screening programs available to the provider network. These programs are reviewed every two years. Information is referenced in the provider manual and available on the Cardinal Innovations’ website.

Members not needing a CCA prior to treatment initiation include those receiving medication management only, those with six or fewer targeted therapy events in a medical or integrated-care setting and those receiving a psychotherapy-for-crisis service.

After completion of the CCA, members are then referred – if medically necessary – to either basic or enhanced services, either of which shall apply evidence-based treatment models for addressing the member’s diagnosis and associated symptoms or functional problems. Also, if additional diagnostic or functional clarity is needed, members may be referred for psychological testing.

Our providers use standardized level of care utilization tools to assist in determining the necessary service array for mental health and substance use disorder services:
1. The Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS)\(^9\) were developed to define the level of care and treatment resources needed for members, based on results of the assessment of their clinical needs and functional status. The tools contain a dimensional rating system with scores ranging from 1 (minimal) to 5 (extreme) on each dimension and a composite score, both of which are used to assist in determining the appropriate treatment service. The dimensions on the LOCUS (used for adults) include:

- Risk of harm
- Functional status
- Comorbidity
- Recovery environment
- Treatment and recovery history
- Engagement and recovery status

The dimensions on the CALOCUS (for youth ages 6 and older) include:

- Risk of harm
- Functional status
- Comorbidity
- Recovery environment
- Resiliency and treatment history
- Acceptance and engagement

It is important to note that the tools were developed to be one element of the level of care decision, and that they are not intended to replace clinical judgment and other relevant information.

2. The American Society of Addiction Medicine (ASAM) criteria\(^{10}\) are used for members engaging in substance use/abuse to determine the appropriate level of service needed, plan treatment, and help make decisions about continued service or discharge. It was developed with six dimensions to guide decisions:

- Potential for acute intoxication and/or withdrawal
- Biomedical conditions and complications
- Emotional/behavioral conditions or complications
- Treatment acceptance/resistance
- Relapse potential
- Recovery environment

The ASAM criteria are also expected to make improvements in the efficient use of limited resources, treatment retention, and treatment outcomes. SUD services needs also are based on the member’s


readiness and willingness to commit to a lifestyle change as well as the home environment, which can be a contributing factor to whether treatment can be accessed in the home or a residential treatment setting. This may mean that a member starts in a level of care that is either lower (for motivation and engagement) or higher (needs residential setting due to lack of stability/support in the home setting) than might be otherwise typically based solely on the frequency of use.

**Basic Services – Adult/Child/Adolescent**

Basic Services consist of specialty, clinical assessments, psychotherapy, psychological testing and medication management tailored to meet the diagnostic and treatment needs of those with mental illnesses and substance use disorders. They can be used alone, in combination with each other, or in combination with enhanced and residential services. These services are typically office-based, but some mobile options are available. Basic Services include the following:

1. **Comprehensive Clinical Assessments (CCAs):** As discussed above, these assessments provide the groundwork for selecting the right service, in the right quantity and in the right setting. They should assure highly accurate diagnostic formulations and recommendations for both paid services and unpaid supports.
2. **Basic Psychotherapies (individual, group and family):** Evidence-based psychotherapies are the core of the mental health system and offer time-limited, problem-focused interventions by licensed clinicians. Cardinal Innovations pays enhanced rates for select best practice interventions, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT), in order to promote access to best practice treatment throughout our network. We also pay enhanced rates for group psychotherapy to promote availability of Dialectical Behavioral Therapy (DBT) and other best practice group interventions.
3. **Psychiatric Medication Management:** Psychiatrists and other psychiatric prescribers provide specialized medication-based treatments for all ranges of adult mental health conditions. Medication management can be an essential component of any treatment plan and can be time-limited or long-term. Cardinal Innovations promotes high-quality psychiatric prescribing. We believe that access to highly-trained, high-quality prescribers is the best practice for those requiring medication management, as is broad psychiatrist oversight of quality care for all members. Thus, in our reimbursement rates, we have significantly enhanced physician and other prescriber rates to assist with ensuring such access. Due to the rural nature of many of our counties, telemedicine can be used to ensure adequate and timely access to psychiatric services while still protecting member confidentiality. Telemedicine can be used at various levels and stages of care. Cardinal Innovations supports and is partnering with the state’s efforts to expand psychiatric access via telemedicine by North Carolina physicians to rural emergency departments across the state.
4. **Psychological Testing:** Licensed psychologists and psychological associates typically provide this service for those who need additional diagnostic and treatment recommendations clarified after an initial assessment. There is a wide array of testing options available.
5. **Psychiatric Consultation:** This (b)(3) service is designed for individuals ages 3 and older with mental health service needs who are under the care of a medical doctor, but not a psychiatrist. This service allows the medical doctor to talk with a psychiatrist about treatment options or medication recommendations. The medical doctor remains responsible for treating the individual’s mental health needs. Note: NC Innovations Waiver participants are eligible for psychiatric consultation.
All basic services must be provided by a licensed clinician and should follow evidence-based and/or best practice treatment models as well as adopted clinical guidelines, based upon clinical expert judgment. Generally, Cardinal Innovations minimally manages basic services in an effort to reduce barriers to early, least-restrictive treatment interventions. No prior-authorization (PA) is required for medication management; PA is only required for basic therapies after 24 unmanaged visits for Medicaid members if they are not receiving any other enhanced services.

While basic services are typically provided in office settings, Cardinal Innovations has developed Mobile Engagement services, which allow for a licensed clinician to provide a comprehensive assessment or basic psychotherapies for a member in the community. Currently, Cardinal Innovations may offer our Mobile Engagement services in the following situations:

- Members recently discharged from an inpatient or other crisis setting when there is no evidence of attending a follow up appointment
- Members recently discharged from an inpatient or other crisis setting when it has been determined the member may be unlikely to attend an office-based follow up appointment
- Members who have been screened to have an urgent behavioral health need
- Members with serious mental illnesses who may have discontinued a psychotropic medication against medical advice
- Members with routine needs who have not attended an appointment within a set timeframe.

Comprehensive Community Clinics

In order to ensure a broad safety net of access to basic services throughout our catchments, Cardinal Innovations developed and implemented the Comprehensive Community Clinic (CCC) model, which is a further refinement of our original Comprehensive Community Provider (CCP) model initiated in 2005. These clinics are the foundation of our MH/SUD continua of care. CCCs are a locally adaptable form of a behavioral health home. CCCs are assigned by county and must provide high quality assessments; the full range of basic-level individual, group and family therapies; and psychopharmacology services for children and adults with MH/SUD diagnoses, as well as dually-diagnosed ID/DD members. Low population counties may have only one CCC, though CCCs may have multiple county sites. When only one CCC is available, choice is offered through Licensed Independent Practitioners or other community agencies. Because the CCC model requires the co-location of multiple specialty clinicians and because they function as critical access centers for urgent and routine member needs, Cardinal Innovations pays CCCs enhanced rates. CCCs are expected to provide a volume of services adequate to meet the needs of their respective communities. CCCs must meet the following standards:

- National accreditation (e.g., Commission on Accreditation of Rehabilitation Facilities or the Joint Commission)
- High quality, same-day accessible Comprehensive Clinical Assessments
- Full spectrum basic therapies and prescribing for adults and children with mental health and substance use disorders
- Primary utilization of psychiatric specialists for prescribing
- An American Board of Psychiatry and Neurology (ABPN) certified physician, either a Medical Doctor or Doctor of Osteopathic medicine, as Medical Director for the agency
• Meet quality standards for access to routine and urgent care needs, timely follow up after crisis/inpatient event, timely initiation and engagement in services
• Provide access to long-acting injectable antipsychotics and clozapine, and maintain evidence-based antipsychotic neurologic and metabolic monitoring
• Provide access to child/adolescent expert prescribing, as well as prescribing for dually-diagnosed ID/DD members
• Maintain low levels of unable to process treatment authorization requests
• Provide access to services for dually insured and outpatient committed members
• Be the first responder by phone 24/7/365 for all members in crisis receiving services at the CCC

CCCs are monitored at regular intervals (quarterly to yearly, depending upon the item being measured) for quality and performance by multiple Cardinal Innovations cross-functional teams.

Enhanced and Residential Services – MH/SUD
For those members whose behavioral health conditions require interventions beyond what office-based, basic services can adequately address alone, our health plan offers enhanced services in both facility-based and community-based settings. All enhanced services require the development of a Person-Centered Plan, which is a strengths- and preferences-based document designed to develop and track member-driven treatment goals.

These services are more highly restrictive than basic services and typically require a team-based, wrap-around approach. Enhanced and/or residential services may be provided alone, or in combination with basic services, depending on the member’s need and the specific service. Generally, enhanced and residential services require prior and continuing authorization to ensure medical necessity and service efficacy.

Community-Based Enhanced Services – Adult
For MH/SUD diagnosed adults, the community enhanced service array includes:

1. **Community Support Team (CST)**: CST is a three-person team led by a licensed therapist. CST provides therapy and case management services together in a short-term, intensive format. This service is intended for members with moderate to severe MH/SUD issues AND who have serious social and/or legal life complications requiring a coordinated treatment approach.

2. **Assertive Community Treatment Team (ACTT)**: ACTT is a wrap-around longer-term service with direct interventions from a psychiatrist that can be provided in the member’s home or community setting; nursing services; individual and group therapy; case-management; and peer, housing and vocational support services. This service is intended for members with serious and persistent mental illness (SPMI), who may have comorbid substance use problems and require wrap-around care to remain out of inpatient or other institutionalized settings.

3. **ACTT Step Down (ACT-SD)**: ACT-SD is the next lower level of care under ACT Team and supports members 18 years of age or older with Severe and Persistent Mental Illness (SPMI) who no longer need the full array of ACT Team services, but who are not yet prepared to move to office-based care. ACT-SD provides longer-term clinical case management supports of moderate intensity. The service also promotes continuity of care and ease of service access across ACT Team and ACT-SD, including the retention of their ACT Team prescriber until transition to office based care is
appropriate. ACT-SD assists members in transitioning from ACTT to other community- and/or office-based services.

4. **Psychosocial Rehabilitation (PSR)**: PSR is a longer-term clubhouse or community center for members with SMI or SPMI where independent living, pre-vocational and social skills are developed on a daily basis to promote greater community integration, independence and recovery. Members cannot be in ACTT and receive this service concurrently.

5. **Opioid Treatment Program (OPT)**: OPT is designed for members with opiate use disorders for greater than one year who benefit from a harm-reduction approach through maintenance dosing of methadone and/or dispensed buprenorphine. OTP services do not require a Person-Centered Plan; additional basic or enhanced SUD treatments are generally an important augmentation to this service. Note that buprenorphine is often also prescribed in a basic medication management setting.

6. **Substance Abuse Intensive Outpatient Program (SAIOP)**: A short-term group with three multi-hour sessions per week designed for members with moderate to severe substance use disorders (ASAM 2.1) for whom outpatient treatment is not adequate.

7. **Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)**: Similar to SAIOP, but at a higher level of intensity with four days per week of programming and longer daily sessions. Members must meet an ASAM level of 2.5 to receive this service.

8. **Individual Support**: Individual Support is a service that teaches independent living skills to adults with SPMI who have recently transitioned to an independent living settings or have a planned transition from an institutional setting to a community home. Teaching focuses on daily living skills such as shopping, cooking, and social and financial management skills.

9. **Peer Support**: Peer Support is an evidence-based practice that employs individuals with behavioral health diagnoses who are in recovery to help engage adults with mental health and substance use disorders. This service promotes the development of wellness self-management, personal recovery, natural supports, coping skills, and self-advocacy skills. Peer support is also used to assist an individual while he or she is receiving outpatient or other services, following a crisis event, with housing transitions and with community reintegration following hospitalization or completion of jail/prison sentences.

10. **Intensive Recovery Supports**: This service helps women continue their recovery from drug or alcohol addiction once they are back in their homes and communities. The focus is on developing a healthy and positive living environment for the family.

11. **Supported Employment (SE)**: SE supports teenagers and adults who want to work in the community. This service takes place in settings where there are people with disabilities and people without disabilities. Examples of supports include help with learning job skills, applying/interviewing for a job, keeping a job and opening a small business.

12. **Transition Management Services**: This service is currently only available to members who are involved in the TCL program. It supports members in obtaining and maintaining independent housing. Staff provide targeted interventions based on the needs of the member to ensure that they develop the skills necessary to be successful and ensure that their service needs are coordinated.

13. **Residential Services**: There is an array of residential treatment services available to members who meet the qualifications for state-funded services. These range from supervised living apartments to more intensive structured group home settings. These co-occur with other treatment services to help members develop skills and manage their recovery so that they can live in the least restrictive
settings as possible and engage in community activities. However, due to limited resources, there is a registry of unmet needs for these services.

Facility-based (Residential) Services – Adult

For those needing short-term MH or SUD Residential services, Cardinal Innovations provides the following residential, non-crisis services in facility-based settings:

1. **Substance Abuse Non-Medical Community Residential Treatment (ASAM 3.5):** These are short-term residential treatment options that often bridge a member’s transition from a more intensive SUD program, such as detox, to community-based treatment. This provides a structured treatment environment where the member can focus on recovery.

2. **Adult Group Homes:** State funded (non-Medicaid) adult group home options may be available for some members with severe mental health or substance use problems: group living low, moderate, and high options. Typically, for members with SUD diagnoses, stays will be less than one month, whereas members with MH or ID/DD diagnoses may stay much longer. For SUD members, group living low can be used for halfway house services, and typically for six months.

3. **Residential Services – Complex Needs:** This is a short-term residential treatment service focused on children and adults with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral challenges. It is designed as an alternative to Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), particularly highly structured state facilities.

Community-based Enhanced Services – Child/Adolescent

For MH/SUD children and adolescents, the community-based enhanced service array includes:

1. **Intensive In-Home (IIH):** IIH is a time-limited (typically six-month) intervention performed by a team of professionals under the direction of a licensed clinician serving as team leader. IIH is available 24/7 to youth and families who require intensive clinical interventions to address chronic symptoms, crisis episodes, and coordination with other services/support resources. The team uses a variety of clinical rehabilitative interventions based on the provider agency’s selected evidence-based practice model.

2. **Multisystemic Therapy (MST):** Multisystemic Therapy is a nationally certified, evidence-based team treatment model designed for youth who have significant behavior problems and who frequently engage in willful misconduct and/or illegal activities. The goal of MST is to maintain the youth in his/her home using intensive therapeutic and rehabilitative interventions with the youth and his/her family within the home/school/community.

3. **Child and Adolescent Day Treatment (DT):** Day Treatment is a time-limited service with mental health or substance use interventions provided in the context of a therapeutic treatment milieu within a licensed facility, often integrated within a local school. Because some youth have difficulty making progress within traditional school settings, the interventions are designed focus on strategies needed to support integration back into traditional educational settings. Individualized Education Plans (IEPs) and Behavior Intervention Plans must have been attempted by the local school before a member would be eligible for this service.

4. **Family Centered Treatment (FCT):** Family Centered Treatment is an evidence-based practice for children with MH/SUD diagnoses (some with co-occurring ID/DD) who have previously been
unsuccessful in residential treatment or who have had multiple treatment episodes without long-term sustained outcomes. It a home-based, systemic family systems change model, designed as an alternative to Residential Level III.

5. **In Home Therapy Services (IHTS):** In Home Therapy Services is a combination of evidence-based therapy services and coordination of care interventions provided to children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. This home-based service is appropriate for children and adolescents who have family systems issues that are complicating factors placing them at risk of out-of-home placement, rather than the severity of their diagnoses alone. The service provides focused family systems work and coordination.

6. **Respite:** Respite is a (b)(3) service that gives primary, unpaid caregivers a break from providing daily care/supervision to children (ages three through 21) with mental health and/or substance use disorder service needs. The primary caregivers are the persons who are mainly responsible for the child’s care who also live in the same home as the child. Respite may be provided in the home or in another setting. It is available during the day, at night and/or on the weekends.

7. **Substance Abuse Intensive Outpatient Program (SAIOP):** Structured similarly to the adult version, this service is available for adolescents with substance use disorders with an ASAM level of 2.1.

8. **Transitional Living:** Transitional Living is a (b)(3) service that helps young individuals (ages 16 through 21) learn the skills needed to live independently as adults. The service helps individuals gain the skills needed to obtain or get ready for employment, maintain suitable housing and live successfully as a participating member of the community.

**Residential Services – Child/Adolescent**

Basic and enhanced behavioral health interventions for children and adolescents are designed to attempt to keep the member in his/her natural setting. At times, due to the severity of symptoms at presentation or due to failure of lower levels of care to stabilize the child’s behavioral health condition, out-of-home treatment may be necessary for safety and stabilization. Cardinal Innovations’ health plan provides the following residential services for children and adolescents with more severe behaviors, including sexually aggressive behaviors:

1. **Level I/Family Type:** This level is similar to DSS (Department of Social Services) foster care, but with a behavioral health trained therapeutic parent figure in the home. Generally, Level I is used as a step-down from Level II/Family Type prior to the member returning to his/her natural environment. Support needs are minimal and the primary focus is on mentoring and behavioral interventions for mildly disruptive behaviors.

2. **Level II/Family Type:** This service is similar to foster care, but with a behavioral health trained therapeutic parent figure in the home. Generally, Level II is the first step for out-of-home treatment if lower levels of care have not been able to adequately address a member’s needs, or as clinically indicated. This service is the same setting as Level I, but at a higher intensity of therapeutic intervention, and can address more moderate to severe problems. Support needs for most life domains are expected.
   a. **Specialty Level II for MH/ID/DD** – This service meets the same service definition requirements as regular Level II family type services, but providers have additional training and oversight in place to have specialized services for children with MH and IDD diagnosis.
These specialized services allow for interventions that are modified with consideration of an individual’s dual diagnosis and unique treatment needs.

b. **Intensive Alternative Family Treatment (IAFT):** IAFT is a specialized form of Level II/Family Type Therapeutic Foster Care. IAFT specializes in serving youth with particularly severe behavioral problems in an effort to prevent use of more restrictive levels of care. IAFT uses a one child per family ratio combined with specialized case management by the agency providing the service, including daily contact with foster care parents. The model also has psychiatric oversight and specialized crisis management.

3. **Level II/Program Type:** This service is similar to Level II/Family Type, but is in a group home setting rather than a family setting.

4. **Level III:** This service is in a group home setting and has 24/7 awake staff in a non-locked facility. Member behaviors are expected to be severe. There must be a constant need for direct supervision but without the need for a locked setting. Level III requires that a licensed therapist oversee care and provide therapy directly to youth at the facility.

5. **Psychiatric Residential Treatment Facility (PRTF):** This service is typically in a locked or staff secure facility-based setting with low staff-to-member ratios. It is intended for members with the most severe behaviors requiring 24/7 supervision and a locked environment, but who do not require inpatient hospitalization. Significant psychiatric oversight is expected, and programming is highly structured.

6. **Residential Services – Complex Needs:** This is a short-term residential treatment service focused on children and adults with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral challenges. It is designed as alternative to Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), particularly highly structured state facilities.

Members in out-of-home treatment settings require monthly Child and Family Team (CFT) meetings, which include treatment, family, community and Cardinal Innovations staff, before initiation of and during residential treatment in an effort to increase the likelihood of a successful return home and to minimize the length of stay in such highly restrictive interventions.
Crisis and Inpatient Services – MH/SUD/ID/DD

Often a member’s first behavioral health system encounter will be during a crisis, and members engaged in behavioral health services may experience crises despite receiving evidence-based therapies. A highly-functioning system will seek to anticipate and prevent crises whenever possible. This can be accomplished through prevention and screening in non-behavioral health settings (e.g., primary care, schools, foster care, legal system); providing behavioral health interventions in a disaster response; ensuring highly-accessible services; ensuring member engagement in evidence-based services by reducing barriers to care; enhancing member motivation; and providing 24/7 crisis de-escalation services.

Cardinal Innovations manages its Crisis Intervention Continuum at two levels: the corporate level (policy and oversight) and the Community Operations level. At the Community Operations level, our Regional Network Managers and/or Senior Community Executives lead local Crisis System Roundtables. These meetings bring our crisis system providers and other community stakeholders together on a quarterly basis to ensure the system is working smoothly. The Roundtables also review local resources, gaps and needs, and work on strategic plans to address gaps and needs. At the corporate level, our Care Management Team monitors our Crisis System Action Plan. The Crisis System Action Plan addresses Pre-Crisis, Crisis, Emergency Room, and Post-Crisis aspects of the system, following the system developed by the State in 2011. Projects are briefly summarized as follows:

- **Pre-Crisis**
  - De-escalation trainings
    - Crisis Intervention Team (CIT)
    - Group Home Employee Skills Training (GHEST)
    - Mental Health First Aid projects
  - High-risk member management (special populations initiatives, complex case management development and implementation, data planning, monitoring of efficacy)
    - Critical case conferences
    - Medication adherence monitoring
    - Care coordination standardization
  - Local resource assessments and capacity building
    - Transportation resources
    - Physical health, pharmacy and laboratory resources
    - Housing/homelessness resources
    - Multilingual service resources
  - Access and Engagement
    - Peer Supports, Family Partners, Assertive Engagement Projects
    - Comprehensive Community Clinics (CCCs)
    - Engagement Services
Routine Access to Care
Urgent Access to Care
Pharmacy Outreach
  o Individual Rights
    § Psychiatric Advanced Directives
    § Wellness Recovery Action Plans

• Crisis
  o Mobile Crisis Management (MCM) access and monitoring
  o Facility-Based Crisis (FBC) and Behavioral Health Urgent Care (BHUC) availability
  o Local crisis continuum roundtables
  o First responder monitoring
  o Medical clearance solutions

• Emergency Room (ER)
  o Daily ER monitoring and dedicated liaisons to high volume ERs
  o Standardized ER interface
  o Enhanced disposition option development (investigating high acuity units, bed availability monitoring, urgent access to enhanced services)

• Post-Crisis
  o Housing (regional housing specialists, grant management)
  o Access and engagement (see above)
  o Post-Crisis follow-up standards and monitoring
  o Engagement Services
    § Follow-Up post Hospitalization
    § Inpatient/ED Acute Admissions
    § Pharmacy Outreach

Even with all those elements in place, a member crisis may still occur. As such, Cardinal Innovations provides the following array of crisis and inpatient services to ensure immediate access to assessments and services in the event of a behavioral health emergency:

1. **Provider First Responder:** Whenever a member is established with a provider, that provider must be available as the first responder telephonically in the event of a behavioral health crisis. For certain enhanced services (e.g., ACTT and IIH), the first responder role must be in-person whenever necessary. As such, all providers, including LIPs (Licensed Independent Practitioners) must have arrangements to ensure a qualified person is available 24/7/365 to help manage urgent and emergent issues. It is expected that such a person will have access to relevant clinical information for that member including, at a minimum, a crisis plan or psychiatric advanced directive if one has been developed.

2. **Behavior Health Urgent Care Clinics (BHUC):** Originally called “Advanced Access Clinics” throughout Cardinal Innovations’ catchments, these BHUCs are capable of managing urgent and emergent clinical needs for assessments, crisis de-escalation, and disposition planning during hours of operation. If open 24/7/365, these clinics will also have “23-hour chairs” where individuals can receive treatment and care while a safe disposition is secured.

3. **Mobile Crisis Management (MCM):** MCM teams are available in every Cardinal Innovations service area to assess members experiencing a behavioral health crisis 24/7/365 in the community setting. Response time is expected to be two hours or less. Any member, provider, or community
agency/organization may call MCM directly or may contact Cardinal Innovations Access Line at 1.800.939.5911, 24/7/365 to request MCM services.

4. **Facility-Based Crisis (FBC) and Non-Hospital Detoxification**: These services are typically co-located in a facility-based unit of up to 16 beds. These are 24-hour services that can be provided in either locked or unlocked units. Some units are capable of admitting members on involuntary commitment (IVC). The average length of stay is generally for to five days. These facilities can handle members who are unsafe to remain in the community, but who do not require an inpatient admission to a psychiatric hospital. Generally, these facilities are for adults, but a new Facility Based Crisis service for children and adolescents has been developed as of 2016 which has limited availability in the state.

5. **Emergency Room (ER) Services**: ERs are rarely a therapeutic place for individuals with behavioral health emergencies. Therefore, Cardinal Innovations provides all of the above crisis services in order to direct members to more appropriate care. However, all ERs in Cardinal Innovations service areas have access to specialty behavioral health teams, either provided by the hospital in-person or through telepsychiatry, or by the local MCM team (via direct contract with the hospital). Any member requiring medical attention prior to psychiatric disposition may require an ER visit for the evaluation.

6. **Inpatient Psychiatric Hospitalization**
   a. **Community** hospital psychiatric units should be able to manage almost any member with a behavioral health crisis who requires inpatient level of care. Excessive violence, age restrictions, treatment resistance or medical complexity occasionally may prevent a community unit from being able to adequately serve the member. These facilities are expected to provide assessments of the highest quality, evidence-based therapeutic interventions, and timely discharge and coordination of care.
   b. **State** psychiatric and substance use disorder treatment hospitals provide the final safety net for the most severely ill members in our service areas. Admission, due to severe capacity restrictions (as of 2013, North Carolina had the lowest number of state psychiatric beds per population in the country), are typically limited to those with severe treatment resistance and/or aggression, and who are likely to require a longer term admission (greater than one month). Cardinal Innovations members from the Piedmont and Mecklenburg regions are eligible for admission to Broughton Hospital and J.F. Keith Alcohol and Drug Abuse Treatment Center (ADATC). Members in our Northern and Triad Regions are eligible for admission to Central Regional Hospital and R.J. Blackley ADATC.
Overview

The 1915(c) waiver allows for the provision of long-term services and supports in an individual’s home and community instead of an institution. In order to qualify for the waiver, a Medicaid beneficiary must meet ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) level of care criteria as follows.

- The member must be diagnosed with an intellectual disability prior to the age of 18

  OR

- The member must be diagnosed with a related condition prior to the age of 22 that is likely to continue indefinitely (such as a developmental disability or a traumatic brain injury) AND have substantial limitations in three of six major life activity areas (self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living) and require active treatment to enable the member to function as independently as possible and prevent or delay loss of optimal functional status.  

Home and Community Based Services (HCBS) Final Rule

On January 16, 2014, CMS developed the Home and Community Based Services (HCBS) Final Rule in an effort to better define life in the community for persons with intellectual disabilities/developmental disabilities. The rule maximizes the opportunities for members participating in HCBS programs to have access to the benefits of community living and to receive services in the most integrated settings.

The rule requires that members are integrated in and receive support to fully access the greater community – including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services. Services must be selected by members from among setting options, including non-disability specific settings, private units in residential settings, and homes of their own. The rule ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint. It also optimizes autonomy and independence in making life choices, and it facilitates choice regarding services and who provides them.

The Medicaid-funded, provider-operated services covered under this regulation are Day Supports, Residential Supports and Supported Employment for both Innovations and (b)(3). North Carolina has submitted its transition plan to CMS. The state must be in full compliance with the final rule by March 17, 2019. The MCO must comply that their policies procedures and practices comply with the rule as well.

Assessments

Psychological evaluations establish diagnoses and may assist with identifying goals and intervention strategies. Psychological evaluations often include IQ testing and adaptive skills testing. They may also include personality, emotional, and behavioral assessments when attempting to identify those with dual diagnoses. When clinically appropriate, evaluations may be needed in areas such as assistive technology, communication, feeding, mobility, and simple and complex activities of daily living. Neuropsychological evaluations are particularly helpful when assessing the cognitive and emotional impairment associated with traumatic brain injury (TBI). The Supports Intensity Scale (SIS®) assesses the level of support needed by members with intellectual disabilities/developmental disabilities to successfully accomplish life activities.

The Functional Behavior Assessment is used when a member is experiencing challenging behaviors that interfere with the ability to function or the ability to access integrated community settings. The Functional Behavior Assessment helps the team identify the function of the behavior, positive support strategies, replacement behaviors, and reinforcement strategies. Most often the function of challenging behavior is related to trauma responses, communication difficulties, skill deficits, medical conditions, access to something desirable, attention, escape, sensory input, or pain relief. Challenging behaviors are subject to improvement when interventions reflect best practices. In addition, intervention must correspond with the function of the behavior in order for the member to achieve optimal outcomes. It is considered best practice for assessments to include an accurate presentation of functioning levels across developmental domains and indicate the member’s preferences.
NC Innovations – 1915(c) Waiver

The NC Innovations Waiver is designed to provide an array of community-based services and supports that promote choice, control, independence and community membership. These services provide a community-based alternative to institutional care for persons who meet the level of care for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Members who seek services funded through the NC Innovations Waiver are served on a first-come, first-served basis. Members apply for the NC Innovations Waiver by contacting Cardinal Innovations. If a member is determined potentially eligible for waiver services, but funding is not available at the time of the request, he/she will be placed on the Registry of Unmet Needs when all necessary documentation has been received. Members on the Registry of Unmet Needs are also referred to other resources, such as (b)(3) services, while they are waiting for waiver funding.

Individual Budgeting Tool

In 2016, DMA implemented a resource allocation model statewide. This resource allocation model, called the Individual Budgeting Tool, provides important information used in the Individual Support Planning process. This tool yields an Individual Budget for each member receiving NC Innovations services. Members are assigned Individual Budgets based on their on their ages, living arrangements, and support needs identified in the Supports Intensity Scale® (SIS®). Individual Budgets are based on arrays of services that would typically meet the needs of individuals with similar clinical needs, ages and living arrangements. The Individual Budget is not a limit on the amount of services members can request or have approved, but it is used as a guideline.

There may be times when members temporarily need more services included in the Individual Budget than other similar individuals may typically need (e.g., when unexpected circumstances arise, such as the loss of a primary caregiver). Some members simply may have needs that cannot be met with their Individual Budgets (e.g., members with significant medical issues not typical of individuals with otherwise similar support needs). There are safety nets that can help members receive the services they need, through a Temporary Change, Permanent Change or Intensive Review. It is important for members to understand that if they have needs that cannot be met within their Individual Budgets, they will be able to receive services to meet those needs.

Services

Waiver services are designed to support opportunities for members to enhance their quality of life by promoting self-determination, self-advocacy, and self-sufficiency. Services are designed to teach and maintain skills, provide support, maximize independence, and foster community integration.

For planning and budgeting purposes, services fall under two categories: Base Budget Services and Non-Base Budget Services. Base Budget services are the core habilitation and support services in the Innovations Waiver. Non-Base Budget services are preventative services and equipment. Base Budget Services are the services that are included in the Individual Budget for NC Innovations Waiver participants. Non-Base Budget Services are sometimes referred to as Add-On Services; they do not count toward the
Individual Budget for NC Innovations Waiver participants. The total cost of Base Budget Services and Non-Base Budget Services combined cannot exceed the cost limit of $135,000 annually.

**Base Budget Services**

1. Community Living and Support
2. Community Networking
3. Day Supports
4. In-Home Skill Building*
5. In-Home Intensive Supports*
6. Personal Care Services*
7. Respite
8. Supported Employment

**Non-Base Services (also known as Add-on Services)**

1. Assistive Technology Equipment and Supplies
2. Community Navigator
3. Community Transition
4. Crisis Services
5. Financial Support Services
6. Home Modifications
7. Individual Goods and Services (for individuals who self-direct)
8. Natural Supports Education
9. Residential Supports
10. Specialized Consultation Services
11. Supported Living
12. Vehicle Modifications

*Beginning November 1, 2016, these services will be replaced by Community Living and Support. The transition occurs when a member’s current authorization expires or when a member chooses to update his/her Individual Support Plan.*
Agency with Choice/Employer of Record

The NC Innovations Waiver gives people with disabilities clear choice about how they receive services. The NC Innovations Waiver refers to self-directed services as Individual and Family Directed Supports. Members can direct some or all of the services that are paid through the Waiver. Cardinal Innovations offers two models of Individual and Family Directed Supports.

- **The Employer of Record Model** allows the member or legally responsible person for the member to exercise authority over support workers and assume the other responsibilities associated with individual direction of services, just as any other agency or employer of support workers would do. The member or the legally responsible person in this model is known as the Employer of Record.

- **The Agency with Choice Model** allows the member or the legally responsible person for the member to work with an agency that agrees to hire employees referred by them. The agency approves/disapproves the hiring of the referred support workers and ultimately retains the responsibility of being the employer, while supporting the member or legally responsible person to partner in managing the employee’s training and supervision. In this model, the member or the legally responsible person is known as the Managing Employer.

Cardinal Innovations has developed a [Self-Direction Booklet](http://www.cardinalinnovations.org/nc-innovations-waiver/individual-family) to assist members and their families choosing how they wish to direct their services.

*For all services described below, please see the North Carolina DMA Clinical Coverage Policies, Behavioral Health section ([http://dma.ncdhhs.gov/document/behavioral-health-clinical-coverage-policies](http://dma.ncdhhs.gov/document/behavioral-health-clinical-coverage-policies)) for complete service requirements.*

**Base Budget Services**

1. **Community Living and Support**: Community Living and Support is an individualized service that enables members to live successfully in the homes of their families or natural supports and be active participants in their communities. Direct support professionals assist members in learning new skills and/or supports members in activities that are individualized and aligned with their preferences. The involvement of unpaid supports is an important aspect to ensure that achieved goals are practiced and maintained. This service may be provided in members’ homes or in their communities.

2. **Community Networking Services**: Community Networking Services support members in creating a day that is personally meaningful and with people who are not disabled. Community Networking Services helps members be more independent and take part in their communities in ways that are valued by other people in their communities.

3. **Day Supports**: Day Supports assist members with obtaining, keeping or improving self-help; socialization and adaptive skills. Day Supports are furnished in and by licensed day programs, including sheltered workshops and developmental day after school programs. Day Supports providers are responsible for transporting members from their homes to/from their Day Supports facilities. Day Support Services are typically provided in group. However, one-on-one Day Support Services are available for members with special needs who require individual support.
4. **In-Home Skill Building:** In-Home Skill Building provides training to enable members to acquire skills to become more independent. In-home skill building consists of

- Training members to develop and maintain personal relationships
- Skill building to help members learn community living skills, such as shopping, recreation, personal banking and other community activities
- Training to help members learn therapeutic exercises, supervision of self-administration of medication and other services that are essential to their health care at home
- Transporting members to activities where they are receiving In-Home Skill Building.

**Note:** Effective November 1, 2016, In-Home Skill Building will be replaced by Community Living and Support when a member’s current authorization expires or when the member chooses to update his/her Individual Support Plan.

5. **In-Home Intensive Supports:** In-Home Intensive Supports are available in a member’s private home if he/she needs extensive supervision, training and support to assist with positioning, intensive medical needs, elopement (running away) and/or behaviors that would result in injury to the member or other people. The member’s Individual Support Plan will include a plan to reduce the need for this service or a plan for obtaining assistive technology to reduce the amount of In-Home Intensive Supports. A member will be approved to receive this service only if he/she has exceptional medical or behavioral support needs. **Note:** Effective November 1, 2016, In-Home Intensive Supports will be replaced by Community Living and Support when a member’s current authorization expires or when the member chooses to update his/her Individual Support Plan.

6. **Personal Care Services:** Personal Care Services helps members with eating, bathing, dressing, personal care, hygiene and other activities of daily living. Personal care services also help members to maintain skills gained during training services. This service also includes housekeeping chores, such as bed making, dusting, and vacuuming, if these are related to member care and are essential to members’ health and welfare. Personal Care Services also include assistance with monitoring member’s health and with transferring, walking, and use of special mobility devices. **Note:** Effective November 1, 2016, Personal Care Services will be replaced by Community Living and Support when a member’s current authorization expires or when the member chooses to update his/her Individual Support Plan

7. **Respite** provides periodic support and relief to the member’s primary, unpaid caregiver(s). The primary caregivers are the persons who are mainly responsible for a member’s care who also live in the same home as the member. Respite may be provided in the home or in another setting. It is available during the day, at night and/or on the weekends.

8. **Supported Employment Services:** Supported Employment Services provides members with assistance in choosing, acquiring and maintaining a job in settings with people who do not have disabilities. Before a member can receive Supported Employment Services funded by NC Innovations Waiver, he/she must first use any services that Vocational Rehabilitation offers.
Initial Supported Employment Services include the following supports.

- Pre-job training such as career counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, and assistance in learning skills necessary for keeping the job
- Assisting a member in developing a micro-enterprise (person’s own business)
- Transportation between work/home or between activities related to employment

Long Term Follow-Up Supports include the following activities:

- Coaching and support to maintain employment in a group such as an enclave or mobile crew (groups of workers with disabilities who work in a business in the community)
- On-going assistance to maintain a micro-enterprise
- Assisting a person to maintain employment
- Consultation with a member’s employer to address any problems or needs
- Transportation between work/home or between activities related to employment

Non-Base Budget Services

1. **Assistive Technology Equipment and Supplies** covers purchases, leasing, shipping costs and, as necessary, repair of equipment required to enable a member to increase, maintain or improve his/her ability to perform daily life tasks. Examples of covered items are certain daily living aids, items to help control the member’s environment, positioning systems and alert systems. Members can spend up to $50,000 on Assistive Technology and Home Modifications combined over the duration of the waiver. The $50,000 limit does not include nutritional supplements and monthly alert monitoring system charges.

2. **Community Navigator** helps members discover and express their interests and talents, locate community resources, and become active participants in their communities. Areas of assistance include helping members direct waiver services, building community connections, locating and obtaining community resources, accessing advocacy services, renting or purchasing members’ own homes and/or assistance and support with planning team meetings.

3. **Community Transition** funds provide one-time, set-up costs for adults to live in homes of their own. These funds can help members moving from a Developmental Center (institution), community ICF/IID Group Home, nursing facility or other licensed living arrangement (such as a group home, foster home or alternative family living home) to living arrangements in which members are directly responsible for their own living expenses. Community Transition Services can pay for security deposits, essential furnishings, window coverings, food preparation items, sheets, towels and deposits for certain utilities. The limit for this service is $5,000 once during the life of the waiver.
4. **Crisis Services** help members in situations that presents a threat to their health/safety or the health/safety of others. This service is intended to help prevent the need for institutional placement or hospitalization. Crisis Services are available 24 hours per day, 7 days per week. There are three types of Crisis Services.

   - **Primary Crisis Response:** Community Living and Support, Residential Supports, and other Provider Agencies have trained staff who are available to provide “first response” services to members in the event of a crisis. They can help evaluate what type of help a member needs, contact other agencies if needed and help staff or caregivers during the crisis.

   - **Crisis Behavioral Consultation:** Qualified Professionals with crisis experience are available to a member who has significant, intensive or challenging behaviors that have resulted in a crisis requiring the development of a Crisis Support Plan.

   - **Out-of-Home Crisis:** Out-of-Home Crisis is a short-term service for a period of structured support due to a crisis. The service takes place in a licensed facility or licensed private home respite setting, separate from the member’s living arrangement.

5. **Financial Support Services** help members make sure that funds for self-directed services are managed and distributed as intended. This service is only available to members who self-direct their services and want to be Employers of Record. Financial Support Services help with the following tasks.

   - Bill for services that members self-direct
   - Pay members’ employees and required employment taxes
   - Help members obtain supplies and facilitate/provide training needed by their employees
   - Obtain background checks when members are hiring new employees, process members’ applications for Workers Compensation Insurance
   - Provide monthly reports about payments for services billed and payments of waiver expenses

6. **Home Modifications** are physical modifications to the private home owned by a member or his/her family that are needed to ensure the member’s health, welfare and safety or to help the member become more independent. Portable items may be requested if the member/family rents a home. This service only includes modifications to existing rooms; it cannot be used to convert a room into a different type of room. Members can spend up to $50,000 on Assistive Technology and Home Modifications combined over the duration of the waiver.

7. **Individual Goods and Services** are available to members who self-direct one or more services. The cost cannot exceed $2,000 per plan year. They include services, equipment or supplies that address an identified need in the member’s Individual Support Plan and meet the following requirements.

   - The item or service would decrease the member’s need for other Medicaid services
AND/OR

- Promote inclusion in the member’s community

AND/OR

- Increase the member’s safety at home

AND

- The member does not have the funds to purchase the item or service

8. **Natural Supports Education** provides for training opportunities to enhance the decision-making capacity of the member’s natural support network. It includes education and training on interventions/strategies and on the use of specialized equipment and supplies. Reimbursement for enrollment fees and materials related to attendance at conferences and classes by the member’s natural support network may be covered.

9. **Specialized Consultation Services** provide training and technical assistance in a specialty areas: psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy and nutrition. Family members and other paid/unpaid caregivers are trained by a certified, licensed and/or registered professional, or qualified assistive technology professionals to carry out therapeutic interventions, to increase the effectiveness of the specialized therapy and to participate in members’ team meetings. Specialized Consultation may include recommendations for Assistive Technology, Home Modifications and Vehicle Modifications.

10. **Supported Living** provides a flexible partnership that enables individuals ages 18 and older to live in their own homes with individualized assistance from an agency. A person’s own home is defined as the place where the member lives and in which the member has all of the ownership or tenancy rights and responsibilities under the law. A Supported Living home may have no more than three residents, including any live-in caregiver who is providing supports. Supported Living includes the following tasks:

- Assistance with activities of daily living and other activities essential to the member’s health and safety
- Training activities and supervision to allow participation in home life or community activities
- Assistance with monitoring health status and physical condition
- Non-medical transportation related to goals and objectives

11. **Vehicle Modifications** are devices, service or controls that can help increase a member’s independence or physical safety by enabling safe transport in and around the community. The installation, repair, maintenance and training in the care and use of vehicle modifications are
The modification must be recommended by an appropriate professional and physician. Vehicle Modifications are limited to $20,000 over the duration of the waiver.

ID/DD (b)(3) Services

Section 1915(b)(3) of the Social Security Act allows states to use savings generated from a managed care delivery system to provide additional services to eligible Medicaid recipients. These services are an entitlement, but only to the extent that funds exist. Funds are replenished on a yearly basis. Cardinal Innovations offers (b)(3) services to support individuals with intellectual disability/developmental disability, mental health, and substance abuse disorders who have Medicaid. Providers who offer (b)(3) services must provide comparable services to all populations covered under the 1915(b) waiver.

Cardinal Innovations provides the following (b)(3) services to members with intellectual disabilities/developmental disabilities who do not have an Innovations Waiver slot.

1. **Community Guide** helps members become more active in their communities and makes sure their voices are heard. The service also assists in finding non-Medicaid community resources and supports. Examples of Community Guide activities include helping members enroll in classes or volunteer activities, helping members build relationships with natural supports, supporting members and their families at Individualized Education Plan (IEP) meetings and other meetings, and assisting members and families who choose the Agency with Choice Model of Individual and Family Direction.

2. **Community Transition** is for members ages 18 and older moving out of licensed facilities, such as a group home or developmental center. To be eligible for the service, the member must be moving to a private home or apartment. Community Transition pays for one-time moving costs, such as a security deposit for the new home or apartment, furnishings for the new home, moving expenses, utility deposits, and one-time cleaning and/or pest control services to make the home healthy and safe.

3. The **Deinstitutionalization (DI) Service Array** is designed for members ages three and older who are moving out of institutions, nursing facilities and other licensed living arrangements. The DI Service Array is not a service in and of itself; rather, it provides access to all services under the NC Innovations waiver with the exception of Financial Support Services. The services noted below are designed to help members become more independent and live in their own communities.
4. **In-Home Skill Building** is a short-term service for members with significant habilitation and behavioral support needs. The member’s family members or caregivers are expected to take part in the skill building sessions. In-Home Skill Building is provided in the member’s private home or the community. In-Home Skill Building activities include learning to interact with others and build personal relationships; skill building in shopping, recreation and other community living activities; and training in health care at home, such as taking medicines or using special equipment.

5. **Respite** provides periodic support and relief to the member’s primary, unpaid caregiver(s). The primary caregivers are the persons who are mainly responsible for a member’s care who also live in the same home as the member. Respite may be provided in the home or in another setting. It is available during the day, at night and/or on the weekends.

6. **Supported Employment** supports teenagers and adults who want to work in the community. This service takes place in settings where there are people with disabilities and people without disabilities. Examples of supports include help with learning job skills, applying/interviewing for a job, keeping a job and opening a small business.

**Additional ID/DD Resources:**

1. **NC Systematic, Therapeutic, Assessment, Respite and Treatment (NC START)** provides prevention and intervention services for individuals with intellectual and/or developmental disabilities and complex behavioral health needs, such as individuals with a dual diagnosis. For adults, with NC START provides crisis response and respite for the person in crisis. It also provides ongoing training, consultation, and support to family members and providers after the NC START respite event is completed. For Children, consultation, prevention services, and training are available to help support these complex individuals. The first priority of NC START services is to provide person-centered supports that enable the individual to remain in his or her home or community placement during and after a crisis.

2. **Traumatic Brain Injury (TBI):** There is a limited amount of resources allocated each year to support this population. This includes possible funding for equipment or services that are not otherwise available for members with TBI.

3. **Applied Behavior Analysis (ABA)** is an evidence-based best practice for persons with Autism Spectrum Disorder, in which principles of behavior and learning are applied systematically to improve behavior by teaching new behaviors and/or implementing interventions focused on behavior change. This service is available to Medicaid-eligible children through Early and Periodic Diagnosis, Screening and Treatment (EPSDT).