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MECKLENBURG COUNTY
Area Mental Health, Developmental Disabilities and Substance Abuse Services
429 Billingsley Rd., 2nd Floor
Charlotte, NC 28211-1098

DHHS, Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Attn: Sherry Cannady, DMA Contracts

April 9, 2010

Dear Ms. Cannady:

Mecklenburg County's LME is pleased to respond to the Request for Proposal (RFA # 2010-261) issued by the North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) on February 18, 2010 for the management of behavioral health services for Medicaid recipients in the Mecklenburg catchment area as part of existing 1915 (b) and (c) waiver established in 2005 as the Piedmont Cardinal Health Plan. Per RFA page 14, Mecklenburg LME has a Medicaid eligible population of 102,780, exceeding the minimum threshold of 70,000 individuals.

Mecklenburg County's Area Mental Health, Developmental Disabilities and Substance Abuse Services (AMH/DD/SAS) Department was established and is statutorily sustained by chapter 122C of the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. The Mecklenburg LME is considered a department of the county and is governed by an elected nine-member Board of County Commissioners (BOCC) serving two year terms, as permitted by state law.

The Administrative Offices of the Mecklenburg LME are located at 429 Billingsley Road in Charlotte (North Carolina 28211). The Service Management Division, including the MH/DD/SA Utilization Management/Review Units, Medical Director and Call Center (MeckLINK) are located on the same campus at 3500 Ellington Street (Charlotte, NC 28211).

In 2001, with House Bill 381, the Mecklenburg AMH/DD/SAS program became an LME or Local Management Entity with a primary focus on the management of service delivery within the Mecklenburg catchment area. In line with this management focus, the Mecklenburg LME applied for and received NCQA accreditation as a Managed Behavioral Health Care Organization in 2001. The full accreditation was successfully maintained until 2008 when the LME voluntarily elected to lapse participation. This was necessitated by the shift in operating models – LMEs were refocused on state funded service management and a single state vendor (ValueOptions, Inc.) was designated to manage Medicaid funded services – generated by the Department of Health and Human Services in 2006. In late 2007, the Mecklenburg LME was evaluated by Mercer Government Human Services Consulting in response to a statewide initiative involving quality and overall readiness of LME's to manage Medicaid funded services. The Mecklenburg LME was one of two LME's across the state ranked in Tier I across all

assessed elements. In broadest terms, the Mercer evaluated categories included: financial and business management; information technology and claims management; and, clinical operations and governance. A significant and clearly relevant finding noted in the Mercer report indicates that "Tier One LMEs could assume Medicaid UM functions and take the lead in consolidating other LMEs in Tier Two or Tier Three" (Mercer Report; 'Independent Evaluation of the Performance of Local Management Entities'; April 3, 2008; page 14; http://www.ncdhhs.gov/mhddsas/announce/mercer-report 4-3-08.pdf).

In 2008, House Bill 2436 directed DHHS to re-integrate behavioral health public sector services under LME management. An RFA was issued and the Mecklenburg LME was awarded, as one of only four LME's across the state, the management of Medicaid services. Subsequently, as a direct result of budgetary constraints associated with the economic downturn and start-up costs involving the project, the Mecklenburg LME voluntarily withdrew from participation in the re-integration project.

In October 2009, the Mecklenburg LME was awarded full Health Utilization Management, Health Network and Health Call Center accreditation from URAC, a Washington, D.C. - based health care accrediting organization. Overall, the Mecklenburg LME is both knowledgeable and experienced in the management of behavioral health service delivery from a managed care perspective. The LME is ready, capable and is presently assembling the core team that will be responsible for the management of the Medicaid business functions across the operation.

The Mecklenburg LME is confident that if awarded this contract, the Medicaid recipients involved with behavioral health services in the Mecklenburg catchment area will receive the highest quality of service; the Mecklenburg provider network will benefit from the LMEs local presence, accessibility, managed care experience and local knowledge of the market; local stakeholders and other community representatives will become closer participants and partners; and, the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) will find a reputable, seasoned and reliable business associate.

As required on page 34 of the RFA, please note that, as Board Chair, I am officially authorized to bind Mecklenburg LME. My email address is Jennifer.Roberts@MecklenburgCountyNC.gov, physical address is 600 East Fourth Street, Charlotte, NC 28202 and telephone number is (704) 336-2659. Also, Deputy Director Carlos Hernandez can be reached at (704) 336-6089; email Carlos.Hernandez@MecklenburgCountyNC.gov. He can answer any questions and provide clarification concerning this proposal.

Sincerely,

Jennifer Roberts, Chairman
Mecklenburg Board of County Commissioners

APPLICATION FACE SHEET

Legal Name of Agency: Mecklenburg County Area Mental Health, Developmental Disabilities and Substance Abuse Services

Address: Mecklenburg County AMH
429 Billingsley Road
Charlotte, North Carolina 28211
(Include physical address if different from mailing address)

Telephone Number: 704-336-6089

Fax Number: 704-336-4383

Email Address: Carlos.Hernandez@MecklenburgCountyNC.gov

Agency Web-address: http://www.charmeck.org/Departments/Area+Mental+Health/Home.htm

Agency Status: ( ) Non-Profit ( ) For Profit (XX) Governmental

Agency Federal Tax ID Number: 56-6000319

Agency's Financial Reporting Year (IRS Audit Cycle) July 1 through June 30

Name and Title of Person Authorized to sign Contracts: Grayce Crockett, Area Director

Name of Program (s): Mecklenburg County Local Management Entity

SERVICE DELIVERY SITE(S): (Per Question and Answer document, this line is not required.)

AREA TO BE SERVED: Mecklenburg County

The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the Centers for Medicare and Medicaid Services.

Grayce M Crockett
LME/Director

4-8-2010
Date

Appendix C: Minimum Requirements Checklist

REQUIREMENTS	REFERENCE	LOCATION	√
1. The LME applying to operate a PIHP has an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older.	Scope of Work: Minimum Requirements, table 2	Please see our transmittal letter, which states that Mecklenburg LME has a Medicaid eligible population of 102,780	√
2. The LME applying to operate a PIHP does not provide State funded or Medicaid reimbursable services (i.e., totally divested of all services at the date of application submission). Submit a list of any services provided by the LME within the past three years and date(s) of divestiture. Include the name(s) of the agency(ies) to which the services were divested and a description of the bidding process. If these agencies no longer provide the services, provide an explanation.	Scope of Work: Minimum Requirements	Please see **Attachment 1** in our Minimum Requirements Documentation for a list of any services provided by the LME within the past three years and date(s) of divestiture. Included are the name(s) of the agency(ies) to which the services were divested and a description of the bidding process.	√
3. The LME applying to operate a PIHP is currently fully accredited for a minimum of three (3) years through an accrediting body approved by DHHS, AND agrees to become URAC or NCQA accredited by the end of the third year of operating the PIHP. *Accrediting Body*: URAC *Date of accreditation:* Health/UM: November 2009-November, 2012. Call Center: November 2009-November, 2012. Health Network: January 2009-November 2012 If accreditation is currently in process: *Date of application:* _____ *Expected date of accreditation:*_____	Scope of Work: Minimum Requirements	Please see **Attachment 2** in our Minimum Requirements Documentation for our URAC Accreditation Certificates.	√
4. The LME applying to operate a PIHP has met the requirements to receive State service dollars through single stream funding.	Scope of Work: Minimum Requirements	Please see **Attachment 3** in our Minimum Requirements Documentation evidence of single stream funding eligibility.	√

5. The LME applying to operate a PIHP has financial resources sufficient to meet all requirements of the transition, implementation, and ongoing performance of all of the functions of a managed care organization, as evidenced by independent audits and other State financial records with no significant findings, by an adequate fund balance reserve to meet the requirements of this RFA, and by a letter of support from the full LME Board for assuming financial responsibility in submitting the application. Submit three copies each of the LME's independent audits for SFY2008 and for SFY2009 with findings. Submit a Letter of Support from the LME Board. Submit current Ratio and Defensive Interval. Submit documentation of either: ☐☐ Restricted insolvency protection risk reserve account. Describe how the account will be managed. OR ☐☐ Insolvency insurance.	DMA Contract, Sections 1.9 & 1.10 RFA, pp. 29, Financial Status & Viability	Please see three binders Marked "Financial Status and Viability Information" for copies of our SFY 2008 and SFY 2009 independent Audits with findings. Please see **Attachment 4** in our Minimum Requirements Documentation for the Letter of Support from the LME Board. Please see page 57 for Current Ratio, page 58 for Defensive Interval, and page 72 for Documentation of Restricted insolvency protection risk reserve account and description of how the account will be managed.	√
6. The LME applying to operate a PIHP shall not serve as legal guardian for any recipient of Medicaid reimbursed mental health, developmental disabilities or substance abuse services. If the LME is currently the guardian for individuals who receive Medicaid services, submit a plan to transfer guardianship.	Scope of Work: Minimum Requirements	Please see **Attachment 5** in our Minimum Requirements Documentation for confirmation of no guardianship role.	√
7. The LME applying to operate a PIHP shall not contract with, or make any referral of a recipient to, any provider entity in which the LME or any member of the LME staff or a board member is an investor.	DMA Contract, Section 1.8	Please see **Attachment 6** in our Minimum Requirements Documentation for disclosures of interest information.	√
8. The LME applying to operate a PIHP shall maintain professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the	RFA, p. 37, Indemnity & Insurance	Please see **Attachment 7** in our Minimum Requirements Documentation for Mecklenburg's Liability Insurance Certificates	√

terms of the contract by the time the contracts are signed. Submit copies of all current insurance certificates. Include one copy of each of medical malpractice, general liability, professional liability, fire/property, and workers compensation.			
9. The LME applying to operate a PIHP must possess and maintain an automated management information system capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission. The system must have the ability for provider access to check the status of their service authorization requests, claims submission and claims payment status.	DMA Contract, Section 7.9	Please see pages 45-49, pages 54-56, and pages 70-72 in our application.	√
10. The LME applying to operate a PIHP shall provide letters of support from the Consumer and Family Advisory Committee (CFAC) of the LME that is submitting the application plus letters of support from any other CFACs that are part of the total configured population.	Scope of Work: Minimum Requirements	Please see **Attachment 8** in our Minimum Requirements Documentation for Letters of Support from our CFAC.	√
11. The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the Centers for Medicare and Medicaid Services.	Application Face Sheet	Please see page 01 in our application for this confirmation.	√

Financial Status and Viability (Pass/Fail)
Submit the following information in an attachment to the application. See Section 1.3 of the DMA Contract.

☐☐ The LME shall provide three (3) copies each of its two most recent annual audits (SFY2008 and SFY2009) to verify its financial status, solvency, and viability. Annual financial statements should be audited in accordance with Generally Accepted Auditing Standards by an independent Certified Public Accountant (CPA) including all audit findings.

Please see the tab marked "Annual Financial Audits" in the three binders labeled "Financial Status and Viability Information."

☐☐ The LME shall submit three (3) copies of all financial statements in accordance with Generally Accepted Accounting Principals (GAAP). Materials submitted must be sufficient to indicate the organizational stability and financial strength of the LME. These reports and statements must be prepared by an independent CPA and at a minimum include a Balance Sheet, Income and Expenditures Statement, and Statement of Cash Flow.

Please see the tab marked "Financial Statements" in the three binders labeled "Financial Status and Viability Information."

☐☐ If the LME is selected for an onsite visit, the LME shall provide to reviewers at that time evidence that the following pro forma financial statements for LME can be prepared on an accrual basis by month for the first three (3) years beginning with the first month of the proposed execution date of the DMA Contract including:

- ☐☐ A statement of monthly revenue and expenses.
- ☐☐ A monthly cash flow analysis.
- ☐☐ A balance sheet.

If selected for an onsite visit, Mecklenburg LME will have these materials available for reviewers.

Customer Services
(Limit to 5 pages exclusive of the organization chart and sample enrollee education materials)
The LME shall provide Enrollees with toll-free telephone access and emergency referral, either directly or through its Network Providers, twenty-four (24) hours per day, seven (7) days per week.
☐☐ Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing customer service functions.
Please see **Attachment 9** for our Customer Service Organization Chart.

☐☐ Describe the educational and experience requirements for customer services staff and supervisors.
Customer Services Director: Master's Degree in human service discipline and minimum of five years of experience in a mental health or substance abuse clinical setting with at least five years combined customer service, clinical and management experience. Supervisory experience required. North Carolina mental health or substance professional licensure required.
Intake Specialist: Bachelor's Degree in related field with one year of related experience; Associate's Degree and three years of related experience; or High School diploma and five years of related experience; or an equivalent combination of training and experience.
Care Manager: Master's Degree in a human service discipline and three years of experience in a mental health or substance abuse setting. North Carolina mental health or substance professional licensure required.
Case Coordinator: Bachelor's Degree in a human service discipline and two years experience in a work setting relevant to the area of assignment or an equivalent combination of education and experience.
Intensive Care Manager: Master's Degree in a human service discipline and three years of experience in a mental health or substance abuse clinical setting. North Carolina mental health or substance professional licensure required.
Director of Service Management: Master's Degree in a human service discipline and five years of experience in a mental health, substance abuse, or developmental disabilities clinical setting. North Carolina mental health or substance professional licensure required.

☐☐ Describe the location of customer services operations and available resources, including the information technology to support customer services functions.
Location
MeckLINK serves as the Customer Service, Call Center, Screening Triage and Referral operation for the Mecklenburg Local Management Entity (LME). MeckLINK is located at the Carlton Watkins Center at 3500 Ellington Street, Charlotte, NC. This building is owned by Mecklenburg County and is part of the Area Mental Health campus.

Available Resources, including Information Technology
Clinicians who respond to phone calls have access to an internet-based provider directory in order to make appropriate referrals and to an updated guide to local resources. Clinicians have access to eCura, the software application that supports enrollment, authorizations and other LME functions. MeckLINK utilizes a phone system that allows contemporaneous call monitoring by supervisors for quality control purposes and support by care managers during emergency or crisis calls. The phone system also supports warm transfers and allows contact with local emergency and police departments. This system allows for real time monitoring as well as reporting of customer service performance standards related to average speed of answer, abandonment rates, individual staff phone performance, call volume and phone traffic measures. We use T-metrics, an automated call distribution and real-time call monitoring system, to ensure that telephone performance standards for incoming calls are maintained. MeckLINK operates Monday through Friday 8am to 5pm local time. The LME contracts with Carolinas Medical Center-Randolph (CMC-R) to conduct the call center function at other times.

☐☐ Describe the work flow process from time of first contact, triage, referral and access to appropriate services. Include the steps for linking calls to care managers.

Mecklenburg's clinical intake process will comply fully with 42 CFR §438.206-210. Our toll-free and local access telephone numbers are widely advertized on our website, in our Enrollee Brochure and Consumer Rights Handbook, and through public service announcements. Our toll-free line is available 24 hours a day, 7 days a week, 365 days a year and is equipped with TTY capabilities and Relay Service. Our LME uses the Pacific Interpreters Language Line to provide interpretation for callers in over 180 languages. Callers are not required to navigate an automated menu and our toll-free line is staffed by licensed mental health or substance abuse professionals. In compliance with 42 CFR §432.50, skilled medical professionals are always available on site for consultation.

Triage and Referral Process and Linkage to Care Managers

During normal business hours, care managers perform telephonic psychosocial assessments to gather historical and clinical information and assess enrollees' current functioning. They triage enrollee needs using clinical decision support tools. The results of assessment and triage determinations are used to refer enrollees to routine, urgent or emergency services. Whenever possible, enrollees are given the names of three providers selected according to their own preferences for type of provider, location, or other factors. Callers are offered the option of contacting the provider directly or being warm transferred to schedule intake appointments. When warm transferred, care managers provide a clinical synopsis to the provider prior to completing the three-way connection. When the enrollee is referred to emergency services, the care manager follows up to verify that the consumer has arrived safely or has engaged in crisis services.

Access standards are as follows:

- Emergency: Face to face services within two hours of the request.
- Urgent: Face to face services within 48 hours of the request.
- Routine: Face to face services within 10 business days or 14 calendar days.
- Provider staff must respond to emergency referrals within one hour, 24 hours a day, 7 days a week.
- As required by contract, Mecklenburg LME will submit quarterly reports to DHHS summarizing emergency, urgent and routine requests for and receipt of services.

Screening

Mecklenburg LME will ensure that any enrollee seeking services, who has not received a service within the past 60 days, receives a screening including the State's uniform screening elements and that the screening results are stored in our clinical and reporting information system. All individuals with substance use or abuse concerns will be identified and triaged as having urgent or emergency needs.

Crisis Services

Mecklenburg LME has built a network of crisis service providers who are fully engaged to support enrollees in their recovery, self-direction and wellness efforts and to engage community and natural supports to assist enrollees in times of crisis and immediately following the crisis. Mecklenburg LME will comply with 42 CFR §438.10, 42 CFR §438.133, 42 CFR §438.114, 42 CFR §438.113, and 42 CFR §422.113, and 42 CFR §422.133, in addition to the Balanced Budget Act of 1997 and EMTALA requirements regarding emergency medical services.

State Operated Facilities

The Mecklenburg LME Director has delegated the responsibility of approving state psychiatric admissions to Carolinas Medical Center-Randolph. All alternative treatment plans will be considered prior to state hospital admission.

☐☐ Describe how enrollees are educated about benefits and services and provide a sample of educational materials. Include any evidence of education for enrollees on emergency services.

Mecklenburg LME understands our requirement to provide enrollee education, which complies with section 6.10-6.13 of the DMA draft contract and with 42 CFR §438.10. All enrollee education material will be approved by DMA prior to release to enrollees and will include:

- DMA generated information to new enrollees regarding benefits and how to access services and LME contact information.
- Enrollee materials generated by the LME in English, Spanish and any additional languages spoken by a substantial number of enrollees, which include, but are not limited to:
  - Description of benefits and services.
  - Notification of program changes, at least 30 days prior to any "significant change".
  - Procedures for accessing care, including authorizations.
  - Rights and responsibilities, including the right to select and change providers, any associated restrictions, and how to select and change providers.
  - List of providers, including languages spoken.
  - Information about emergency services.
  - Referrals for specialty care and associate policies.
  - Out-of-network provider procedures.
  - Information about transportation.
  - Treatment of minors.
  - How to recommend LME policy changes.
  - Advance Directives.
  - Accommodations for non-English speakers, including interpretation services.
  - Information about the structure and operation of the LME, including any physician incentives (upon enrollee request).
  - Notification of provider terminations within 15 days of the date the LME is notified by DMA of the provider termination or 15 days of the date the LME makes the termination decision.

Mecklenburg County Area Mental Health was recently recognized with a Programs of Excellence Award for Public Awareness and Advocacy for its "Ask Me How I Am" Campaign.

Written materials will be simple and easy to understand and Mecklenburg will accommodate special needs such visual impairment and limited reading or English proficiency. Please see **Attachment 10**. Additional educational and outreach materials will be available during the on-site review.

Behavioral Health Education Services

Per DMA contract requirements (section 6.14) Mecklenburg will continue to offer education to enrollees about our services on an ongoing basis at times and locations convenient for enrollees. A wide variety of topics related to access, rights and responsibilities, etc. will be presented. Attendance records at these events will be maintained for examination review during on-site reviews by contract monitoring teams.

Education on Emergency Services

On our Enrollee Brochure and on our website, we clearly advertise that emergency services are available anytime, day or night, 24 hours a day, 7 days a week, and we provide our local and toll-free numbers in several locations on the Brochure and website. Our Consumer Rights Handbook informs enrollees that:

- In an emergency, another doctor or nurse or counselor who is treating the enrollee may see their records.
- The enrollee may be treated without consent only in an emergency situation such as when the enrollee is a danger to themselves or others or if treatment has been court-ordered.
- The enrollee will never be denied emergency or inpatient services due to not being able to pay for services.
- Some emergency situations may require police help or court proceedings.

Community forums include directions on how to access emergency services. Recent community meetings include the Medicaid Waiver informational session held on March 31, 2010, and our upcoming gathering for our award-winning video "Ask Me How I Am." This educational program celebrates National Children's Mental Health Awareness Day and is scheduled for May 6, 2010.

- Describe how your website ensures ease of use by enrollees such as consumer friendly language and ADA compatibility.

The LME's website ensures ease of use by involving consumers and families in the process of website development. Through this engagement process, we ensure that the LME is using consumer friendly language, format, structure, design, and navigation. Consumers, providers, advocates, and employees representing LME divisions convene bi-annually to review, update and adapt the website content. Ultimately, we ensure that not only is the information offered in languages appropriate to the populations that we serve, but that the language and messages are also tested by the community to confirm that there is ease in comprehension and that the language reflects the culturally diverse needs in our community.

ADA Compatibility

Currently, the website provides access to those with disabilities, who use assistive technologies to easily navigate the pages and retrieve information. The content is provided in a large font, with contrast in color and dynamics and no flashing or blinking text, and can be read with a screen reader. As our county migrates to an updated web content management system (Microsoft Office SharePoint Server) effective August 1, 2010, meeting ADA requirements for the entire county website will be of paramount importance.

- Describe how emergency calls will be managed by customer services, during regular hours and during weekends or after hours. Address the following items:
- How it is determined that an emergency exists.

Licensed clinical staff perform scripted telephonic assessments to determine the level of urgency and the nature of presenting issues. If the consumer has so elected, staff in our Call Center have access to consumer crisis plans submitted by providers so that the consumer's plan can be implemented once a crisis is identified. The LME uses clinical decision support tools that are based on recognized clinical principles for the assessment of potential risk for homicidality, suicidal and psychotic individuals, substance abusers, and callers with more routine concerns. The decision tools guide the clinicians in assessing enrollee risk along the dimensions of a need for safety or supervision, the presence of risk of harm to self or others, the presence of severe incapacitation in one or more areas of physical, cognitive or behavioral functioning, or in the case of substance abuse, the presence of withdrawal symptoms indicative of severe withdrawal or a history of severe withdrawal. Carolinas Medical Center-Randolph (CMC-R) Call Center who provides after hours coverage utilizes the same clinical decision support tools as the MeckLINK Call Center.

The clinical decision support tools are reviewed annually by the LME Credentialing Committee composed of licensed behavioral health practitioners, who are active in practice within Mecklenburg County. They evaluate the continued effectiveness for clinical triage and referral decisions in the context of any new evidence-based practices or changes in local standards of care. The LME Medical Director reviews the recommendations of the Committee and renders final approval of the clinical decision support tools.

- How the caller is connected with an individual or service that can help him or her.

MeckLINK utilizes a phone system that allows contemporaneous call monitoring by supervisors for quality control purposes and support during emergency or crisis calls. The phone system supports warm transfers and allows contact with local emergency and police departments. When a crisis plan is on file, the care manager consults and implements the plan whenever possible by making contact with the clinical home provider.

Enrollees at risk will be seen face to face within two hours or less. If necessary, another member of MeckLINK staff will call 911 to dispatch emergency services while the clinician keeps the caller on the

phone until the arrival of those services. In every instance, the clinician confirms the arrival of crisis services before terminating the call. If appropriate, a Mobile Crisis Team may be dispatched to the location of the enrollee. If a responsible individual is with the enrollee and confirms the ability to provide safe transportation to the psychiatric emergency department, the clinician will follow up with that facility to confirm that the caller has arrived.

☐☐ Describe the interface with crisis services and 911/fire/rescue.

When an enrollee is in immediate danger to harm self, others or property, 911/fire/rescue and Mobile Crisis will be contacted through the use of the MeckLINK telephone system. This system has caller identification functionality to assist in identifying enrollees' potential locations and allows us to provide warm transfers, and do three-way calls to maintain phone connections with at risk callers.

☐☐ Indicate the licensure requirements for those responsible for call resolution and required follow-up.

MeckLINK staff responding to enrollees' requests for service, complaints or clinical questions are licensed clinicians. Accepted licenses are Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Psychological Associate, Licensed Psychologist, Nursing Professionals, and Licensed Clinical Addictions Specialist. Care Managers follow up with all emergency providers to ensure that the caller has arrived safely.

☐☐ Describe how customer services will respond to calls related to grievances and appeals.

Mecklenburg LME will have in place a grievance and appeals system which complies with 42 CFR §438.400-424. In general, callers with a grievance are directed to the Consumer Advocate. Appeals are directed to our Appeals Coordinator. Those staff guide the enrollee through the appropriate processes and provide any necessary support and information throughout. However, MeckLINK staff often assist enrollees and families by making a warm line transfer or collecting information and sending it directly to the appropriate staff. Regardless of the staff member who first hears the enrollee's concern, the receiving staff member will assist the enrollee in filing the complaint, grievance or appeal by taking the information or connecting the enrollee with another staff member who can assist the enrollee. A Medicaid enrollee can appeal to the State Division of MH/DD/SAS or State Office of Administrative Hearings (OAH) and by-pass the DMH/DD/SAS level by completing the appropriate form. If the enrollee requests an impartial review by the local area program, DMH/DD/SAS notifies the Appeals Coordinator. If the enrollee does not indicate a local review, the Appeals Coordinator is not responsible for initiating the appeal process but only responding to DMH/DD/SAS or the State's Office of Administrative Hearings (OAH) requests for information. If the Medicaid enrollee calls the Appeals Coordinator directly and requests a local impartial review, the Appeals Coordinator initiates the review and notifies DMH/DD/SAS.

☐☐ Describe the LME's training plan for customer service staff including approaches to ensure consistency among staff in responding to calls.

For each position in the LME, there is a New Employee Job Specific Checklist that guides the orientation of new staff. Along with weekly case discussions and monthly supervision for staff, there is a list of annual mandatory in-service trainings for each staff position. Clinical supervision is conducted by the Customer Service Director and by the LME's Medical Director. On a quarterly basis, inter-rater reliability studies are conducted with Call Center staff. Based on the results of these studies, further training, mentoring or supervision is provided. All clinical triage calls are reviewed by the Customer Service Director to verify compliance with the clinical decision support tools and with standards of assessment for determining clinical risk and disposition of triage calls. Any discrepancies are reviewed with the LME Medical Director who may recommend remediation for individual staff members. The results of the monitoring of MeckLINK triage calls are reported quarterly to the Quality Management Committee.

Care Management/Utilization Management
(Limit to 15 pages exclusive of the organizational chart)
The LME shall have a care management (CM)/utilization management (UM) program that is staffed by licensed professionals and is sufficient to meet the care coordination needs of the enrolled population.
☐☐ Describe how the care management/utilization management program will be organized. Provide a detailed organizational chart that identifies the number of FTEs, titles of each care manager/utilization management position and supervisors.

Mecklenburg LMEs Utilization Management (UM) program will comply with the requirements of 42 CFR §456 and 42 CFR §438, Subpart D. The Mecklenburg UM program comprises two units. The first group of licensed clinicians responds to requests for authorizations from network and non-network providers. Requests are processed in conformance with LME policies. The second group, Intensive Care Management (ICM) Staff, work with providers and enrollees to attend to high risk/high cost special health care needs. Clinical and administrative supervision is provided by UM supervisors and the Customer Service Director. The LME Clinical Director (proposed for the Waiver) and Medical Director provide additional clinical supervision. Please see **Attachment 11** for a detailed CM/UM organizational chart.

☐☐ Describe the educational background and experience requirements for care management/ utilization management staff and supervisors. Include a description of licensure requirements.

Director Service Management: a clinician licensed in North Carolina who has a minimum of five years utilization review and management experience in mental health, developmental disabilities and substance abuse care.
DD Eligibility and Membership Coordination Supervisor: Bachelor's Degree in a human service discipline with five years of experience in a developmental disabilities clinical setting. Designation: Qualified Professional, Developmental Disabilities.
UM Supervisor: Master's Degree in a human service discipline with five years of experience in a behavioral health setting. Licensure requirements: North Carolina Clinical Licensure; Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Psychological Associate, Licensed Psychologist, Licensed Clinical Addictions Specialist.
Developmental Disabilities Non Licensed Care Manager: Bachelor's Degree in a human service discipline and three years of experience in a developmental disabilities clinical setting or equivalent combination of education and experience. Designation: Qualified Professional, Developmental Disabilities.
Care Manager: Master's Degree in a human service discipline and three years of experience in a behavioral health clinical setting. Licensure requirements: North Carolina Clinical Licensure; Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Psychological Associate, Licensed Psychologist, Licensed Clinical Addictions Specialist.
AMH Specialist: Bachelor's Degree in related field and three years of experience in developmental disabilities or an equivalent combination of education and experience. No licensure requirement.
DD Case Coordinator: Bachelor's Degree in a human service discipline and three years of work experience in a clinical setting specific to CAP-MR/DD General Principles of Case Management for the Developmentally Disabled. Designation: Qualified Professional, Developmental Disabilities.

☐☐ Describe the location of CM/UM operations for this contract and available resources, including the information technology to support CM/UM functions.

The UM Program is physically located at the Carlton Watkins Center at 3500 Ellington Street, Charlotte, North Carolina. This building is owned by Mecklenburg County and is part of the Area Mental Health Campus. The UM Program operates Monday through Friday 8am to 5pm. Also, once awarded the waiver contract, UM will expand authorization request as specified in the requirements. Clinicians who

respond to requests for authorizations and who provide intensive care management have access to a web-based provider directory in order to make appropriate referrals when needed and to an updated guide to local resources. Clinicians have access to eCura, the software application that supports enrollment, authorizations and other LME functions. Clinical practice guidelines are available online. In addition, clinicians have access to clinical decision support tools that are based on recognized clinical principles for the assessment of potential risk for homicidal, suicidal and psychotic individuals, substance abusers, and callers with more routine concerns. The decision tools guide the clinicians in assessing enrollee risk along the dimensions of a need for safety or supervision, the presence of risk of harm to self or others, the presence of severe incapacitation in one or more areas of physical, cognitive or behavioral functioning, or in the case of substance abuse, the presence of withdrawal symptoms indicative of severe withdrawal or a history of severe withdrawal.

☐☐ Describe the care management process from the time the member or provider contacts the LME to request services through the time of first appointment. Address how the LME:

☐☐ Handles requests for services through the 24-hour access line.

Requests for services through the 24-hour access line are handled according to the urgency of need. Individuals in emergency situations are connected using warm transfer by a care manager to a provider who can perform a face to face evaluation within two hours. Enrollees in an urgent situation are connected to a provider who can perform a face to face evaluation within 48 hours. Enrollees with routine needs are connected to a provider based on the individual's needs and preferences with expectation that the enrollee will be offered an appointment within 14 calendar days.

☐☐ Matches enrollees to providers.

Our first responsibility is to match enrollees to providers according to urgency of need. Therefore, our care managers refer to providers who can see enrollees within required access timeframes for emergency, urgent and routine needs. Whenever possible, enrollees are connected to providers based on their individual preferences. For example, some enrollees may have a preference as to the location, gender, languages spoken, specialties or other element of provider's profile and Mecklenburg LME tries to match enrollees' requests to providers based on these preferences whenever possible.

☐☐ Provides enrollees with real choice among the providers.

For most services, the enrollee is offered a choice of three or more providers, based on the enrollee's stated preferences. In addition, enrollees may use our web-based provider directory to select a provider or practitioner.

☐☐ Tracks and manages requests for out-of-network and out-of-region providers.

Best practice service models emphasize that enrollees should be treated within their home community in order to ensure that their families are able to participate in treatment. However, it is occasionally necessary for an enrollee to see a provider outside our network due to special circumstances or unusual clinical needs which cannot fully be addressed by one of our network providers.

The LME Utilization Management Supervisor will review out of network service requests to verify that the request meets medical necessity criteria and confirm that there are no available providers within the contracted network. If it is determined to be clinically necessary, out-of-network providers may be approved for payment under a single case or enrollee specific agreement for the provision of that service. All such service authorization requests will be monitored clinically under the standard utilization management protocols until the enrollee discharges from that service.

In other instances, an enrollee may be out of the catchment area and experience a behavioral health emergency necessitating an inpatient admission to a non-contracted facility. If the LME is notified close

to the date of admission, UM staff will immediately initiate medical necessity review as well as work with Provider Network Management for negotiation of a rate for payment of the admission.

There may be other situations when the LME is notified of an out of area inpatient admission after the enrollee has been discharged. These cases will be reviewed retrospectively to determine the length of stay meeting medical necessity criteria. UM staff will notify Provider Network Management of the retrospective review so that negotiation of a rate for payment can be accomplished. Both the enrollee and the provider will be notified of the results of the retrospective review as well as any appeal rights for adverse decisions.

☐☐ Assures providers are accepting new referrals.

To assure providers are accepting new referrals, we:

- Contractually require providers to notify us if for some reason they are unable to accept new referrals for a brief period so that we do not continue to refer enrollees to that provider.
- Monitor complaints and grievances for issues about providers not accepting new referrals.
- Follow-up with enrollees in emergency or urgent situations to make sure they received necessary services.
- Request feedback from CFAC and at community meetings regarding any issues with providers not accepting referrals.
- Collaborate with CFAC and Quality Management to conduct "mystery shopping" calls to providers to confirm acceptance of new referrals.
- Check acceptance of new referrals during onsite quality checks as part of routine monitoring or credentialing visits.

☐☐ Confirm the individual was seen in a timely manner.

To confirm enrollees were seen in a timely manner, we:

- Contractually require providers to see enrollees according to our access standards for emergency, urgent and routine services.
- Monitor complaints and grievances for issues about timeliness of care.
- Follow-up with enrollees in emergency or urgent situations to make sure they received necessary services in a timely fashion.
- Request feedback from CFAC and at community meetings regarding any issues with providers not providing timely services.
- Perform on-site reviews of enrollee clinical records at our provider sites to determine whether emergency, urgent or routine services were appropriate and if services were provided correctly according to access standards.

☐☐ Conducts follow up with individuals who do not show up for an appointment.

Our care management staff follow-up with enrollees who were referred for services in urgent and emergency situations to see that they received necessary services. If not, our Care Manager will work with the enrollee to arrange for services. For enrollees with routine needs, we require our providers to follow-up with enrollees to determine the reason for a missed appointment and to reschedule appointments as necessary. Follow-up of this type is also included in our on-site provider clinical record reviews.

☐☐ Addresses and tracks requests to change providers.

The LME's longstanding policy with respect to enrollee choice states that individuals have the right to every reasonable opportunity to make informed choices about the services and supports they receive from the LME and its contract providers. Enrollees may use the web-based provider directory to select a new provider or practitioner. MeckLINK is available to assist in finding a new provider.

Once the enrollee decides on a new provider, he or she signs a release of information form with his/her current provider. The current provider contacts the new provider to arrange the transition within 15 days of the request by the enrollee. Upon completion of the transfer, the current provider completes a "Discharge Event" in Provider Connect (system interface with the LME), noting the date of discharge to the new provider and adjusting the names of providers in the current plan if applicable. Required transition documentation from the current provider shall include, as appropriate, a current Person Centered Plan, current Target Population, NC TOPPS, NC SNAP, Service Order, signed release form, and progress notes, and any other information the new provider may request.

The new provider completes the Enrollee Request to Change Provider Form and faxes it to the LME Consumer Advocate's office. The new Provider will then submit an authorization request to our utilization management staff to begin on the first day the provider accepts the enrollee.

Requests to change practitioners or providers originating from the enrollee's ethnic, linguistic, gender or cultural preferences are tracked by the LME to inform gaps and needs in the provider network.

□□ Describe the LME's process for monitoring high risk and high cost consumers and individuals with special needs to ensure that all needs are addressed through clinically indicated services.

The Intensive Care Management (ICM) program supports and encourages positive treatment outcomes through identification of individuals who require ICM services to achieve and maintain treatment goals. The program targets those who are at risk for inpatient readmission, those who are utilizing the greatest amount of Medicaid services as identified through the LME's analysis of paid claims, individuals with complex clinical needs such as children with emotional disturbance, adults who are seriously and persistently mentally ill, individuals with co-occurring disorders, and those enrollees with co-existing medical disorders, particularly chronic diseases that affect behavioral health treatment.

The ICM Team is chaired by the LME Medical Director and includes the Customer Service Director, the UM Supervisor, and Intensive Care Managers. When a case of concern is identified, the Intensive Care Manager contacts the clinical home provider to obtain appropriate clinical information regarding the enrollee's treatment. The collected information and the Person Centered Plan are reviewed with the Medical Director for treatment recommendations during regular ICM rounds. Recommendations are communicated to the clinical home provider. Enrollees whose care is identified for inclusion in ICM remain under the purview of this program until the LME Medical Director approves their discharge from ICM.

For three years, the Mecklenburg LME has had a highly successful collaboration with the Chronic Care Program of Greater Mecklenburg (the disease management program for Community Care of North Carolina (CCNC.) We have been so successful that, in advance of recent DMH case management initiatives, the LME has had access to the CCNC electronic case management system for the past year in order to coordinate care for high risk Quadrant 4 (medical and behavioral) enrollees.

Currently, the LME conducts retrospective reviews of high cost enrollees identified in the Mecklenburg County paid Medicaid claims. UM staff request the Person Centered Plan, most recent comprehensive clinical assessment and a statement of the enrollee's current clinical status from the clinical home provider. Cases are reviewed with supervisors and referred to the Medical Director for additional oversight if necessary. A number of these cases are referred to the ICM program for ongoing care coordination. The LME will continue to monitor high cost/high utilization enrollees, including those with special health care needs who meet these criteria.

☐☐ Describe the care management process for assisting enrollees choosing consumer directed care available under the Innovations waiver program.

Consumer directed care aligns well with Mecklenburg LME's best practice of self-determination for IDD enrollees because it allows individuals to take personal responsibility for planning and controlling services and remain in their homes and communities. When an enrollee chooses self-directed care under the Innovations waiver program, we will provide the following care management supports to the enrollee and providers:

- Verification that enrollees have received pertinent and complete information related to Self-Direction:
  - Evidence of clear communication of the roles and responsibilities for the enrollee or legally responsible person.
  - Education on how to choose representatives to assist with decision making.
  - Confirmation that enrollees have been educated regarding all processes so that they can make informed decisions and that they have a thorough understanding of Self-Direction (rights, risks, responsibilities, and program limitations).
- Monitoring the enrollee's situation to assure that quality care occurs and that the health, safety and well being of the enrollee is maintained:
  - Clear evidence in the Person Centered Plan that the safety and welfare of the enrollee are met.
  - All risks have been carefully assessed and addressed in the plan.
  - Verification that the Person Centered Plan identifies emergency back-up services or the need for on-call back-up services.
  - During plan review, evidence of the degree that goals and outcomes are being accomplished through the selected supports.
- Evidence that critical incidents are documented and reported to the LME.
- Monitoring the performance of any selected providers.
- Responding to any enrollee complaint or grievance.

☐☐ Describe the LME's current efforts to assist consumers in overcoming barriers to services. Specifically address transportation, interpretation and coordination with community resources. Describe how these issues are addressed in staff training.

Mecklenburg LME staff is aware of our requirement (DMA draft contract section 6.17) to provide support services to enrollees in relation to the following:

Transportation Barriers

The LME has a system in place to address difficulties and barriers with treatment. Care Management staff including the Intensive Care Management Team, MeckLINK clinicians and State Facility Liaisons actively assist enrollees with transportation issues. The Care Management staff use bus passes as well as county transportation to help enrollees access services and substance abuse 12 step meetings (for those on involuntary outpatient commitments.) During FY 09 – 9,307 bus tickets were distributed by the LME. A county van is used to transport enrollees to and from Julian Keith Alcohol and Drug Addiction Treatment Center (ADATC) in Black Mountain. Potential expansion includes transporting recently discharged Julian Keith enrollees to their first aftercare appointments in an effort to ensure a smooth transition following return to Mecklenburg County. Some of our network providers have their own transportation and provide it to enrollees.

Care Management staff also refer enrollees to programs such as Special Transportation services and Social Services to help connect with transportation services. Contact information regarding resources is compiled and disseminated during staff meetings to keep staff apprised of current resources.

Interpretation
The LME is acutely aware of the importance of interpretation and translation services for our enrollees. The LME demonstrates adherence to the value of diversity to our enrollees by exhibiting sensitivity to language and cultural communication needs as evidenced by the availability of a full-time Spanish speaking staff within the Customer Service-MeckLINK unit. Interpretation services are available when dealing with other languages or when our own staff interpreter is not available. The LME arranges for our documents to be translated into Spanish (greater 5% of population) for our enrollees. Providers are required to provide interpreter services (all languages as well as assistive – Deaf & Hard of Hearing population) for enrollees at no charge to them.

Coordination with Community Resources
Mecklenburg LME provides coordination of services with community resources to all enrollees as part of our care management process. High Risk consumers are linked with the Intensive Care Management team in an effort to assist those in need of more intensive and extensive management. The LME liaisons follow the high risk consumers after discharge from state facilities for 90 days to link to resources and work towards stability in the community. If the consumer continues to need support, they are then referred to our ICM Team. MeckLINK staff maintains a Community Resources list that is updated quarterly to ensure accuracy.

Staff Training on Addressing Consumer Barriers
The LME Training Division provides training opportunities that help staff gain greater awareness of the behavioral health issues that impact access to services, including methods to reduce barriers to services. The Training Administrator also serves as the Chair of the LME's Cultural Competence Committee. Trainings include Cultural Competence, Enrollee Rights and Customer Relations. Resources are constantly changing, so resource lists are often revised and disseminated during staff meetings in an effort to keep staff up to date on resources and changes.

☐☐ Describe how the LME will conduct the utilization management program. Address the following issues:
☐☐ Describe the ongoing monitoring protocols for utilization management staff. Include the nature and frequency of supervision, documentation of audits, call monitoring, and any other oversight activities.

Monitoring and Supervision of UM Staff
Day-to-day monitoring of UM staff is provided by UM supervisors. Care Managers staff cases regularly with a UM supervisor and participate in weekly clinical rounds with the LME Medical Director. Supervisors monitor the volume and equalization of work loads using staff authorization reports available in eCura.

Audits of completed work products, i.e., service authorizations, Person Centered Plan reviews, are compiled on a monthly basis and are part of biweekly individual supervision with UM staff. Additional supervision is provided by the Director of Service Management who regularly reviews utilization reports, reviews and revises utilization review policies and procedures. The LME Medical Director, who facilitates weekly UM rounds, is responsible for the overall consistency in the application of medical necessity criteria to requests for authorization and for making denial and appeal determinations.

Consistency of Application of Medical Necessity Criteria
The UM Supervisor and Customer Service Director are responsible for conducting quarterly assessments of activities. The assessment includes an evaluation of how well the criteria are applied by non-physician staff. Findings are reviewed by staff during staff meetings. The unit supervisors identify opportunities for improvement and take appropriate actions when performance goals are not met.

Inter-Rater Reliability Studies
The Medical Director, the Clinical Director (proposed for the Waiver) and the Director of Service Management are responsible for inter-rater reliability studies. Inter-rater reliability studies include all staff who participate in utilization decision-making, screening and triage. On a quarterly basis, the LME Medical Director creates clinical vignettes that address services offered by the LME. During a regularly scheduled staff meeting, each care manager is given the vignettes. They are asked to review the vignettes and make the following determinations:

- Specific criteria set that apply to each scenario,
- Level of care and service most appropriate in each scenario, and
- The criteria that support their level of care and service decision.

The Supervisors and the Medical Director collect and evaluate the results of the study. An overall concordance score of less than 85% on any level of care or service will result in additional training, with the study being repeated three months later. Written summaries are submitted to the Quality Management Committee.

UM program Evaluation
On an annual basis, the Director of Service Management submits a full UM report to the Quality Management Committee. Based on this report, the UM program description and work plan are modified for the upcoming year. The UM program description and any revisions are submitted to the Quality Management Committee for review and approval on at least an annual basis.

Call Monitoring and Other Oversight
The Director of Customer Service-MeckLINK monitors live enrollee and provider calls for quality purposes. This is a regular component of orientation for new employees and is done on a monthly basis for existing staff members.

A key component of call monitoring is the disposition of clinical triage activities that occur during those calls. Those dispositions are directly related to the appropriate utilization of call center clinical decision support tools and are subject to weekly quality assurance reviews by the Customer Service Director. They are reviewed for satisfactory documentation, compliance to standards for emergent, urgent and routine care and the appropriateness of service referrals. Any discrepancies are reviewed with the LME Medical Director who may make recommendations to the Director of Service Management and the Quality Improvement Director regarding additional inter-rater reliability studies, modifications to the clinical decision support tools, or the need for additional supervision or training for clinicians responding to calls. Monthly reports are trended on a quarterly basis for continued review and interpretation by the Medical Director. Those results are reported to the Quality Management Committee each quarter for additional recommendations.

☐☐ Describe the utilization management workflow and processes for authorization and denials of care, including the qualifications of the professionals that can deny care.
The UM Division reviews and authorizes requests for routine, urgent and emergency care. The following UM functions are performed within the Utilization Management Division.

Initial Clinical Review
Initial clinical reviews are conducted by Care Managers who are North Carolina licensed behavioral health professionals. They have access to the LME Medical Director (or his/her designated back-up) and the Clinical Director (proposed for the Waiver) for consultation. Care Managers are capable of issuing approvals for service requests but do not render clinical non-certifications for any level of service request. All non-certifications are issued by the Medical Director or Clinical Director. However, if there are

administrative deficiencies such as an incomplete or missing Person Centered Plan or lack of pre-certification, the Care Managers may render an administrative denial.

For initial non-emergency review requests, the practitioner or provider submits service requests using Provider Connect software that links to eCura, the LME's electronic information system, or by faxing or mailing a standard authorization request form. The electronic or written request form provides the Care Manager with consumer demographic information, practitioner or provider information, requested services, and appropriate substantiating clinical information. Services may not be rendered prior to the completion of a comprehensive clinical assessment. Enhanced services require the completion of a Person Centered Plan. The Care Manager reviews the information against the service definition criteria, taking into consideration the local Mecklenburg County delivery system, environmental and social support for the enrollee and individual needs of the enrollee. The Care Managers base all review determinations solely on the clinical information that has been obtained by the LME at the time of the review determination. Authorization letters for all levels of care are generated by eCura.

The LME will utilize telephonic initial clinical reviews to precertify inpatient services. Providers will call MeckLINK who will transfer the call to UM staff assigned to inpatient precertification. Approval for inpatient care may only be made by a physician or physician's assistant as required by 42 CFR Part 456 and the information will be forwarded to the Medical Director or designee for certification approval. If the clinical documentation substantiates medical necessity for inpatient treatment, the caller will receive a verbal approval as well as an authorization letter documenting the number of initial days approved, authorization number, and date of first concurrent review.

Concurrent Review
The request for concurrent review must be received prior to the end of the previous authorization and is a request for continued authorization of the previous service. The LME bases review determinations solely on the clinical information that has been obtained by the LME at the time of the review determination. Frequency of review for the extension of initial determinations is based upon the specifications contained in the medical necessity criteria in the service definitions.

The Care Manager determines if the service continues to be clinically appropriate, and if not, recommends alternative services or resources to the provider. If the provider does not accept a negotiated level of services or an alternative, the case is forwarded to the peer clinical review process with the Clinical Director (proposed for the Waiver), Medical Director, or Physician Advisor.

Clinical Peer Review
If the Care Manager is unable to verify medical necessity, the case will be referred to a psychiatrist or psychologist, who conduct peer clinical review. They are available by telephone to discuss review determinations with attending physicians or other ordering providers prior to making a determination. Every effort is make to speak with the provider prior to rendering a decision. In instances where telephonic contact is not completed during the peer review, the LME will offer an additional opportunity for telephonic review or reconsideration. The purpose is to discuss an adverse determination with the clinical peer reviewer who made the initial determination or an alternate clinical peer reviewer if the initial reviewer is not available. If the result of a peer level conversation is an adverse determination, the notification letter to the enrollee and the provider will contain the necessary information to initiate an appeal.

Only a licensed psychiatrist, certified addictionologist or a licensed doctoral level psychologist reviewer can make an adverse determination at the LME. The Medical Director or designee will make decisions regarding physician services, acute inpatient services, ICF-MR and PRTF (Psychiatric Residential

Treatment Facility.) The Medical Director or the Clinical Director (proposed for the Waiver) will make decisions non-physician directed services.

The reviewer may reach one of four determinations:

- a denial (denial of a services),
- a reduction (denial during a concurrent review),
- a suspension (a time-limited and temporary denial of a current service), and
- a termination (the total closing of a case.)

The enrollee is notified if at any time the LME denies, reduces or terminates services. Enrollees and providers are notified in writing by mail of the decision, including instructions regarding the appeal process. The notification includes instructions to the enrollee regarding how to appeal an adverse determination and contains LME contact information.

Please note that, in compliance with 42 CFR §438.6(h) and §422.02, Mecklenburg LME prohibits compensation to any individuals or entities to deny, limit, or discontinue services to an enrollee. Please see **Attachment 12**.

☐☐ Describe how the LME will use data and clinical decision support information systems to support care management activities. Specify the types of data used.

The following decision support tools are used by Mecklenburg LME in care management activities:

Medical Necessity Criteria

Consistent application of Medical Necessity Criteria is one of the strongest tools our staff have in supporting care management. The LME uses the North Carolina Enhanced Service Definitions Criteria and the American Society for Addiction Medicine (ASAM) criteria for substance abuse services.

Clinical Decision Support Tools

Upon award of the contract for Mecklenburg County, the LME proposes the use of formalized mental health clinical decision support tools such as the LOCUS and CALOCUS. We will continue our current use of ASAM levels. Clinical decision support tools facilitate the standardization of the assessment of clinical levels of care both from the perspective of the provider and that of the utilization management and review entity. Further, they introduce assessment commonalities along specified clinical dimensions between both parties. These decision data support systems will strengthen consistency among Care Management staff in monitoring variations and degrees of clinical complexity as well as assist in projecting and managing potential treatment costs over an episode of care. On the provider level, they facilitate and support effective treatment planning and help guide the inclusion of best practices particularly for special needs enrollees, one of the critical groups for care management under the Waiver scenario. The decision tools can also be used to standardize outcomes measurements along varying dimensions.

Clinical Information System

Our eCura system provides Care Managers with access to historical information for enrollees who have previously accessed services. This allows Care Managers to view new authorization requests in light of the services previously received by the enrollee and the enrollee's response and progress in treatment.

☐☐ Describe the methodology for identifying over- and under-utilization of services.

In order to predict service capacity needed for appropriate access to services, as required by 42 CFR §438.206, Mecklenburg LME will use a variety of reporting tools to monitor utilization of services and to identify over and under utilization of services. Monthly reports will be run to display:

- Number of visits per/1000 enrollees for outpatient and enhanced services.
- Number of days per/1000 enrollees for 24-hour service settings.
- Inpatient admissions per/1000 enrollees.
- Average length of stay for inpatient services.
- Average number of visits for outpatient and enhanced episodes of care.
- Readmission rate for 24-hour settings.

These reports establish a baseline for service utilization so that we can detect when utilization is abnormally low or high. When over- or under-utilization thresholds are met, Quality Improvement and Utilization Management leadership will work to determine the root cause for the variance and address issues that are discovered whether on provider or system level. Over-and under- utilization benchmarks will be used to identify individual enrollee outliers whose cases may be referred for more intensive care management as well as individual providers whose practice patterns require more focused oversight and monitoring.

In addition, enrollee satisfaction results, grievances and appeals are monitored for any trends toward dissatisfaction with the length of services delivered by our providers.

Describe how the LME will provide an outreach program to ensure that high-risk mental health, developmental disabilities and substance abuse recipients understand the benefits and services available to them.

- Describe how the LME defines and identifies high-risk mental health, developmental disabilities and substance abuse recipients.

Mecklenburg LME defines "high-risk mental health, developmental disabilities and substance abuse recipients" as enrollees who, without intensive management and services, are likely to have poor health outcomes, to diminish in functionality, lose or not develop the ability to participate in their communities, and who may become a risk to themselves, to others or to property. Enrollees currently identified for Intensive Care Management include:

a. Enrollees with two (2) or more admissions to state-operated facilities or acute inpatient level of treatment within thirty (30) days;
b. Enrollees who are utilizing the greatest amount of services. The Clinical Team will review paid claims data bi-annually to identify those enrollees and the "threshold" for inclusion will be a decision made by the Clinical Utilization Management Team with plan to review monthly once the contract is implemented.
c. High risk medically compromised enrollees, particularly those with co-existing major medical issues, such as diabetes or COPD that affect behavioral health treatment;
d. Additional admission criteria will be added at the discretion of the Clinical Team to address specific needs within the community.

Additionally, the LME Outreach Coordinator continually engages with providers, stakeholders and community partners in distribution of enrollee informational material targeting at risk as well as under-represented populations.

Per DMA draft contract section 6.13, Mecklenburg LME also will identify the following special needs population and screen for the need to refer these enrollees into our ICM program:

- Adults who are severely persistently mental illness.Children who are severely emotionally disturbed.
- Enrollees with intellectual or developmental disability (IDD) who are functionally eligible for ICF-MR.
- Female Temporary Assistance for Needy Families enrollees (TANF) enrollees with SA dependency diagnoses.

- Enrollees who are IV drug or opiate users.

Describe how the LME will obtain clinical advisory input from licensed mental health and substance use treatment professionals in the review of practice guidelines utilized for authorization of services.

Mecklenburg Credentialing Committee provides clinical advisory input in the review of practice guidelines. This committee serves as a fair and impartial representative of all service providers. Further, committee members include both internal (LME) and external (Provider Network) licensed clinicians. The Committee facilitates open exchange of ideas, share values, goals and vision and promotes collaboration and mutual accountability among providers. The Credentialing Committee strives to achieve best practices to empower enrollees within our community to achieve their personal goals. Recently the LME adopted the use of the American Psychiatric Association Guidelines for Adults and American Academy of Child and Adolescent Psychiatry Practice Parameters.

Describe the role of the LME Medical Director in working with Care Management and Utilization Management.

The LME Medical Director provides medical oversight to Care Management and Utilization Management. Utilization review and intensive care management staff consult the Medical Director regularly on complex cases and have regularly scheduled rounds. Specific duties include:

1. Direct responsibility for adverse medical necessity determinations including oversight of the medical necessity determinations made by other Physician Advisors.
2. Participation in the appeal process (when not involved in the initial denial determination).
3. Providing input and guidance in the development of all utilization management activities and processes.
4. Annual review and approval of the medical necessity criteria mandated by the NC Division of Mental Health, Developmental Disabilities, Substance Abuse Services (DMH).
5. Annual review and approval of clinical practice guidelines and LME medical policies.
6. Providing direct oversight of utilization management activities.
7. Ensuring consistency of application of medical necessity criteria through the development of inter-rater reliability activities.
8. Developing clinical training curriculum for UM staff, as well as the provision of ongoing staff training.
9. Approving other behavioral health professionals as qualified to render an opinion about the medical condition, behavioral health condition, procedures or treatment under review.

Describe the LME's clinical guidelines for medical necessity criteria and level of care determination guidelines. Address the following:

List the source of the criteria/guidelines with which the LME has experience and indicate the LME's experience in utilizing guidelines.

The LME utilizes the NC Enhanced Service Definitions criteria and the American Society for Addiction Medicine criteria for substance abuse services. Prior to the implementation of the Enhanced Service Definitions in 2006, the Division utilized the North Carolina Level of Care Criteria. Utilization Management staff had several years of experience in the successful administration of those level of care criteria. Our utilization management staff have used the Enhanced Service Definitions' medical necessity criteria continuously for the past four years and have significant experience applying them to authorization requests.

Describe the training provided to care managers, physician advisors and afterhours clinicians regarding the application of the criteria/guidelines in managing care. Include a plan for determining inter-rater reliability of medical necessity criteria application.

During the orientation phase of employment, all clinical staff receive thorough training on the application of medical necessity criteria, including discussion of the requirements for each level of care, practice vignettes, role playing and inter-rater reliability testing. In addition, during the first few weeks on the job, clinical staff have an assigned clinical mentor who is available to answer questions about application of medical necessity criteria and to staff cases with the new employee prior to making authorization decisions when necessary. Once awarded the waiver contract, all after-hours/weekend/holiday coverage staff will receive this standardized training program.

Inter-Rater Reliability Studies
The Medical Director, the Clinical Director (proposed for the Waiver), the UM Supervisor and Customer Services Director are responsible for inter-rater reliability studies. Inter-rater reliability studies include all staff who participate in utilization decision-making, screening and triage, including physician advisors and other clinical peer-reviewers. On a quarterly basis, the LME Medical Director or Clinical Director creates clinical vignettes that address services offered by the LME. During a regularly scheduled staff meeting, each care manager is given the vignettes. They are asked to review the vignettes and make the following determinations:

- Specific criteria set that apply to each scenario,
- Level of care and service most appropriate in each scenario, and
- The criteria that support their level of care and service decision.

The Supervisors and the senior behavioral health practitioners (Medical Director and Clinical Director) collect and evaluate the results of the study. An overall concordance score of less than 85% on any level of care and service will result in additional training, with the study being repeated three months later. Written summary of results is submitted to the Quality Management Committee.

☐☐ Describe the process for assuring the criteria/guidelines are properly and consistently applied in the utilization review and care management process.

Inter-rater reliability studies, as described in the previous question, are used to help assure consistent application of medical necessity criteria. In addition, UM Supervisors provide oversight of the utilization review and care management process on a daily basis and are always available to discuss particular authorization requests with utilization review staff. Supervisors perform regular audits of authorization determinations, clinical reviews and other care management functions to ensure consistency in staff performance.

☐☐ Describe the transition process, gearing up staff process, and MIS process for providing UM for all Medicaid recipients within the region of the PIHP who receive mental health, developmental disabilities and substance abuse services within the region of the PIHP.

If awarded 1915 (b) and (c) Medicaid Waiver expansion in the Mecklenburg catchment area, the LME will actively collaborate with Division of Medical Assistance (DMA) to ensure a seamless transition for enrollees and providers. A functional implementation plan and a timeline have been attached to our application, as required. The LME recognizes that a detailed implementation plan will be created in conjunction with DMA once contracted. Also, the LME recognizes that the newly selected LME(s) will collaborate to develop basic statewide guidelines and requirements.

Upon award, the Director of Service Management will work closely with the Mecklenburg County Human Resources Department to create a HR plan for the Waiver implementation. The plan includes posting for new positions, interviewing, hiring and new employee orientation to meet staffing requirements for the implementation date.

In general, the transition process includes writing the Medicaid Waiver Utilization Management Plan incorporating all contractual requirements for the PIHP and revising policies and procedures to reflect the

finalized plan. Training materials will be developed including Train the Trainer materials for UM Supervisors and training staff. All customer service, UM and care management staff will be fully trained in all PIHP requirements. Administrative support staff will be trained on appropriate procedures for the disposition of paper authorization requests, duplicate requests, and notices of determination.

Additional training will be provided for customer service staff related to issues and concerns for network providers calling for assistance. UM staff will provide training for network providers in Waiver UM policies and procedures.

MIS transition requirements are specified in the Implementation Plan. Briefly, this includes the UM Department's need for final testing of internal reports used to manage the UM operations and Customer Service functions as well as the Waiver reporting package.

One of the critical items in the UM transition involves collaboration with the current Medicaid UM vendor to transition existing authorizations to us. This most likely will involve the transition of higher level services such as open residential authorizations. At a minimum, communication regarding the current census is critical for the transition. Likewise, all current inpatient authorizations will be transitioned and staffed between the previous vendor and the new contractor.

Quality Assurance and Quality Improvement
(Limit 8 pages exclusive of organizational chart)
The LME shall provide a quality assurance and improvement program that supports increased access to services, improved outcomes and efficiency.
Internal Quality Assurance/Performance Improvement Program:
☐☐ Describe how the LME ensures quality across all aspects of its internal operations and service area through the use of the CMS Quality Framework model. Specifically, describe how the LME will implement the four components of the model as listed below.
Design: How will the LME structure roles, relations, and policies and procedures to support quality internally and in its relations with providers and consumers?

Mecklenburg LME's Quality Assurance/Quality Improvement program is designed to comply with URAC standards and will comply with 42 CFR §438.240 and support state compliance with 42 CFR §438.200-204 and 42 CFR §438.310 through §438.370. In addition, we fully acknowledge and accept our responsibility to provide the Department of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH) with all information, data and reports necessary to evaluate our performance as described throughout the RFA and contracts, and in particular, in the DMA draft contract sections 1.4 -1.7. Currently, we have in place quality assurance and improvement processes which will support contract monitoring efforts and which will take feedback received through contract monitoring and integrate that feedback into our documented improvement efforts on an ongoing basis. This will include the creation and ongoing monitoring of any necessary corrective action plans. If awarded the waiver contract, the LME would simply extend the QA/QI structure, role and function to include the expanded provider network and enrollee community, establishing working relationships, designing quality initiatives and supporting best practice models focused on enhanced outcomes. All applicable policies and procedures would be developed and reviewed in the Quality Improvement Committee.

☐☐ Provide a detailed organizational chart that identifies the number of FTEs, list of each position and supervisory relationships of staff providing quality management functions.

Please see **Attachment 13** for a quality management organization chart.

☐☐ Describe the required qualifications for each position that will participate in the quality management program including licensure requirements.

Quality Improvement staff include:

- **Quality Improvement Director**, preferably a licensed clinician, with at least five years recent quality management experience and two years managed care experience or experience in mental health, developmental disabilities and substance abuse care. The Director will have a Bachelor's Degree in a Human Services Field or a Master's Degree in a human services field.
- **Management Analyst,** Bachelor's Degree in Business Administration, Public Administration or a related field, no license required.
- **Training Administrator**, Bachelor's Degree**;** no license required.
- **Administrative Assistants**, high school diploma; no license required.
- **Quality Analysts,** Bachelor's Degree; no license required. However, for the Analysts assigned to UM Appeals, behavioral health clinical license is required.
- **Consumer Advocate,** Master's Degree in a human services; no license required.

☐☐ Describe the location of QM and QI operations for this contract and available resources, including the information technology to support QM/QI functions.

QM -QI Program staff are located at 429 Billingsley Road, at the LME's administrative building.

Available Resources, Including Information Technology
The Quality Management Program has access to, and utilizes data from eCura, the LME's information management software supporting enrollee membership, claims processing, and utilization management. Additional sources of information are NC TOPPs data, enrollee and provider satisfaction data, internal databases of incident reports and complaints and appeals, US Census data.

□□ Describe the essential elements of the LME's Quality Management Plan and how the applicant will assure that the plan is a dynamic document that focuses on continuous quality improvement activities. Include:
□□ Service delivery, administrative and clinical processes and functions to be addressed.

The QM program encompasses a broad range of clinical and service issues relevant to the treatment of mentally ill adults, emotionally and behaviorally disordered adolescents and children, individuals with substance abuse or dependence issues and developmentally disabled adults and children. The program's scope is amended as needed following an analysis of the enrollee population and its characteristics, input from stakeholders, and a review of successes and unfinished improvements from prior years. At a minimum, the program includes the monitoring and evaluation of high volume, high risk, and problem-prone clinical and service issues. Performance goals and thresholds are established for these issues and are trended over time. The Quality Management Committee selects specific clinical and service areas and brings to bear sufficient resources to improve quality of services delivered. The QM program monitors and evaluates services and care provided throughout the network, use and effectiveness of services, and the availability and accessibility of services and enrollee satisfaction. A comprehensive summary of clinical and service measures and the specific objectives describing areas selected for focused improvement is located in the QM Plan. The current QM plan incorporates URAC standards and is used for the Non-Medicaid consumers and services currently managed by the LME. Performance and targets will be updated as needed. Below is a sample of indicators:

Performance	Target
Customer Service: Call Center Performance (Telephone Service Levels)	95% callers reach live person in 30 seconds or less <5% calls abandoned
Access to Appointments	95% Emergency cases seen <1 hour 95% Urgent cases seen within 48 hrs 95% routine cases seen w/in 10 days
Utilization management Functions: Turn-around time for auth requests Turn-around time for denial notices Turn-around time for Enrollee Appeals of UM denials	100% compliance within time frames for processing Auth requests, notification of Denials and Appeal requests
Provider and Practitioner Availability	Targets set for inpatient, outpatient and ambulatory care; for age groups; for specialty care (mh/dd/sa)
Enrollee Satisfaction	85% satisfaction overall
Provider Satisfaction	85% satisfaction overall and for each service area of LME (finance, provider relations, UM, IT, etc)

Performance	Target
Clinical Improvement Projects: Follow up post hospital discharge Coordination between Non-Behavioral Health and Behavioral Health Providers Adherence to Practice Guidelines	Enrollees are seen in community after inpatient discharge (specifics based on type of inpatient service) To be developed with local CCNC* Targets to be developed by the Credentialing Committee*
Service and Clinical Project: Engagement of Spanish Speaking Consumers into service	Spanish Speaking Enrollees will engage in treatment at same rate as English speaking consumers

☐☐ Committee(s) structure, responsibility and membership.

The Quality Management Committee meets monthly and includes the Medical Director as Chair, a representative from Consumer and Family Advisory Committee (CFAC), and senior managers from the LME. Guests are invited as needed. Input from the Provider Network is obtained through the Credentialing Committee, which acts as an advisory committee. Performance Improvement Teams are chartered based on need and are time-limited. Standing Subcommittees of the Quality Management Committee include the Data Integrity Subcommittee (DISC) and the Risk Management Committee. DISC is responsible for the policies on privacy, confidentiality, oversight of data and information processes.

☐☐ Necessary data sources.

The Quality Management Program has access to and utilizes data from eCura, the LME's information management software supporting enrollee membership, claims processing, and utilization management. Additional sources of information are NC TOPPs data, enrollee and provider satisfaction data, internal databases of incident reports and complaints and appeals, and US Census data.

☐☐ Proposed outcome measures and instruments.

The QM Program will use NC TOPPS data at the aggregate and individual levels to assess effectiveness of behavioral health services. Consideration will be given to use of other instruments. Additionally, we will work with the provider network to identify Best Practice outcome measures and will begin data collection as needed.

☐☐ Monitoring activities (e.g., surveys, audits, studies, profiling, etc.).

The table below lists some of the activities that are continually monitored by the LME. Measurement and monitoring activities references above are not repeated here.

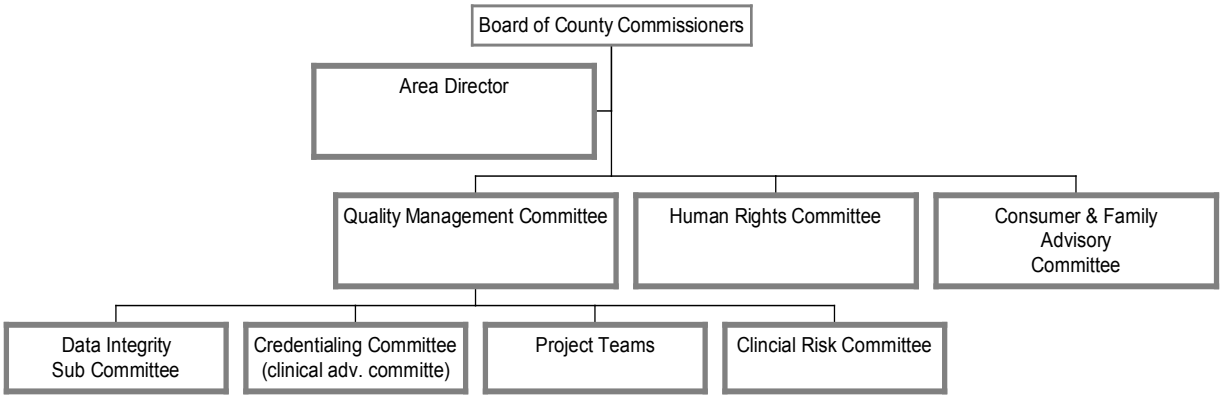
Cultural and Linguistic attributes of the Provider Network	First Responder Capability of Individual Provider Agencies
Timely Initiation and Engagement of Enrollees (md/dd/sa)	Performance Measures for Timeliness of Complaint Response and resolution
Performance Measures for Endorsement	Frequency and Extent Monitoring of Providers

☐ Feedback loops.

Reports are presented by managers with direct responsibility for the area. Managers receive feedback in person. Minutes of meetings are recorded and reviewed at subsequent meetings to ensure follow up. Results of QM activities are posted for public review.

☐☐ QM program workflow, including how the QM Committee(s) structure coordinates with the utilization management program and client rights oversight.

After review by the Credentialing Committee, the Quality Management Committee gives final approval to the UM Program. The Quality Management Committee receives routine reports on the performance of the Utilization Management Program, including setting the performance standards and thresholds for improvement. Mecklenburg LME will fully comply with 42 CFR §438.100-116: Enrollee Rights and Protections. Our Quality Management Committee has final approval of Consumer and Enrollee related policies. However, both CFAC and Human Rights Committee (HRC) have multiple opportunities to give input. Currently, CFAC, HRC and time limited focus groups assist the LME in developing improvement projects, such as the Provider Performance Reporting System, and the QI Activity (QIA) for First Responder Capability. Below is the committee structure:



Discovery: How will the LME monitor internal and external operations at the individual and aggregate level to ensure effective management and a high quality service delivery system?

☐☐ Describe how the LME monitors and conducts QA on a system-wide and individual case basis.

The LME's QM Plan describes monitoring undertaken by the LME on a monthly or quarterly basis. Call Center Performance, timely follow up after hospitalization, turnaround times for authorization requests and inter-rater reliability are some of the system–wide and individual quality monitors. Additionally, the LME monitors and tracks its performance on penetration rates, timely initiation and engagement of new enrollees, conformance to the standards and timelines for monitoring of providers. Timely processing of UM denials, appeals and other complaints are monitored quarterly. Over/under utilization, outlier and high cost/high risk analyses are is also reviewed on a regular basis. These established processes allow for examination and analysis on both a macro (system wide) as well as micro (individual case) level.

☐☐ Describe how the QM program monitors, tracks and reports on applicable performance measures, performance guarantees and incentives.

The QM Plan is used to monitor, track and report on applicable performance measures, performance guarantees and incentives. The QM Plan is developed each year as part of our QM Program Description. Performance on Plan items, such as performance measures is updated on a monthly, quarterly and annual basis. Also, if awarded the waiver contract, performance guarantees as well as incentives will be integrated into provider performance and will be measured and monitored for compliance. See **Attachment 14**.

☐☐ Describe how the LME uses member and provider feedback (including the annual customer service satisfaction survey and complaints) and/or provider profiling to identify problems and improve service delivery.

The LME conducts annual enrollee satisfaction surveys and annual provider satisfaction surveys. The results of the satisfaction surveys are analyzed for opportunities for improvement. Enrollee and family feedback, in the form of complaints and other feedback and results of the annual satisfaction surveys are

analyzed quarterly and annually. Any requests to change providers or practitioners are tracked in order to identify gaps in the provider network.

Remediation: How will the LME identify and address quality issues in its internal operations, its service provider agencies and its overall service delivery system?

☐☐ Describe the method the LME will utilize to prevent, identify, and correct quality issues with contracted providers, including the role of QM in relation to provider network management.

Improvement: How will the LME identify areas for improvement and implement and evaluate improvement initiatives?

When performance does not meet established targets, corrective actions are implemented. The action plans may focus on individuals, individual agencies or groups of providers as needed. Quality Management staff collaborates with other LME staff and providers to bring about improvements. Methods for addressing quality issues include use of data analysis tools such as flow charting, process mapping, Pareto graphs, statistical analysis, brainstorming and focus groups to identify improvement strategies. Gant charts and project plans are documented to support follow up and ongoing management of the improvements. Enrollees and families are included in focus groups. Whenever possible, those directly involved in the process or activity are part of the solution. The LME will also continuously evaluate available data looking for opportunities for the development of Quality Improvement Projects (QIPs).

☐☐ Describe how the QM program will identify and prioritize areas for Improvement

The QM program prioritizes improvement projects based on risk mitigation process. Areas of poor performance that pose serious physical and psychological risk to enrollees and the community are high priority. Areas that can be solved quickly are high or near high priority.

☐☐ Describe how the QM program will utilize data to support quality improvement.

All activities of the QM program are based on data. Ideally, data are drawn from existing sources such as claims, authorizations and enrollee and community demographic databases. The LME utilizes stand-alone databases for incident reports and complaints as a method of monitoring performance and making improvements when needed.

Describe how the QM program will implement and evaluate improvement initiatives

Any improvement activities or projects include timelines for re-measurements. Adjustments in strategies are made when re-measurements do not show expected improvements.

Enrollee Grievances and Appeals:

☐☐ Recognizing that the LME must provide a system for Medicaid appeals, state separately, for each of the most recent two calendar years:

☐☐ The number and types of complaints and grievances received from consumers.

Year	Total # of Complaints
CY 08	161
CY 09	166

Types of Complaints/Rank Order*

CY08	#
Other	52
Accessibility	42
Quality of Care	39
Attitude	25

Financial	2
Confidentiality	1
Referral	0
Availability	0

CY 09	#
Quality of Care	59
Other	28
Administrative Issues	25
Access To Services	22
Payment, Billing, Authorization	11
Basic Needs	8
Service Coordination Between Providers	6
Abuse, Neglect, Exploitation	3
Client Rights	3
Provider Choice	1

*NOTE: Beginning CY 2009 DMH standardized the complaint categories for the DMH report. The LME utilizes those categories.

☐☐ The number and types of complaints and grievances resolved within thirty days.

For CY 2008: 99% of the above listed complaints were resolved in 30 days or less. Two complaints were resolved in more than 30 days, but less than 60 days. One was an administrative issue and the other, quality of care.

For CY 2009, 99% of the above listed complaints were resolved in 30 days or less. Two quality of care complaints were resolved after 30 days, but before 60 days.

☐☐ Rank in order from the greatest to least, the three most common types of grievances received regarding your contracted providers.

CY 09	#
Quality of Care	59
Other	28
Administrative Issues	25

We used the DMH definitions and processes in CY 2009.

☐☐ Describe the staffing plan for the grievance system, including an organization chart and job descriptions, and staff resumes that describe pertinent experience and certification/licensure.

Mecklenburg LME has an Appeals Coordinator and a Consumer Advocate/Representative who work with consumers, families and others to resolve complaints and appeals and UM appeals. Currently, the resolution processes are based on guidance and rules from DMH, DMA and URAC. Should the LME be awarded this 1915 b & c Waiver, the Appeals and Complaints processes will be compliant with the contract requirements. The Appeals Coordinator will also produce any reports necessary and be available to provide training to all Mecklenburg LME staff, providers and enrollees on the complaint, grievance and appeals processes. The Medical Director or designee will make UM Appeals determinations and communicate decisions to the Appeals Coordinator for notification of enrollees and providers according to required timelines.

Please see **Attachments 13** for an organization chart and **Attachment 15** for job descriptions and staff resumes.

☐☐ Describe the orientation and education that will be given to the LME's staff that interact with enrollees and providers regarding the recognition and processing of enrollee grievances, complaints and Medicaid appeals.

Mecklenburg LME strongly believes that all staff must be familiar with the grievance, complaint and appeals policies and procedures. Therefore, training on these topics is included in new employee orientation and regular refreshers are given as part of continuing education for employees. Orientation includes:

- Defining a complaint, grievance and appeal.
- Procedures and timelines for complaint, grievance and appeal.
- Requirement that all necessary assistance be given to an enrollee to file a complaint, grievance or appeal.
- External DHHS Fair Hearing process.

☐☐ Submit the policies and procedures that cover the process for ensuring decision makers about grievances and appeals have not been involved in previous levels of review of decision making.

Please see **Attachment 16** for our Complaint Management Policy and Procedure and **Attachment 17** for our UM Appeals Policy and Procedure. Please note these are Mecklenburg's existing policies. Upon award of the DMA contract, the policies will be amended to be in compliance with applicable requirements.

☐☐ Submit the policy and procedure that describes the assistance that will be provided to enrollees in completing the procedural steps in the complaints and grievance system.

Please see **Attachment 16** for our Complaint Management Policy and Procedure and **Attachment 17** for our UM Appeals Policy and Procedure. Please note these are Mecklenburg's existing Policies. Upon award of the DMA contract, the policies will be amended to be in compliance with applicable requirements.

☐☐ Describe the consumer education materials that will be developed to explain the Medicaid appeal and the complaint and grievance systems.

Enrollee education materials explaining the Medicaid appeal and the complaint and grievance systems will be included:

- In the Enrollee Handbook.
- On the LME website.
- In community forums/discussions.
- In Enrollee Newsletters.
- In the appeal system for Utilization Management Denials, included with the written denial notice.

Provider Network Management

(Limit 8 pages exclusive of organization chart, provider lists, and sample reports)

The LME shall provide a network management program that supports the needs of enrollees and includes the following functions: Provider relations, contracting, credentialing, development, profiling and training. The LME shall have a provider manual that outlines network participation requirements.

☐☐ Describe the LME's provider network management strategies to arrange for required covered services.

Mecklenburg LME acknowledges our responsibility to supply enrollees with all of the covered services identified in Attachment K of the DMA draft contract and that the amount, duration and scope of these services must not be less than is received through fee-for-service Medicaid (DMA draft contract p. 15, Covered Services). Also, per Section 6.4 of the DMA draft contract, we are committed to offering a network with a "sufficient number, mix and geographic distribution" to ensure timely and appropriate access for enrollees.

The LME gathers data and information in three ways to determine unmet needs and gaps in the provider network. Annually, the LME evaluates the size and scope of the Provider Network. Criteria for the evaluation include cultural and linguistic needs and preferences of enrollees, geographic distribution of services, and ratio of providers and practitioners to enrollees. Availability of specialty care, multiple providers and use of evidence based and emerging technologies are included in the assessment. A standing agenda item on the LME Management Team agenda is network status. This allows for rapid response to expected and unexpected changes in the provider network. In addition, throughout the year, through a variety of advisory and community committees, Mecklenburg LME identifies needs and service gaps. Finally, the LME staff, in partnership with CFAC, conducts six community meetings with enrollees and families in the third quarter of the fiscal year. Input is obtained from community best practice committees and the Mecklenburg Provider Council.

Mecklenburg LME uses electronic survey software to poll enrollees, family members, providers, community partners, and stakeholders. Three surveys are utilized: one for enrollees, one for staff of provider agencies, and one for stakeholders and advocacy organizations.

When deficits in the network are identified, the Provider Network Director in concert with the Quality Management Committee and the LME Management Team quantify the type and scope of the gap. The LME communicates the need to providers in the network as the most expedient method of filling the gap. If the need cannot be addressed by current providers in a timely fashion, the LME will implement its Request for Proposal process. On a regular basis, Provider Relations staff review and update contract information; monitor credentialing requirements and assist with provider profiling as well as training.

☐☐ Provide a detailed organizational chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing network management functions.

Please see **Attachment 18** for a Network Management Organization Chart.

☐☐ Describe the required qualifications for each position that will participate in the network management program including licensure requirements.

- **Network Director:** a licensed clinician with at least five years combined clinical, network operations, provider relations and management experience
- **AMH Manager:** Bachelor's Degree in a human service or business field with 2 years of directly related experience in the area assigned or an equivalent combination of education and experience.
- **Contract Coordinators:** Bachelor's Degree in a human service or business field with 5 years of experience in human services, business or direct management. Experience can be a combination in the three areas.
- **Administrative Assistants:** High School Diploma or G.E.D. with four years of progressively responsible clerical experience, or an equivalent combination of education and experience.

☐☐ Provide evidence that staff is representative of the population's ethnic and racial makeup according to the latest US Census Bureau data.

LME Staff

In keeping with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) promulgated by the US Department of Health and Human Services Office of Minority Health, Mecklenburg LME will seek to recruit, retain and promote diversity when hiring staff for waiver-related positions. We will regularly examine the ethnic and cultural makeup of our service area and make efforts to reflect this diversity in our personnel at all levels of the LME. See **Attachment 19** for the LME Cultural Competence Plan.

For reference, Table 1 reflects the actual make-up of AMH employees as of April 2010.

Table 1

	Number	Percent
Male	22	19.82%
Female	89	80.18%
Total	111	100.00%

	Number	Percent
Am-Indian	0	
Asian	1	0.90%
Black	53	47.75%
Hispanic	6	5.41%
White	51	45.95%
Other	0	
Total	111	100.00%

Provider Staff

The LME's Vision is "To be a community that supports individuals and families who are fully empowered to lead healthy and independent lives" and our mission is "To assist persons, families and communities affected by mental illness, substance abuse, or developmental disabilities to achieve their life goals." Our focus has been to develop a network of providers to meet the needs of, and that is representative of, the population served. For the non-Medicaid system, the enrollee population does not mirror census data for Mecklenburg County (See sample comparison below for 2008).

Race	Census Data	Non-Medicaid Consumers Served
Black	29.6%	59%
White	64.4%	32%
Hispanic and Latino	10.8%	0.40%
American Indian/Alaskan Native	0.5%	0.11%

It is vitally important that we are able to meet the needs of enrollees with respect to ethnic and cultural characteristics. To deliver services to all target populations (including DHH), we have focused on:

- Identifying gaps in serving enrollees and developing a strategy to provide those services.
- Defining existing provider capacity: service, volume, special populations, ethnicity (cultural & linguistic needs, race, religion, nationality).
- Developing a network of providers with a mission and vision consistent with that of the LME.

Reports are developed and used to assess how well the staff of network providers is representative of the enrollees they serve. Information and data collected:

- Cultural and Linguistic surveys conducted yearly (**See Attachment 19** for the provider survey).
- Gaps Analysis.
- Providers have a Cultural Competence Plan.
- Practitioner Availability Analysis.
- Quality Improvement Project: Increase Community of Providers' Capacity to Serve Limited English Proficiency Consumers (**See Attachment 20**).
- Customer Satisfaction Survey question: Staff were sensitive to my cultural background (race, religion, language, etc.).

☐☐ Describe the LME's plan in implementing cultural competency awareness and plan for the Provider Network to meet the demographic needs of the community population.

Each year, Mecklenburg LME reviews the demographic makeup of the consumers we serve. Based on this analysis, we tailor our cultural competency plan to the needs of our region. To determine the capability of the provider network, the LME has conducted a total of three surveys in the last four years. The most recent survey was conducted in 2009 and a total of 51 providers responded.

In the credentialing process, the LME invites licensed independent practitioners to describe any unique cultural or ethnic characteristics pertinent to their work. Any information provided to the LME is used in the provider directory so that enrollees can make informed choices.

Provider Employee Information
Providers report 3,160 employees. 7.11% were reported as multi-lingual with 3.32% reported as Spanish–speaking and 3.79% are reported as having "other" language skills.

Positions held by the reported bilingual staff vary from administrative, clerical to professional, and clinical. There are several teaching positions noted, as well as teaching assistants. Three registered nurses and one psychotherapist, and one psychologist were reported. Twenty-four Qualified Professionals (QP's) were reported as well.

Cultural and Linguistic Competence Plan
Of the 51 that responded, 76% indicated that they had a Cultural and Linguistic Competence plan. However, 29.4% submitted a written plan. The LME continues working with the provider network on this important issue.

☐☐ Describe the location of network operations for this Contract and available resources, including the information technology, to support network management functions, as well as use of encounter claims that identify providers.

The Provider Network Management Division is located at 429 Billingsley Road, at the LME's administrative building.

Available Resources, Including Information Technology
The Provider Network Management Division has access to and utilizes data from eCura, the LME's information management software supporting enrollee membership, claims processing, and utilization management and network management. Additional sources of information are NC TOPPs data, enrollee and provider satisfaction data, internal databases of incident reports, complaints, standardized monitoring tools, and US Census data. Provider Network Management utilizes paid claims data in the aggregate and individual levels for quality improvement projects and targeted improvement strategies.

☐☐ Provide a listing of fully executed contracted providers by level of care and by zip code.

Please see **Attachment 21** for a list of fully contracted providers by level of care and by zip code

☐☐ Describe the LME's continuum of crisis services.

Mecklenburg County AMH provides a full continuum of crisis services including the following:

- MeckLINK - 24 Hour Customer Service Line
- Adolescent Rapid Response Crisis Respite
- Facility Based Crisis Stabilization Unit
- START:DD Crisis Services/Crisis Respite
- Mecklenburg Substance Abuse Services Center (Detox)
- Walk-in Crisis Services
- Crisis Stabilization Unit (second unit to open July 2010)
- Comprehensive Health Clinics scheduled to begin operation prior to July 2010
- Mobile Crisis Team
- Crisis Intervention Team (CIT)
- Dedicated Psychiatric ED (CMC-Randolph)
- Two additional walk-in clinics
- Inpatient Treatment – CMC-Randolph
- Capacity for telepsychiatry remote access
- Multi-disciplinary crisis teams
- First Responders – All clinical home providers are available 24/7

☐☐ Describe how the LME ensures choice of at least two providers for each service, noting approved exceptions for specialties.

The LME monitors the scope and depth of the community of providers at present. Weekly, the LME management team reviews any changes in the provider network as reported by the Provider Network Director. If approved for the 1915 b and c waiver, the LME will contract with at least two providers of each service except where agreed upon by DMA. When additional providers are needed to meet this obligation, the Provider Network Director, in concert with the Quality Management Committee and the LME Management Team, will define the type and scope of the need. Currently, the LME communicates the need to current providers as the most expedient method of filling the gap. If the need cannot be addressed by current providers in a timely fashion, the LME will implement its Request for Proposal process. The LME expects to use this same process in the future.

☐☐ Provide a listing and brief description of contracted culturally and linguistically appropriate services that address the needs of the diverse populations residing in the LME's service area.

Mecklenburg County has approximately 60,000 Latino residents with 54% of Mexican heritage, 5% from Cuba, 8% from Puerto Rico and 32% from other countries. It is our responsibility to our community to see that services are delivered in a culturally and linguistically appropriate manner. We give our providers links to a variety of tools on our website from the National Center for Cultural Competence including resources on: (**See Attachment 22**)

- Cultural Competence Health Practitioner Assessment (CCHPA).
- Cultural and Linguistic Competence Policy Assessment (CLCPA).
- A Consultant Pool: researchers, evaluators, training, technical assistance or consultation.
- Cultural Brokering.
- The Curricula Enhancement Module Series.
- Información en Español: materials in Spanish.
- Promising Practices: a listing of evidence-based promising policies.
- Publications: materials developed by the NCCC, including policy briefs, checklists, guides, articles, tools monographs, and multimedia products.
- The Resource Database: a searchable database.

A snapshot of a recent survey, produced by the Outreach Coordinator, of the provider network, resulted in 8% of respondents (n=186) having multi-lingual staff; 3% reporting Spanish capable staff; and 4% claiming "other" language and culture specific capacity (see full report attached).

In addition, our Outreach Coordinator has created a presentation titled "Cultural Competence: Working with Latino Families," which he has delivered to providers and which is available anytime for providers and other stakeholders to view on our website.

☐☐ Provide a listing and brief description of the contracted evidence based services and promising practices available in the LME's service area.

Contracted evidence based services and promising practices available in our service area include:

- Motivational Interviewing (MI)
- Motivational Enhancement Therapy (MET)
- GAINS
- Strengthening Families Program (SFP)
- Assertive Community Treatment (ACT)
- Functional Family Therapy
- Multisystemic Therapy (MST)
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy
- Trauma Focused Cognitive Behavioral Therapy
- Multi Dimensional Treatment Foster Care
- Parent Child Interaction Therapy
- Wellness Management and Recovery (WMR)
- Seven Challenges
- Integrated Dual Disorders Treatment (IDDT)
- Individualized Placement and Support Program (IPSP)

☐☐ Provide a list of the gaps that exist in the proposed network and the LME's proposed strategies to develop the network to close the gaps.

While we have all levels of care well covered in our service area, we conduct an annual survey of consumers and stakeholders to get their perception of service needs within the community. The following chart represents the perceived gaps in our network as identified in the 2009 annual survey:

2009 Mecklenburg Service Needs Identified in Surveys & Forums	
Housing	• Affordable housing options, in safe neighborhoods. • Available housing for special populations (young adult, substance abuse, homeless).
Employment	• Employment training: appropriate to individual's abilities. • Workforce development and training of job coaches.
Transportation	• Public transportation connection points beyond city center. • Additional bus routes to access service locations. • Training to use public transportation that supports independence.
Developmental Disabilities	• An array of services for individuals with Traumatic brain injury. • Integrated services (DD/MH and DD/SA).
Mental Health for Adults	• Additional Psychosocial Clubhouse programs. • Add outpatient therapy/counseling sites across community • Residential support services appropriate for young adults.
Substance Abuse	• Medically monitored community residential treatment. • Additional halfway house options. • Establish wellness recovery & management groups. • Peer run and peer support programs.
Child & Adolescent	• Additional outpatient therapy/counseling sites across the community. • Substance Abuse treatment services, with focus of co-occurring disorders (SA/MH). • Sex offender treatment. • Additional psychiatric/medication evaluation and management services. • Residential treatment all levels & substance abuse.

Strategies To Close The Gaps - Next Steps in the Process:
The next steps in sharing, communicating and prioritizing how community needs survey findings will be used are:

- Share results with Mecklenburg's CFAC and solicit their feedback and recommendations.
- Communicate findings with the LME's Community Advisory Committee, Provider Council's Executive Board and the Best Practice Committees. Each committee will provide feedback on how to prioritize the needs identified. Each committee will use this data in combination with other relevant data collected through community collaborations; examples include: Annual Indicators Report produced by the Mecklenburg Drug Free Coalition and the LME's Regional Crisis Plan.
- Once focus areas and needs are prioritized, it will be determined which committee or advisory group, in collaboration with LME staff, will take the lead in exploring solutions to address the needs.
- Provide survey findings and quarterly updates to the Board of County Commissioners.
- LME staff will develop Request for Proposals as appropriate and within available State or County funds or participate in seeking other funding opportunities at the state or national level.
- Quarterly updates will be completed to track the LME's progress on addressing each focus area/need over the course of the next year and will be reported to CFAC and the Community Advisory Committee.

□□ Describe the specific strategies the LME has used and will use to recruit and retain providers to assure the network will meet the needs of a diverse population for culturally appropriate care including enrollees with limited English proficiency.

The LME conducts an annual assessment to identify the needs and service gaps within the community. The goals of each annual assessment are to:

- Determine current service needs across the full service array, including special populations, and cultural and linguistic considerations.
- Prioritize service expansion and provider enhancement efforts particularly in the area of services that are more likely to develop or maintain community, family and natural support connections.
- Determine service needs utilizing Best Practice standards that are currently not available to Mecklenburg County enrollees.
- Define existing provider capacity for special populations, and cultural and linguistic special needs.

Methodology for data collection includes the following:

- Conduct enrollee, family, stakeholder and public forums.
- Gather data from best practice committees, advisory committees, the Mecklenburg CFAC, and from the Provider Council Executive Board.
- Electronic surveys: one for enrollees, one for staff of provider agencies and one for stakeholders.

Community Best Practice Team for Mental Health proposed and developed Mecklenburg's Promise, a recovery focused, peer driven training and education initiative.

Once data is collected and analyzed, the findings are presented to Mecklenburg CFAC, the Community Advisory Committee, the Community Best Practice Committees and the Provider Council's Executive Board. Additional feedback and prioritization of service need occurs with each of these committees, and based on all information gathered, a determination is made as to which services will be developed or expanded via a competitive Request for Proposal (RFP) process.

A comprehensive RFP is developed following a standardized format that includes a Service Specification section that is unique to each service proposal. Each RFP proposal must ensure that the agency complies with:

- Title VI of the Civil Rights Act of 1964.
- Policy guidance issued in 2000 by the federal Office of Civil Rights.
- Final standards on culturally and linguistically appropriate services (CLAS) in health care issued by the United States Department of Health and Human Services' Office of Minority Health.
- Cultural and linguistic competence representation of the community.

One of the Review Criteria against which all proposals are rated states:

- The proposal demonstrates a commitment to service delivery which is culturally competent and utilizes natural community supports as integrated components of service delivery.

The RFP process includes both an internal technical review completed by the LME, who will rate each proposal based on compliance with requirements of the RFP. Proposals that pass that review are then reviewed by a Community and Consumer/Family Review Team who review each proposal as well as interview the agency, select the top candidate, and make a recommendation to the Mecklenburg CFAC. Additionally, our Outreach Coordinator is regularly involved in Provider training and assessment, with a focus on under-represented and under-served populations.

☐☐ Provide a description of how the LME will monitor the network's adequacy and sufficiency, including performance measures and evaluation methodologies.

Currently, as described in Policy # PO-04 'Assessment of Adequacy of the Provider Community', the LME completes an annual assessment of the provider community with a focus on type and availability of services as well as access standards and other quality indicators. Please note: the Provider Availability Report (PAR) is done on a calendar year basis and completed during May of the following calendar year. The PAR for January – December 2009 will be completed in May of 2010 and will be presented to the Quality Management Committee at their June 2010 meeting (**See Attachment 23**). Additionally, there

are five other standardized tools currently used to monitor the provider adequacy and sufficiency of the network:

- **Frequency and Extent of Monitoring (FEM):** The FEM assesses the level of confidence and determines the frequency in which providers will receive routine monitoring.
- **Provider Monitoring Tool (PMT):** The PMT is designed to access provider performance in an efficient manner and to identify areas requiring more follow up or in depth inquiry.
- **Provider Performance Report (PPR):** The PPR is a local, four star measurement of the performance of child and adult mental health, developmental disability and substance abuse service providers based on specific quality indicators.
- **Quality of Care Reviews:** Whenever a quality of care issue is raised by an enrollee, staff member, or other stakeholder, Mecklenburg LME conducts a Quality of Care review.
- **Mystery Shopper access monitoring:** The mystery shopper program is used to determine if providers are delivering care according to contract requirements for emergency, urgent and routine needs.

If awarded the waiver contract, The LME will expand its current measurement process to include all services.

☐☐ Describe how the LME will manage providers to assist enrollees' use of the consumer directed care option under the Innovations waiver.

Enrollee directed care aligns perfectly with Mecklenburg LME's self-determination philosophy, because it allows individuals to take personal responsibility for planning and controlling services and remain in their homes and communities. When an enrollee chooses self-directed care under the Innovations waiver program, we provide care management support to the enrollee and the provider in correctly implementing the waiver, including:

- Verification that enrollees have received pertinent and complete information related to Self-Direction:
  - Evidence of clear communication of the roles and responsibilities for the enrollee or legally responsible person.
  - Education on how to choose representatives to assist with decision making.
  - Confirmation that enrollees have been educated regarding all processes so that they can make informed decisions and that they have a thorough understanding of Self-Direction (rights, risks, responsibilities, and program limitations).
- Monitoring the enrollee's situation to assure that quality care occurs and that the health, safety and well being of the enrollee is maintained:
  - Clear evidence in the Person Centered Plan that the safety/welfare of enrollee is met.
  - All risks have been carefully assessed and addressed in the plan.
  - Verification that the Person Centered Plan identifies emergency back- up services or the need for on-call back-up services.
  - During plan review, evidence of the degree that goals and outcomes are being accomplished through the selected supports.
- Evidence that critical incidents are documented and reported to the LME.
- Monitoring the performance of providers and responding to complaints/grievances.

☐☐ Provide an outline of the provider manual.

The provider manual will comply with DMA contract section 7.8 and will include the following topics:

- Introduction, Purpose, Mission Statement, Values and Guiding Principles.
- Treatment Philosophy and Community Standards of Practice.
- Network requirements, including: nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.
- Appointment access standards.
- Authorization, utilization review, and care management requirements.

- Care Coordination and discharge planning requirements.
- Documentation requirements, as specified in APSM 45-2 or as required by the Physician's Services Manual.
- Appeals, Complaint and Grievance processes.
- Performance improvement procedures, including at a minimum: recipient satisfaction surveys; provider satisfaction surveys; clinical studies; incident reporting; and outcomes requirements
- Compensation and claims processing requirements.
- Patient rights and responsibilities.
- Provider Relations.
- State and Federal Requirements and Policies with Access Information.
- MeckLINK and Authorization Processes.
- Quality Improvement & Performance Monitoring.
- LME Specific Policies/Forms/Provider Documentation.
- Glossary of Terms (Division and LME).

□□ Describe the transition process from an open provider network under the current Medicaid and DMHDDSAS funded system to a closed Provider Network and issuing new provider contracts as a PIHP for state funded and Medicaid providers.

Provider Star Rating will determine inclusion into the network. All providers having a two star rating or better will be invited to join the network. The Provider Performance Report (star rating system) was developed by the Mecklenburg CFAC, with the support and collaboration of the Mecklenburg Provider Council's Executive Board. The primary purpose of the report is to assist enrollees and families in making informed choices about providers. The Performance Report is a four star rating system that rates each provider within the LME's community of providers; it includes 20 standards across the categories of:

1. Provider actively pursues quality in providing services,
2. Provider participates in local efforts to improve quality,
3. Provider demonstrates focus on the enrollee's expressed goals, strengths, and needs,
4. Provider demonstrates focus on enrollee and family involvement.

The Mecklenburg LME currently does not establish contractual relationships with a large volume of licensed independent practitioners; therefore, during the initial cycle of establishing a closed network, all licensed independent practitioners who are interested and willing to join the network will be included. During the first year of implementation, the LME will begin the credentialing of those practitioners according to URAC standards and the LME's policy specific to 'Credentialing Licensed Independent Practitioners' (**See Attachment 24**).

□□ Provide a one page description of the network transition of care plan that limits disruption and permits most members to continue treatment with their current providers.

Mecklenburg LME's goal is minimal disruption to members. In order to limit the disruption that sometimes occurs when an enrollee changes plans, we will take the following steps:

- Begin to work with ValueOptions immediately upon contract award to agree upon transition plan for enrollees, including transfer of authorization data and plans of care.
- Perform a disruption analysis of our network of providers compared to ValueOptions network to determine additional providers who may need to be added to our network.
- Notify enrollees of "what will stay the same" and "changes to expect" at least 30 days prior to implementation.
- Notify any enrollees currently being seen by a provider, who will not participate in our network, of providers available within the network who can meet their needs at least 30 days prior to implementation.
- Allow for some use of out-of-network providers during the first 90 days of the program so that enrollees may complete already started treatment plans with providers who will not participate in our network.

Appointment Availability:

☐☐ Describe how the LME will ensure that enrollee appointment access standards are met, including two (2) hours if need is emergent, 48 hours if need is urgent, and 14 calendar days if need is routine.

To confirm enrollees are seen in a timely manner, we:

- Contractually require providers to see enrollees according to our access standards for emergency, urgent and routine services.
- Monitor complaints and grievances for issues about timeliness of care.
- Follow-up with enrollees in emergency or urgent situations to make sure they received necessary services in a timely fashion.
- Request feedback from the CFAC and at community meetings/forums regarding any issues with providers not providing timely services.
- Perform on-site reviews of enrollee clinical records at our provider sites to determine whether emergency, urgent or routine services were appropriate and if services were provided correctly according to access standards.

☐☐ State separately for each of the most recent two (2) calendar years, the average number of days from the date of receipt of a request for an eligibility determination to the first appointment for a member.

Calendar Year 2008: Average of 1.44 days.
Calendar Year 2009: Average of 0.75 days.

☐☐ Describe how the LME will address access for individuals who require services when they are outside the LME's catchment area (e.g., while traveling in North Carolina or when residing in a group home outside the LME's catchment area).

The LME UM Supervisor will review out of network service requests to verify that the request meets medical necessity criteria and confirm that there are no available providers within the contracted network. If it is determined to be clinically necessary, out-of-network providers may be approved for payment under a single case or enrollee specific agreement for the provision of that service. All such service authorization requests will be monitored clinically under the standard utilization management protocols until the enrollee discharges from that service.

Appointment Wait Time:

☐☐ Describe how the LME ensures that providers meet the requirements regarding wait times for scheduled enrollee appointments, walk-ins, and emergencies as specified in the DMA Contract.

Mecklenburg LME will monitor wait times according to the following standards detailed in Section 6.6 of the DMA draft contract. As these services will be provided by our network providers, we will contractually require providers to adhere to wait time requirements and we will monitor wait times through the following:

- Enrollee Satisfaction surveys will include questions which ask if services were delivered according to these required timeframes.
- We will conduct a medical record review of a random sample of enrollees who received routine and emergency services to determine if wait times were within contract standards.
- Complaints and grievances will be monitored to identify and address any issues with wait times.
- Staff will routinely ask enrollees at community forums and meetings for feedback regarding wait times and if negative feedback is received, document the feedback as a complaint/grievance to be followed up on by quality improvement staff.

If a negative trend is noted in regard to wait times, the LME may charter a Performance Improvement Team to establish a formal quality improvement activity.

☐☐ Provide a sample report for LME appointment wait times.

Please see **Attachment 25** for a sample report of LME appointment wait times.

Disclosure of Information on Ownership and Control
(Limit to 2 pages exclusive of disclosures)
☐☐ Submit a list of current members and terms of the Board of Directors.

The Mecklenburg LME is considered a department of the county and is governed by an elected nine-member Board of County Commissioners (BOCC) serving two year terms, as permitted by state law. The BOCC has accountability for and oversight of the county budget, services and maintenance. In particular, the BOCC has responsibility for establishing community priorities in areas such as health, education, welfare and mental health among others. In compliance with 42 CFR §455.100-104, the following is a list of the individuals who serve on our Board of Directors and their membership terms:

Board of County Commissioners: Term of 2008-2010	
Name	**Position**
Jennifer Roberts	Chairman
Harold Cogdell Jr.	Vice Chairman
Dan Murrey	At Large
Karen Bentley	District 1
Vilma Leake	District 2
George Dunlap	District 3
Dumont Clark	District 4
Neil Cooksey	District 5
Bill James	District 6

☐☐ Submit a list of current members and terms of the local Consumer and Family Advisory Committee.

The Mecklenburg CFAC began its 8th year in 2010 and is very proud of the achievements made in fulfilling its mission to be a strong advocate for enrollees receiving mental health, substance abuse or developmental disability services. The following is a list of CFAC members and terms:

Name	Term Ends	Disability Area
Ron Reeve, Chairman	06/2010	DD, MH
Lora C. , Vice-Chair	06/2010	Youth DD
Steve M., Vice-Chair	06/2012	DD
Kathy A.	06/2010	MH
Pearlie C.	06/2013	MH, SA
Dorothy D.	06/2012	DD, SA
Sandy D.	06/2012	DD, MH, SA
Rina F.	06/2011	Youth DD
Ken G.	06/2010	DD
Barbara J.	06/2011	DD
Pat O.	06/2011	SA, MH
Peggy Q.	06/2013	SA
Chelsi S.	06/2010	DD
Joanne H.	06/2011	MH, SA, DD
Jim W.	06/2011	DD
Dennis L. Knasel, LME Staff Liaison		

Mecklenburg LME's CFAC initiated mystery shopping for First Responder capacity of providers, leading to a QI Project on Functional First Response.

Disclosure of Information on Business Transactions
(Limit to 4 pages exclusive of disclosures)
☐☐ Submit any disclosure as described in Attachment R of the DMA Contract.

Per 42 CFR §455.100-104 and Attachment R of the DMA Contract, the Mecklenburg LME has no "party in interest" related to business transactions. Please see **Attachment 6** in our Minimum Requirements Documentation.

☐☐ Describe your internal controls and systems to account for contract related and noncontract related revenues and expenses and to prevent and detect fraud.

Written requirements are in place for the various accounting procedures. As a department of Mecklenburg County, the LME utilizes the County's financial policies and procedures as well as LME specific policies and procedures on how the LME will carry out Mecklenburg County's policies and procedures. The LME maintains accounting and financial processes that provide assurance that transactions are properly authorized, recorded, and accounted for in compliance with all applicable laws, rules, and regulations. Transactions are carried out by employees who have been adequately trained. Please see **Attachment 26.**

The LME uses the Advantage system for all accounting entries and general ledger. Budget units are created to record revenues and expenditures by funding source and population. In addition accounts are established for each revenue source and type of expenditure. Administrative expenses are recorded separately from service related expenses. Reconciliations are performed to ensure expenses have been recorded correctly. In the event an error is found a journal voucher is prepared to correct the entry.

Contracts are encumbered based on estimates of current enrollees and historical data. Encumbrances are adjusted (increased or decreased) as necessary during the contract period. A purchase order is required for non-contract related expenses. Questionable purchases are resolved prior to expenditure. There is a separation of duties for all transactions including contracting, accounts payable and accounts receivable. Contracts are prepared by Provider Relations staff. Payments are prepared by front line LME Financial Services staff and approved by the supervisor and also by Mecklenburg County Finance Staff.

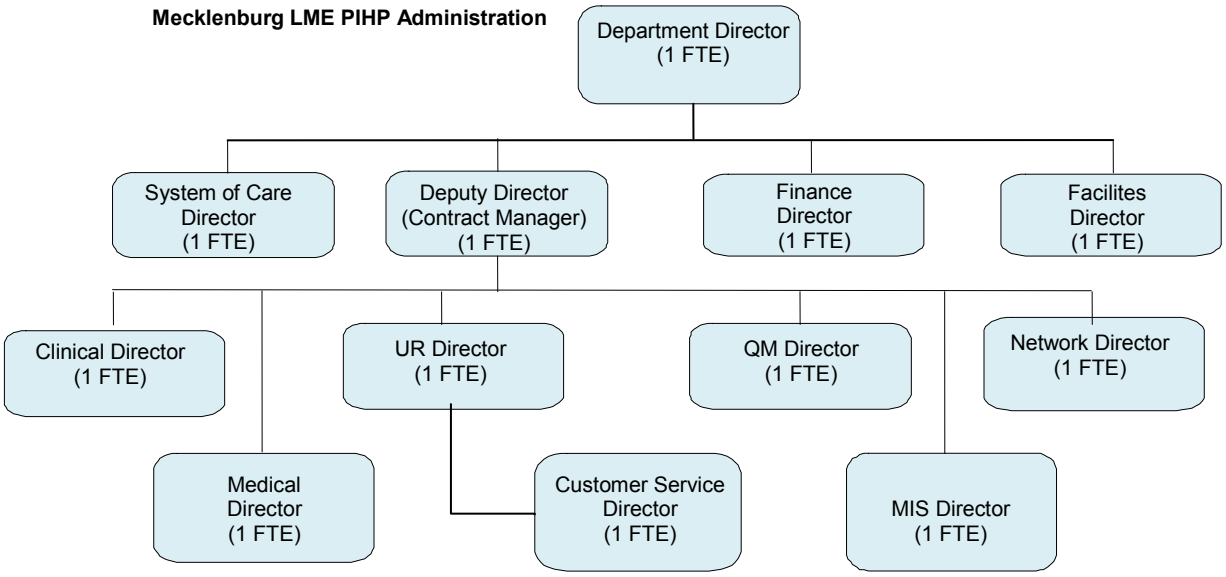
- The audit for the LME is included in the Mecklenburg County audit. Mecklenburg County contracts with a public accounting firm to perform annually the financial and single audits.
- Mandatory Ethics training and education for LME staff including a hotline for reporting of potential fraud.
- Paid Claims Review by Provider Relations and QI staff to determine patterns or trends.
- To comply with the Federal Deficit Reduction Act's false claims recovery process, the LME developed and follows specific written policies. See **Attachment 27**.

Facilities and Organization
(Limit to 5 pages)
The LME shall have facilities and an organizational structure that is sufficient to support the operations of the waiver program.
☐☐ Identify the main place of business of the waiver entity where the majority of services described in the RFA will be provided. If there are multiple sites, describe the functions at each site and the approach to coordination of requirements specified in the RFA.
The Administrative Offices of the Mecklenburg LME are located at 429 Billingsley Road (Charlotte, NC 28211). The Utilization Management Division, Medical Director and Customer Service Center (MeckLINK) are located on the same campus at 3500 Ellington Street (Charlotte, NC 28211). Because these offices are located on the same campus, coordination to meet the requirements of the RFA is not restricted by distance. To ensure coordination, Mecklenburg LME engages in the following regular communication steps:

- The LME Senior Management team meets weekly. This meeting includes Directors of UM, Provider Network Management, Finance, IT, QI, the Deputy Director, the Executive Director of the LME, and Medical and Clinical Directors and representatives of County Legal and Public Service and Information Departments.
- Senior leaders have an "open door" policy so that all staff can approach them at any time with questions, issues, improvement ideas, etc.
- Quarterly LME-wide staff meetings are held.
- Monthly internal newsletters are published.

☐☐ Submit an organizational chart to demonstrate that the LME meets the clinical, administrative and financial management positions required to perform the functions of the contract as specified below:
☐☐ One full time medical director holding an unencumbered North Carolina medical license and who is board certified in psychiatry.
☐☐ One full time contract manager with a minimum of at least seven years of management experience preferably in human service that will act as the primary contact to DHHS.
☐☐ One full time director of management information systems with a minimum of two years experience in data management for health care.
☐☐ One full time utilization review director that is a clinician licensed in North Carolina and has a minimum of five years utilization review and management experience in mental health, developmental disabilities and substance abuse care.
☐☐ One full time quality management director that is preferably a licensed clinician with at least five years recent quality management experience and two years managed care experience or experience in mental health, developmental disabilities and substance abuse care.
☐☐ One full time customer services director with at least 5 years combined customer service, clinical and management experience.
☐☐ One full time provider network director that is a licensed clinician that has at least five years combined clinical, network operations, provider relations and management experience.
☐☐ One full time finance director with at least 7 years experience managing progressively larger budgets

Please see the following organization chart:



Mecklenburg LME acknowledges our contract requirement to notify DMA in writing of any changes in key personnel.

☐☐ For each position, attach current resume / curricula vitae, or documentation sufficient to evidence education and experience pertinent to the position.

Please see **Attachment 28** for current resumes or curricula vitae for each required waiver position, with the exception of the Clinical Director (proposed for the Waiver) and the Provider Network Director, which are currently vacant/proposed positions.

☐☐ For staff not yet hired, attach a job description with minimum requirements of the position.

Please see **Attachment 29** for the Clinical Director and the Provider Network Director Job description.

☐☐ Describe the LME's plan to hire or otherwise include consumers and family members in daily operations.

Consumer and Family Advisory Committee

Mecklenburg LME was the first in the state to have a fully functioning Consumer and Family Advisory Committee (CFAC) in 2002. Our CFAC developed their own set of By-Laws (later used as a prototype by other developing CFACs), and immediately set to work on participating and helping to create the LME's first business plan, and on developing policies specific to Consumer Choice and to the Request for Proposal (RFP) process. They have been active since then, setting the standard and expectation for the LME and the community that consumers play a valuable role in the day to day operation of the LME, as well as the in the day to day operation of the provider agencies. The Chair of CFAC is a member of the LME's Quality Management Committee, and is a member of the Provider Council's Executive Board. Below are additional CFAC activities:

- CFAC members have been directly involved in Mystery Shopper activities on the First Responder system. Agencies that do not have correct response systems in place are then documented and the LME provider relations staff follow through with issuing Plans of Correction for those agencies.
- CFAC members developed the Provider Performance Report, a 4 star rating system, to provide consumers and family members with information that will assist them in making informed decisions when choosing a provider.
- CFAC members are active in planning, organizing, and participating in the LME's quarterly InfoShare meetings with the community of providers.

In addition to the participation of CFAC members, consumers are members of the LME's Community Advisory Committee and bring the self-advocacy and peer support perspective to all discussions and decisions made by that committee.

Consumers and family members attend and participate on all of the LME's best practice committees, i.e., System of Care Gaps Committee, DD Self Determination Best Practice Committee, the Mental Health Best Practice Committee, and the Substance Abuse Best Practice Committee.

Consumers participate in a variety of feedback sessions on assessing community needs, for example, 6 forums were held between January-March 2009 as part of the LME's annual community needs assessment.

Consumers also participate in a variety of focus groups, on an average of 5-6 per year on topics such as the Consumer Handbook, the LME's website design and content of information, marketing and outreach to increase penetration rates, communication strategies to increase awareness of services and the actual development of marketing materials and video presentations.

Consumers are well represented on the Community Collaborative helping to implement systems of care county wide.

Employment First Initiative
The Mecklenburg LME has been a key player in the development of a community wide initiative called Employment First. The following is the vision statement and basic guiding principles of the initiative:

<u>The Vision</u>
The Community values and actively promotes employment as the first priority and preferred outcome for all working-age youth and adults with disabilities.

The "Employment First" Initiative in Mecklenburg County means –

- The Community expects, encourages, provides and supports integrated employment in the workforce of people with disabilities.
- All categories - physical, intellectual and developmental disabilities, mental health and substance abuse disabilities are included.
- This encompasses those with complex and significant disabilities, for whom job placement in the past has been limited, or has not traditionally occurred.
- Prioritization will be on effectively transitioning young adults with disabilities from school into the workforce or into continuing education that will enhance future employment opportunities.
- Individuals receiving publicly funded services will be expected to consider employment or employment enhancing education as the first option in their recovery or self-determination plans.
- Public agencies that provide employment services for individuals with disabilities will adopt an individualized placement and support philosophy.

Hiring Practices
The Mecklenburg LME intends to operationalize these principles in its hiring practices and is working with County Human Resources to integrate appropriate procedures that promote the hiring of individuals with disabilities. Mecklenburg County is also a member of the Charlotte Business Leadership Network (BLN) which is a chapter of the National Business Leadership Network. BLN membership is comprised of employers whose sole purpose is to educate and promote businesses hiring individuals with disabilities.

Health Information System
(Limit to 5 pages)
- Describe the LME's management information system and submit documentation to support items listed in section 7.9 of the contract pertaining to the required Health Information System. Recommended items include system flow charts, policies and procedures, reports, training manuals and any other information that demonstrates the LME's capabilities.
- Describe the LME's automated management information system and submit documentation that it is capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission, provider access to check the status of their service authorization requests, claims submission and claims payment status.

The LME utilizes an electronic health information system to record and facilitate all managed behavioral healthcare functions. The LME implemented eCura, a proprietary product of InfoMC of Philadelphia, PA, on October 1, 2004. The LME has a dedicated team of software business analysts whose only role is to support eCura and related data processes. Other traditional information technology services, such as network services, help desk, security, server maintenance, desktop services, back-up and recovery, procurement, etc. are provided by Mecklenburg County Information Services and Technology Department. Each LME staff member is provided with a computer and is required to use the electronic system for all work functions.

ECura is a Fox Pro database (InfoMC, the eCura vendor, has already implemented an upgrade to eCura that is a .net application and moves most modules out of Fox Pro) with a graphic user interface layer upon that. The LME software team has full access to the database and can not only pull information out for reports but can insert or upload data at any time. The software team communicates regularly with the vendor to evaluate all known issues, upcoming patches or upgrades, and makes decisions as to which upgrades to consider for testing. Audit tables and time stamps allow the system administrator to identify all changes to any fields (inserts, edits, most recent change.) In addition, this team has reduced vendor dependency and has developed HIPAA sets such as an outgoing 834 and an outgoing 837 file. The LME can add unique forms to collect a variety of data types and make these forms available to providers in order to collect data directly from them.

Information system components include:

- **Contact Tracking:** This subsystem is designed specifically for call center functions and is currently in use by the LME Call Center MeckLINK. Member demographic information is stored and then, upon referral, electronically transferred into the main eCura Membership subsystem.
- **Messaging:** This system allows the LME and providers to send messages back and forth, and for providers to message each other in a secure FTP setting.
- **Membership:** This subsystem stores member demographic information as well as insurance and eligibility information. This subsystem stores commercial insurance coverage that must be taken into account during coordination of benefits functions (third party liability). The LME software team can upload membership eligibility files. ECura has in place functionality to "hide" members from any staff other than managers if and when that member is an employee or the relative of an employee.
- **Relationship Manager:** This subsystem stores provider information, including addresses, sites, key staff figures, specialties, etc. This information is utilized by MeckLINK when searching for provider options for members. This subsystem also stores contract terms, or "agreements." These agreements are referenced during the processing of both authorizations and claims.
- **Clinical:** The clinical subsystem stores all authorization activity and holds a function known as a "stoplight" or provider search for Call Center queries. Each authorization is stored with service code,

modifiers, units, ICD-9 diagnosis, start date, end date, etc. Edits are in place to prevent duplicate authorizations or the approval of units beyond a specified benefit plan.

- **Maintenance:** The system administrator utilizes this subsystem to maintain key functions such as user roles, key tables, etc. Users are established only after Human Resources verification of employment in the LME and are assigned to specific user roles with appropriate security.
- **Claims:** Providers can submit electronic claims via manual entry or via an 837 file. Those claims are processed in three steps. First, the 837 file is checked for format and is automatically returned to the provider in the event of a failure on format. This takes place with no manual intervention by the LME, though the LME provides technical assistance in this situation. For claims that pass on format, a matching step is next – evaluating claims to be sure that the enrollee in the claim is in eCura and that an authorization is in place. Providers can view exception reports at this level via PR Web (explained later) down to the claim level. Exceptions are evaluated and acted upon by the LME (update contract terms, resolve demographic information disputes, etc. The third step is adjudication of claims (pay, pend, or deny.) Providers can see the results of adjudication by checking the claim status in Provider Connect (below). An 835 file is produced for providers who submit 837's and it is distributed via Provider Connect. As of March 2010 over 80% of the dollars paid to providers come to the LME in the form of an 837 and roughly 50% of all network providers submit 837 files. Accounts Payable staff can adjust claims, post payment or post denial in a process known as "reversion." Reversions are illustrated in all reports and are accounted for in payments and adjustments. The LME has the ability to prevent the issue of any further authorizations or the payment of any more claims when a contract or agreement amount has been reached. This internal control assures that no contract amount is surpassed. This can be adjusted by the LME at any time (adding dollars to a contract). Authorizations are continually adjusted via an electronic feedback loop from providers so that amounts authorized are accurate. Accounts payable staff measures all claims processing functions for prompt payment and continually conduct analysis on root causes related to any variance. The LME's information system has the ability to store all third party resources as part of the coordination of benefits module. The application allows the LME to decide, per third party resource, whether to pend, deny or approve claims when the claim is received with no information about what the third party has paid.
- **Other HIPAA Sets:** The LME has the capacity to utilize other HIPAA transaction sets, such as the 270/271 (eligibility inquiry and response), 276/277 (claim inquiry and response), 278 (authorization) when necessary.
- **Provider Connect**: This is a web-based portal through which network providers conduct business with the LME. Based in a secure FTP site, Provider Connect allows network providers to verify member status, submit authorization requests, submit claims (manual electronic or 837 file upload), check the status of any authorization or claim, view claims that are edited out prior to adjudication due to matching errors, see 837 files that could not be imported due to format errors, etc. Passwords are changed each quarter for security purposes and are only sent to the agency director for distribution.
- **Terminal Server:** This internal server is used to allow staff access to eCura from any remote site. With internet access and secure login and password staff can utilize eCura as if they are at the office. The LME will provide the NC DMA and DMH access to eCura in this fashion. No functionality is lost with this type of access and the user is seeing the system in real time.
- **AMH Web:** This is a data report warehouse used by LME staff. Over 40 reports reside in this system, which pulls day-old data from eCura and other sources. Reports address general data query requests as well as specific work functions such as exception reports, prompt payment time frames, data queries to create CDW submissions, etc. Report samples can be provided upon request.

The tools for launching and analyzing outgoing 834 and 837 files, CDW submissions, are stored in the system. Specialized financial reports illustrate exact amounts of all claims paid by provider, service and

fund type. Reports in this warehouse also illustrate all incurred or authorized services by member, service, provider, fund source, and site to number of units and dollars to the penny. Reports exist to analyze claims payment processing time, Value Options authorization and Medicaid paid claims data, MeckLINK staff productivity and other key indicators. These reports are used during a weekly budget meeting where managers evaluate service utilization and budgets. The software team in conjunction with the county information services and technology department can expand this warehouse to meet any reporting need. All staff have access to the warehouse on a continuous basis from their desktops or remotely via Terminal Server.

PR Web: This is a data report warehouse used by providers. With a login and password, a network provider can access reports describing authorization letters, the status of submitted 837 files, paid claim totals by service and fund source, etc. This warehouse complements Provider Connect.

- **Ad Hoc Report Capabilities:** Aside from the above warehouses, the software team writes and prepares ad hoc reports on a daily basis. For example, the LME CFAC requests summaries of paid claims by provider and service in order to evaluate the network. If approved for a Medicaid Waiver, the LME would set up a data warehouse specifically for NC DMA and DHS staff to log into to obtain on a 24/7/365 basis the desired reports via a secure login. The software team uses Crystal Reporting, structured query language, and Microsoft Access. The team is evaluating Microsoft Reporting Services at this time.
- **Custom Databases:** Within AMH Web the software team in conjunction with the county information and services technology department can create small custom databases in order to accomplish two goals: "stay off paper" and minimize ancillary databases that are in Excel or Access formats and that exist only on individual workstations or home drives.

As stated above, contract providers can submit authorization requests and claims to the LME via Provider Connect. The LME then submits the status of those adjudication functions. PR Web makes data viewable to providers via reports. The LME submits data to NC DMA and DMH via established FTP protocols and uses the same feature to obtain data from the state (Medicaid paid claims, Value Options authorizations). Data can be formatted to a flat file, Excel file, Access database or any other format desired.

The Mecklenburg County Information Services and Technology Department conducts all server and data backup functions and conducts annual testing with reports showing all standard metrics. ECura is completely backed up on a weekly basis, though an image can be captured at any moment if the system were to become unavailable. A contracted server hosting agreement is in place, all servers being hosted off site in a secure setting. The data backup site is outside Mecklenburg County. A disaster recovery test took place on March 16, 2010 and the results are forthcoming.

Upcoming Developments: Managers within the LME have expressed a desire for a number of functions and the software team is on track to provide them effective 7/1/2010 as ongoing effort to make eCura support the business.

- **Add Member:** Providers will have the ability to type Screening, Triage and Referral and Admission forms directly into Provider Connect and, after a review by LME staff that data will migrate directly in to eCura. The Mecklenburg Provider Council has also expressed a desire for this, which would eliminate paper faxing.
- **Batch Claim Processing:** To reduce staff time needed in the claims matching process, multiple batches will be selected rather than one batch at a time.
- **Simplified Claim Form:** A claim form that is contingent upon current authorizations will be implemented so that providers who manually enter claims can no longer enter the authorization

number on the claim but simply select the correct authorization from a drop-down menu of all authorizations, including service, date range, and units.

Efforts to Support Data Integrity

Searching and Prevention of Duplicate Member Entry: Search functions can take place by last name or first name, or social security number or by date of birth. The search results list meeting those criteria gives the user, twelve (12) identifying criteria to check, including gender, age, race, language, etc. The system electronically prevents the creation of a social security number that already exists in the database, the only exception being a social security number consisting of all zero's in order to allow the entry of a member with no such number. File merge is an electronic tool that can resolve duplicate member files.

Field Formats: Fields have been pre-set to accept only certain data formats. Examples include date fields, time fields, zip code fields, check boxes, numeric fields, view-only fields, fields with variable characters allowed only when necessary, look-up options, and drop down menus. Before a new field is allowed to accept typed information a drop down menu or validation list is first considered and deemed to not meet the business need of the organization.

Required Fields: This is common in the LME database, eCura. For example, in the main member face sheet or Membership screen, of the 49 fields referenced in the previous section, only 3 can be left blank before a new member is considered added to the system (Hide Member Checkbox, Additional ID#, and HIPAA Subscriber ID) - as these three fields may not apply to the new member. In forms that are created by the LME's eCura System Administrator, the option exists to make fields required.

Exception Reports

An array of exception reports are in place at pre-data submission points and at post-data submission points. Managers communicate needs for additional reports to IT system administrators through a report request process.

Pre-Submission Reports

Consumer Data Warehouse Pre-Submission: Prior to the submission of an electronic member file to the CDW, the LME conducts exception checks. Staff can check this report at any time. Corrections and adjustments are made so that the member file does not appear on this report in the future and is therefore available for submission.

837-Out Exceptions: Prior to the LME creating and sending an 837 billing file to state fund sources, an exception report provides the Accounts Receivable manager with exceptions and errors that would have resulted in a claim denial.

Post-Submission Reports

Financial Services: A number of reports are used in LME Web to track claim adjudication performance by the LME. The LME is contractually required to pay "clean" claims promptly – with specific time frames determined. Several of the reports are used to track those time frames and the claims that are "sitting" and for how long.

Please see **Attachment 30** for additional documentation support items listed in section 7.9 of the contract Supporting Documentation.

Security of protected information is a vital component of our service to enrollees. Therefore, we are committed to complying with 45 CFR §§164.304 - 31842 requirements for administrative, physical, and technical safeguards to protect health data, 45 CFR §164.308 regarding rules for conducting risk analysis and risk management activities, 45 CFR 164.308(a) (5) requirements for security awareness training and 45 CFR §164.308(a) (6) requirements to have security incident identification, response, mitigation and documentation procedures in place.

☐ Describe the LME's ability to work with DHHS to test and implement a health information system in conjunction with the Provider Network for the collection and reporting of consumer health record information.

The LME maintains test and training environments for eCura. This allows for extensive evaluation of a wide variety of scenarios, patches, upgrades, etc. Contract providers can log into the test version of Provider Connect once identified and set up to participate in any and all testing of new functions. These processes can be applied to a variety of tasks – such as being sure that the consumer record is complete, that new fields are in place, that new reports are pulling those fields, that basic functions are working correctly (authorizations, claim entry and adjudication, etc.), etc. It is typical for the Mecklenburg LME to apply project management principles to all testing of new functions. Staff of NC DHHS can be apprised of all testing activities and results. As required by the contract, DHHS staff may be given access to log into eCura and Provider Connect to view, participate, and check on all functions.

Records
(Limit to 5 pages)
The LME shall assure that the standards for the establishment, maintenance and retention/disposition of clinical care records by the LME and network providers are met according to the Records Management and Documentation Manual (APSM 45-2) and the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3) and any ensuing updates thereof. The LME shall maintain all LME Administrative Records and other service management records in accordance with APSM 45-2 and APSM 10-3 and the terms of the DMA Contract and with all specifications for record keeping established by DMA for purposes of audit and program management. Where there are inconsistencies, the more stringent standard applies.
Clinical Records:
☐☐ Describe the content of records the LME maintains for providers, including consumer records.
Mecklenburg LME will require our network providers to maintain clinical records that meet the requirements in the NC DHHS documents captioned Records Management and Documentation Manual for Providers (APSM 45-2) and Rules for MH/DD/SAS Facilities and Services (APSM 30-1) and in the Basic Medicaid Billing Guide. Medical Records will be maintained and controlled by the providers and therefore, enrollees may have more than one record if they receive services from more than one provider. We will monitor Medical Record documentation to ensure that the standards are met. The LME shall have the right to inspect Provider records without prior notice. Mecklenburg LME's Network Provider contracts will require providers to transfer original medical records to Mecklenburg LME in the event that the provider closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state, or any other reason.

The LME information system (eCura) contains an extensive data set at the consumer or enrollee level. In order to conduct business with the LME providers must have access to a certain amount of that information. This is provided via Provider Connect, the secure web interface tool that is connected to the eCura database. Providers can view general data (name, etc.) but can only view authorization and claim data that they submitted.

Provider Connect Secure Login			Secure Internet Login
Membership Subsystem	**Clinical Subsystem**	**Claims Subsystem**	**Provider Web**
Last Name	Authorization Number	Claim Status	IPRS Eligibility Verification
First Name	Auth Service Code	Claim Amount	837 Status
Sex	Auth Service Description	Paid Amount	Claim Exception Report
Birth Date	Auth Service Modifier(s)	Denied Amount	Authorization Letters
Age	Auth Start	Denial Reason	Contract Terms (Agreements)
SS#	Auth End	Claim Number	Authorization Report
Religion	Auth Site	Claim Diagnosis	Paid Claims by Service
System ID	UM Staff Authorizing	Clean Claim Date	Paid Claims Summary
Race	Auth Status	Service Category	
Language 1	Units Authorized	Provider Claim ID	
Language 2	View Completed Forms	Claim Received Date	

Provider Connect Secure Login			Secure Internet Login
Membership Subsystem	**Clinical Subsystem**	**Claims Subsystem**	**Provider Web**
Ethnicity	Service Frequency Parameter		
Address			
Home Phone			
Work Phone			
Marital			
School			
Grade			
Insurer or Fund Source			
Funding Date Span			
Diagnosis			
Target Pop or Benefit Plan			
Guardian Information			
Alias Names			

☐☐ Prepare for an on site review of LME records that demonstrate the process of authorizations and how medical necessity is documented.

Mecklenburg LME will maintain our service management records in accordance with DMA contract section 8.1 rules regarding content and length of retention and will be prepared for an on-site review of records.

☐☐ Describe how the LME meets the requirement to maintain LME service management records according to APSM 45-2 and APSM 10-3.

Mecklenburg LME will maintain the Service Management Records in compliance with applicable APSM 45-2 and APSM 10-3. Additionally, the LME will maintain the Service Management Records in accordance with the terms of the DMA Contract and with all specifications for record keeping established by DMA for purposes of audit and program management. All books and records will be maintained to the extent and in such detail as shall properly reflect each service provided. The LME will maintain records in an electronic format. The LME will maintain all data elements as required by Section 8 of the DMA contract. This information is maintained in eCura.

☐☐ Describe how the LME assures that providers maintain records in accordance with State policies.

Mecklenburg LME Provider Relations staff will audit a random sample of provider records on an annual basis as part of our network quality assurance activities. In addition to this random sampling methodology, Mecklenburg LME has the right to access and audit provider records at any time. Any provider who does not meet standards will be asked to submit a corrective action plan which Mecklenburg Network and Quality staff will jointly monitor. The corrective action will remain in place until Mecklenburg LME is confident that the provider's documentation processes and products are fully compliant.

☐☐ Describe how the LME assists providers in maintaining adequate consumer records and provide evidence in 3 pages or less.

Mecklenburg LME's Provider Relations staff are here to provide monitoring and technical assistance for compliance with contractual and agreement requirements. Mecklenburg LME will assist providers in maintaining adequate enrollee records in the following ways:

- Provider contracts include specifications regarding enrollee record documentation.
- The provider manual includes a section with specifications regarding enrollee record documentation.
- Provider training sessions are held on a routine basis to provide technical assistance on documentation standards.
- Our website includes a provider training calendar.
- Online training is available to our providers 24 hours a day, 365 days a year at our website.
- Online information updates such as "Hot Sheets" can be used to remind providers of documentation standards.

Please see the following excerpt from our provider manual, which shows a link to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services "Manuals and Forms" page. Referencing this page allows us to direct providers to the most updated set of APSM 45-2 and APSM 10-3 requirements, rather than including printed requirements which might become outdated over time.

Excerpt from page 8 of our Provider Manual:

SECTION II

State and Federal Requirements and Policies with Access Information

The chart below serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement and Article I, Section 1.1 of the State Contract. These documents change based on legislative action, change in federal and state policy, and state procedures.

There is a mutual responsibility for Providers and LME's to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if an LME has concerns about how a change will be implemented, then the LME shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the LME for information.

If a Provider has problems obtaining or understanding the information referenced in this section, please contact the LME Provider Relations and Support Service Analyst.

REQUIREMENT	SUGGESTED CONTACTS
APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) **APSM 45-1** (Confidentiality) **APSM 45-2** (Service Record Manual) **APSM 45-2a** (Service Records Resource Manual) **APSM 95-2** (Client Rights) **APSM 10-3** (Records Retention and Disposition Schedule) **APSM 75-1** (Area Programs Budget Procedures Manual) 45 CFR Part 2 & 164 (HIPAA Standards for Privacy and Security of Health Information)	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699-3001 (919) 733-7011
CAP-MR/DD Manual – (CAP Providers and Core Competencies Training Requirements for MR/MI service providers)	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699-3011 (919) 733-7011
Medicaid-Related Documents	DMH MH/DD/SAS

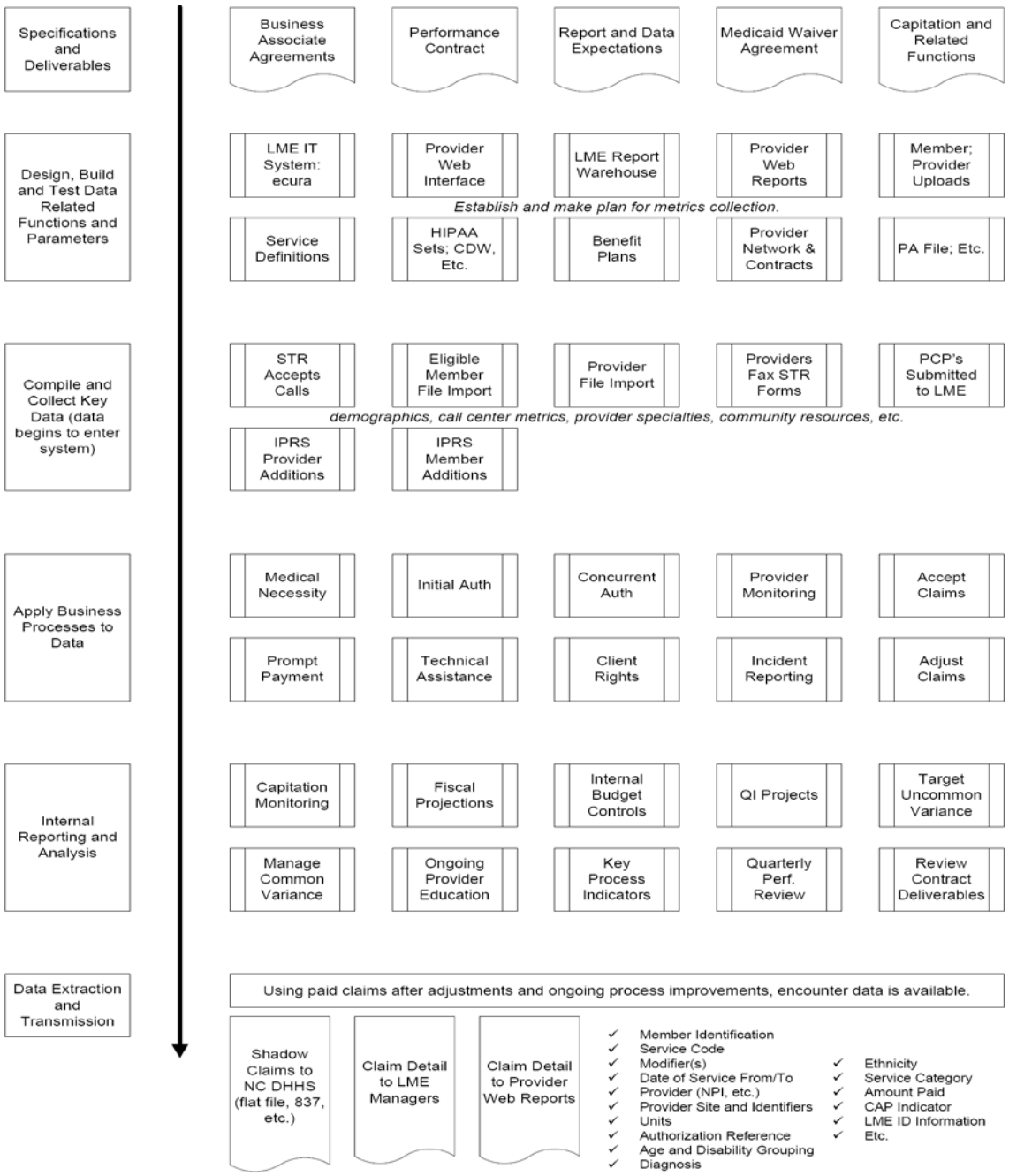
REQUIREMENT	SUGGESTED CONTACTS
Medicaid-covered services definitions Medicaid Services Guidelines Medicaid Communiqués	3001 Mail Service Center, Raleigh, NC 27699-3011 (919) 733-7011 or (919) 851-8888
Substance Abuse Services Cluster Requirements	DMH MH/DD/SAS 3021 Mail Service Center, Raleigh, NC 27699-3021
Health Care Personnel Registry	2709 Mail Service Center, Raleigh, NC 27699 (919) 855-3968
SB 163- Monitoring of Providers	
Endorsement Policy and Procedures	DMH MH/DD/SAS 3001 Mail Service Center, Raleigh, NC 27699 (919) 733-7011

Included below is an excerpt from our provider contract regarding enrollee record requirements: Service Record Compliance for Providers. Provider shall maintain a Service Record for each individual served in accordance with the Service Records standards set forth by State or federal law, Division's regulation or DHHS policy. The original Service Record related to services provided in accordance with this Contract shall be accessible for review for the purpose of monitoring services rendered, financial audits by third party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by the LME and by State and Federal law, regulation and policy. If for any reason Provider can no longer maintain the Service Record, Provider will contact the LME staff member responsible for Service Records to facilitate resolution. Upon request, Provider shall provide data about individuals for the research and study to the LME as permitted or required by DHHS and applicable Federal law. Upon request, Provider shall provide Service Records information about consumers referred by the LME for Quality Assurance and Utilization Management purposes of the LME.

Please see a screen shot of our website showing provider Hot Sheets, which can be used to remind providers of documentation standards.

Website Screen Shot:

Encounter Data and Claims
(Limit 3 pages, excluding attachments)
The LME shall report encounters for all services provided.
The LME shall provide as documentation a pictorial system flow of the process for creating encounter data. LME should include policies and procedures, reports and user documentation that are used in the encounter data process.
Please see **Attachment 31**.
Please also see the following system flow chart:



☐☐ Describe and provide supporting documentation for creating and transmitting encounter data to DMA using the current HIPAA compliant 837 transaction format via secure FTP (File Transfer Protocol)
Currently, the LME submits encounter data (claims) to DMA and DMH only after services provider claims have been approved and payment has been made to the service provider. Each night, approved claims are copied to a database to prepare the claims for submission to DMA and DMH. The current HIPAA complaint 837 transaction is used. In the event DMA or DMH makes changes in the format requirements, the 837 format is updated and tested. All 837 files are saved to a folder on a network directory. Secure FX, the HIPAA compliant software provided by DMA to transmit the 837 file to the DMA and DMH is used to upload the files. This is a secure FTP site. Each 837 file is placed in the "in" folder for transmission. An EDI number is provided in the "out" folder as confirmation of receipt. EDI data denotes if the file is approved or not. The file is error-free if the EDI file reveals an AK9*A at which point it is approved and is submitted to payer for processing. Any other file number is researched for errors and re-submitted for processing. Contact is made with Provider Services, EDS or HP to seek help in reviewing the file for errors.

AMH Web is also used to download the 835, to provide a history of claims generated for the 837 and includes reports for posting revenue, denied claims and paid claims. The provider and practitioner set-up for billing numbers, NPI and taxonomy information is also maintained in this area. Please see **Attachment 32**.

☐☐ Describe and provide supporting documentation for reconciling any and all errors found during encounter claim processing by DMA's fiscal agent.
Mecklenburg submits 837 claim files daily to the state through Secure FX, the software provided by the state to transmit claims to DMA's fiscal agent securely. When a claim error occurs in which the fiscal agent cannot process the claim, reports are returned to the LME via email and postal mail to the LME's post office box. All errors returned by the fiscal agent are researched by the LME's Billing and Reimbursement unit. As batches are submitted to the fiscal agent, an out file is generated in Secure FX. This out file indicates whether or not the batch is accepted. When a batch has errors, the LME reviews the error, identifies the cause, and resubmits the batch once corrected. If necessary the LME contacts the fiscal agent to assist with determining the cause of the error.

Currently, the most common error is "NPI unknown." Please see **Attachment 33**. The claim is researched in the LME's software system to determine the consumer and the provider or practitioner with the unmatched NPI number. The correct NPI number is researched in the NC DMA NPI Address Database. If it appears the provider submitted the incorrect identification number, the provider is contacted to obtain the correct information. The correct NPI is then entered into the LME's software system and the claim is regenerated and sent to the fiscal agent.

☐☐ Submit written policies and procedures that have been formally adopted by the LME for ensuing system recoverability both for LME information systems and for those of subcontractors.
Please see **Attachment 34** for policies and procedures regarding system recoverability.

☐☐ Submit written policies and procedures that have been formally adopted by the LME for providing primary and backup system for electronic submission of data to DMA and DMH/DD/SAS.
Each HIPAA file generated and submitted to DMA and DMA/DD/SAS is saved and backed up. Those files are available for review at any time in the future. The HIPAA sets (834, 837) were developed internally and are queried from eCura, the LME's information system. LME IT staff, therefore, have the ability to modify these data files and address issues quickly when required changes are announced. In the event that eCura became unavailable for any reason the disaster recovery plan allows for an eCura backup

to be utilized on a different server in order to generate the above data files. Upon resumption of eCura data entry the file transmission process would resume as normal, with no gaps in consumer data transmission. Please see **Attachment 34** for the LME Policy and Procedures IT Disaster Recover Plan and **Attachment 35** for the IT Support of LME Business.

☐☐ Submit written policies and procedures that have been formally adopted by the LME that address how LME information systems are used for utilization review and resource management.

Please see **Attachment 35** for policies and procedures regarding use of information systems for utilization review and resource management.

☐☐ Provide a description of internal controls regarding fraud and abuse.

The following internal controls are in place regarding fraud and abuse:

- Access to the IT systems is limited to need to know information. Employees are given account names and passwords by IT staff upon written request from supervisors. The supervisor must specify level of access to the individual software and application. Confidentiality, privacy and security of confidential information are part of New Employee Orientation and annual mandatory inservice training requirements. All LME desktops and laptops are configured with password protected screen savers, initiated after ten minutes of inactivity. The 10 minute duration prior to screen lock can be adjusted to any duration for both laptops and desktops. Users do not have sufficient security access to modify this duration.
- Written requirements are in place for the various accounting procedures. As a department of Mecklenburg County, the LME utilizes the County's financial policies and procedures as well as LME specific policies and procedures on how the LME will carry out Mecklenburg County's policies and procedures.
- There is a separation of duties for all transactions including contracting, accounts payable and accounts receivable. Contracts are prepared by Provider Relations staff. Payments are prepared by front line LME Financial Services Staff and approved by the supervisor and also by Mecklenburg County Finance Staff.
- The claims adjudication process is automated in the eCura system. Edits include but are not limited to: enrollee match, provider authorized to perform the service, duplicate claim, unauthorized units, date of service authorized and maximum units per day.
- The LME has comprehensive desk procedures for claims processing. Each provider is assigned to a Financial Services staff member, who is familiar with the services and billing patterns. Claims data is reviewed weekly and any unusual increases or decreases are researched.
- To comply with the Federal Deficit Reduction Act's false claims recovery process, the LME has a formal policy in place **Attachment 36**.

☐ Provide copies of submission reports that are generated during the encounter submission process, both from subcontractors to the LME and from the LME to DMA and DMH/DD/SAS.

Please see **Attachment 37** for copies of submission reports.

☐☐ Provide copies of enrollment and eligibility reports that demonstrate accurate receipt, processing and reconciliation.

Please see **Attachment 38** for copies of enrollment and eligibility reports.

Financial Reporting Requirements
(Limit to 5 pages excluding the financial statements)
The LME shall submit financial reports that are timely, accurate, and complete.
☐☐ Provide a description of the LME's accounting and information system and the LME's ability to implement changes in reporting requirements or provide ad-hoc data requests as required by DMA.

The LME utilizes AMS Advantage for our accounting system needs. This system is a Web-based product that is scalable and has layers of flexibility. The following is a list of some of the software's capabilities.

- Includes a detailed chart of accounts with coding capabilities for tracking/ segregating revenue sources and their corresponding expenses.
- Accounting line setup can include the funding source, program, organization, function, location, object, grant, and project structures.
- The software is fund and program accounting compliant.
- It includes encumbrance, pre-encumbrance accounting functions.
- Can easily develop reports that are in accordance with GAAP and the current GASB pronouncement.
- Facilitates the control and monitoring of spending by producing up-to-date data regarding departmental budgets and balances.
- Capacity for multiple bases of accounting (accrual, modified accrual, or cash).
- Contract management tracking and reporting.
- Multiple levels of approval for transaction processing to ensure internal control.
- Report building and development through Business Objects allow for ad-hoc reporting.
- Electronic funds transfer capability.

The information system the LME utilizes for managing claims and enrollee data is the eCura Information System. The following list summarizes the software's functionality:

- Incorporates clinical, administrative, provider, authorization, claims, and billing data into one information management system.
- It is a flexible relational database architecture that can be adjusted to meet changing business requirements via table set up.
- Billing and claim information for services is stored and tracked by disability, age, and funding source.
- Generates reports on provider payables that are transferred to the Advantage accounting system.

☐☐ Provide a copy of the LME's most current annual audit.

Please see the tab marked "Annual Financial Audits" in the three binders labeled "Financial Status and Viability Information." Please note that the LME is a single county operation and is integrated into the Mecklenburg County annual audit.

☐☐ Provide the LME's Current Ratio = current assets / current liabilities.

	Fiscal 2009
Current and other assets	$607,915,000
Current and other liabilities	$104,580,000
Current Ratio = current assets divided by current liabilities	5.82

Source:
CAFR 2009–Management's Discussion & Analysis; Government Activities column, Page 5

☐☐ Provide the LME's Defensive Interval = (cash + cash equivalents) / (operating expense - non-cash expense) / (period being measured in days)).

		Fiscal 2009
A	**Cash & cash equivalents - CAFR 2009; Page 13**	$462,835,772
B	**Operating expenses – CAFR 2009; Page 14**	$1,541,862,467
C	**Non-Cash expense – CAFR 2009; Page 13**	$102,610,502
	A divided by (B-C) divided by 365 days	.32

Source:
CAFR 2009–Management's Discussion & Analysis; Government Activities

☐☐ Describe the LME's process for certifying financial records submitted as reports.

Per 42 CFR §438.606, Mecklenburg LME shall certify all financial records submitted to DHHS as reports. Certification will attest that, to the best of the certifier's knowledge, information and belief, the data is accurate, complete and true. Data certifications will be delivered concurrently with reports.

LME financial reports are prepared by a Senior Fiscal Analyst. The AMH Senior Fiscal Administrator (LME Finance Officer) reviews the report by reconciling the financial information on the report to the supporting documentation from the Advantage ledger. If required, the report is reviewed and signed by the Area Director. Reports that require Board Chair approval are forwarded to County Finance for final review and signatures of the Director of Finance and the Chairman of the Board of County Commissioners.

Clinical Reporting Requirements
(Limit to 3 pages)
The LME shall have a clinical reporting system that includes reports on utilization data, on performance measurements and on performance improvement projects sufficient to manage and improve services to enrollees.
□□ Describe how the management information system used by the LME creates clinical reports and explain the process for making changes to meet new reporting requirements.
The LME utilizes an electronic health information system to record and facilitate all managed behavioral healthcare functions. The LME implemented eCura, a proprietary product of InfoMC of Philadelphia, PA, on October 1, 2004. The LME has a dedicated team of software business analysts whose only role is to support eCura and related data processes. Other traditional information technology services, such as network services, help desk, security, server maintenance, desktop services, back-up and recovery, procurement, etc. are provided by Mecklenburg County Information Services and Technology Department. Each LME staff member is provided with a computer and is required to use the electronic system for all work functions.

ECura is a Fox Pro database (currently upgrading to .net) with a graphic user interface layer upon that. The LME software team has full access to the database and can not only pull information out for reports but can insert or upload data at any time. The software team communicates regularly with the vendor to evaluate all known issues, upcoming patches or upgrades, and makes decisions as to which upgrades to consider for testing. Audit tables and time stamps allow the system administrator to identify any and all changes to any fields (inserts, edits, most recent change). In addition, this team has reduced vendor dependency and has developed HIPAA sets such as an outgoing 834 and an outgoing 837 file. The LME can add unique forms to collect a variety of data types and make these forms available to providers in order to collect data directly from them.

Ad Hoc Report Capabilities
Both IT and QI staff have capability to create ad hoc queries and reports. For example, the LME CFAC requests summaries of paid claims by provider and service in order to evaluate the network and the system. The QI's Outcomes Information Manager supports the QM program and the LME Management by providing weekly and monthly reports. Some of the reports address payment, contract and budget discussions. Other reports are integral to performance monitoring and quality improvement activities. For example, post hospital follow up is an important measure of clinical quality.

If approved for a Medicaid Waiver, the LME would set up a data warehouse specifically for NC DMA and DHS staff to log into to obtain on a 24/7/365 basis the desired reports via a secure login. The software team uses Crystal Reporting, structured query language, and Microsoft Access. The team is evaluating Microsoft Reporting Services at this time.

Custom Databases
Within AMH Web the software team in conjunction with the county information and services technology department can create small custom databases in order to accomplish two goals: "stay off paper" and minimize ancillary databases that are in Excel or Access formats and that exist only on individual workstations or home drives.

Specialized financial reports illustrate exact amounts of all claims paid by provider, service and fund type. Reports in this warehouse also illustrate all incurred or authorized services by member, service, provider, fund source, and site to number of units and dollars to the penny. Reports exist to analyze claims payment processing time, Value Options authorization and Medicaid paid claims data, MeckLINK staff

productivity and other key indicators. These reports are used during weekly budget meetings where managers evaluate service utilization and budgets. The software team in conjunction with the county information services and technology department can expand this warehouse to meet any reporting need. All staff have access to the warehouse on a continuously from their desktops or remotely via Terminal Server.

☐☐ Describe the LME's enrollee outcomes data collection, tracking and utilization.

The QM Program will use NC TOPPS data at the aggregate and individual levels to assess effectiveness of behavioral health services. Consideration will be given to use of other instruments based on recommendations from the Provider Council. Since 2002, the LME has used responses to the Customer Satisfaction Survey to inform quality improvement needs. Survey items related to cultural competence are aggregated and reported to the Cultural Competence Committee. The overall assessment of Consumer Satisfaction has included results of the annual Survey mandated by DMH, our internal complaints data and feedback from public meetings and CFAC. As more data becomes available, the LME anticipates measurements of specific portions of practice guidelines such as pharmacotherapy.

Fraud and Abuse
(Limit to 3 pages)
The LME shall adopt and implement policies and procedures to guard against fraud and abuse.
☐☐ Describe the process for identifying potential fraud and abuse.

In compliance with 42 CFR §438.608, Mecklenburg LME has in place a Corporate Compliance Plan and has instituted policies and procedures focused on integrity and both on external fraud and abuse detection and detection of fraud and abuse internal to our organization. To comply with the Federal Deficit Reduction Act's false claims recovery process, the LME has a formal policy in place: Policy # CC01 – False Claims Act Compliance Policy. We also have in place Policy # CC02 – Reporting and Investigating Compliance Concerns. Please see **Attachment 39**.

Mecklenburg County Local Management Entity, in compliance with relevant laws, prohibits:

- Knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval;
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government;
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid;
- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
- All employees, management, contractors, and agents of Mecklenburg County Local Management Entity are required to be aware of these laws and are expected to report any issues immediately to supervisors or to the County Attorney's office.
- Mecklenburg County Local Management Entity posts copies of fraud and abuse policies on our intranet site and provides an overview during orientation for new employees.
- Mecklenburg County makes available a copy of our fraud and abuse policies to all contractors, agents, and members of the public via the County's internet website.
- The claims adjudication process is automated in the eCura system. Edits to prevent fraud and abuse include but are not limited to: enrollee match, provider authorized to perform the service, duplicate claim, unauthorized units, date of service authorized and maximum units per day.
- The LME has comprehensive desk procedures for claims processing. Each provider is assigned to a Financial Services staff member, who is familiar with the services and billing patterns. Claims data is reviewed weekly and any unusual increases or decreases are researched.
- Written procedures are in place for the various accounting procedures. As a department of Mecklenburg County, the LME utilizes the County's financial policies and procedures as well as LME specific policies and procedures on how the LME will carry out Mecklenburg County's policies and procedures.
- There is a separation of duties for all transactions including contracting, accounts payable and accounts receivable. Contracts are prepared by Provider Relations staff. Payments are prepared by front line LME Financial Services Staff and approved by the supervisor and also by Mecklenburg County Finance Staff.
- Paid Claims Review by Provider Relations and QI staff will be conducted on random sample by provider agency and type of service.

Compliance Procedures
If any compliance related questions arise, including questions about fraud and abuse, employees are encouraged to first report their concerns to their immediate supervisor. Employees who receive inadequate responses or who are uncomfortable reporting the issue to their supervisor should contact the next appropriate person in the chain-of-command or report their concerns directly to the Compliance

Officer. At any time, employees may contact the Compliance Officer to report concerns or anonymously via the county hotline. Types of violations that should be reported include but are not limited to:

- Billing issues.
- Patient safety.
- Fraud or abuse issues.
- Actual or potential criminal violations.

Upon receiving notification of an allegation, the Compliance Officer will make a preliminary determination of what sets of skills or expertise might be needed for the investigation. Responsibility for conducting the investigation will be determined on a case-by-case basis, with written status and resolution reports provided to the Compliance Officer in accordance with the program's requirements. A summary report detailing the type of allegation and the final disposition of all incidents will be maintained by the Compliance Officer. Upon completion of an investigation, if a corrective action plan is required, the Compliance Officer shall have the responsibility and authority to take appropriate action to address any compliance issues that have been identified. Corrective action plans will be in writing with consultation from the appropriate administrative or clinical senior level official.

Confidentiality regarding employee concerns and problems will be maintained at all times insofar as is legal and practical. Staff who report in good faith will not be subjected to retaliation, harassment, or intimidation as a result of reporting concerns. Reported acts of retaliation, harassment, or intimidation against any individual who is a party to an investigation will be investigated promptly and appropriate corrective action implemented as necessary.

Subcontracts
(Limit to 3 pages)
The LME may enter into subcontracts for the performance of its administrative functions and for the provision of covered services to enrollees. The LME shall obtain DHHS prior written approval before subcontracting any of its administrative or clinical functions.
☐☐ Describe and provide transition plan for implementation of subcontractor function and give a detailed description of the scope of work, along with background reference checks of work performance and credibility of performance.

For any function that Mecklenburg LME subcontracts, a contract agreement and amendments will be in place and will comply with the requirements of 42 CFR §434.6 and 42 CFR §438.6. Currently the LME has a written delegation agreement with two contractors. These agreements have been in place since 2009 and were reviewed by URAC during the accreditation process.

Carolinas HealthCare System, Carolinas Medical Center-Randolph
Carolinas Medical Center-Randolph (CMC-R) has a written agreement with the LME for after hours call center functions. The agreement defines the scope of work, prohibition of further subcontracting, performance standards, periodic and ongoing quality reviews, requirements for corrective actions if needed, and monthly reporting requirements.

Current Scope of Work
CMC-R's scope of work includes:

- Answer 24-hour access line after hours, holidays and on weekends.
- Respond to emergency requests for service.
- Arrange for any emergency transportation and 911/Fire Department involvement as necessary.
- Refer enrollees to appropriate levels of care based on access standards for emergency, urgent and routine care.
- Document referrals and submit to LME the next business day.

Background and Reference Checks of Work Performance and Credibility of Performance
Prior to the implementation of this delegation arrangement, the LME conducted an assessment of the vendor's capacity to fulfill the obligation. This assessment included confirmation that the contractor was not excluded from Medicaid and Medicare program participation; met the licensing and accrediting standards; had written policy and procedures to support the service and had adequate clinical supervision.

Transition Plan
Because CMC-R currently provides after-hours coverage for the LME and given the long history of CMC-R's role in the community, we expect minimal change in volume and functions for the call center. However, we will provide detailed training on any changes which occur with implementation of the PIHP.

Prest and Associates, Inc
Prest and Associates (Prest) is a nationally known firm that is accredited by URAC and NCQA, as an Independent Review Organization. The LME contracts with Prest to provide physician reviews and psychiatric consultation in the event the Medical Director is unavailable. There is a written agreement between the LME and Prest. The agreement defines the scope of work, prohibition of further subcontracting, performance standards, periodic and ongoing quality reviews, requirements for corrective actions if needed, and monthly reporting requirements.

Background and Reference Checks of Work Performance and Credibility of Performance

Prior to the implementation of this delegation arrangement, the LME conducted an assessment of the vendor's capacity to fulfill the obligation. This assessment included confirmation that the contractor was not excluded from Medicaid and Medicare program participation; met the licensing and accrediting standards; had written policy and procedures to support the service and had adequate clinical supervision.

Current Scope of Work

Prest's scope of work includes:

- During periods when the Medical Director is unavailable, such as planned vacations, respond to quality of care concerns where health and safety of enrollee or community is at risk due to poor clinical care.
- Conduct physician level reviews to make utilization management decisions, such as authorizing acute inpatient care; or denials.
- Participate in routine and expedited appeals of UM decisions.
- Document all work according to agreed up specifications.

Transition Plan

Because Prest currently provides this service for the LME, we anticipate minimal transition being required. Training on specific requirements of the Waiver contract and any new forms that are implemented should be accomplished within 30 days prior to implementation.

Timeliness of Provider Payments
(Limit to 5 pages)
The LME shall have evidence of the LME's history of prompt payment to providers.
☐☐ Describe the LME's provider payment history for the past three years.

The LME is committed to the prompt payment of providers and reviews the payment rate on a quarterly basis. The LME Financial Services staff are responsible for processing claims and determining the amount payable to providers. Invoices are generated from the LME software system and keyed into the accounting system where actual payment occurs. Mecklenburg County Finance Department generates the payment. Payment can be made in the form of a check mailed to the provider or electronic funds transfer (EFT). EFT is encouraged but not required. Mecklenburg County has established a standard of 30 calendar days to pay providers; 21 days for the LME to process the claims and nine days for Mecklenburg County Finance to generate the payment. The process typically takes less than 30 days. Due to the expected increased volume of providers and claims, the LME will increase the number of claims staff under this waiver.

Over the last three fiscal years, the LME processed an average of 96 percent of claims within 21 days: 99% in FY09, 97% in FY08 and 93% in FY07. The tables below detail the payment history for the LME by fiscal year and provider.

Payments Processed Between 07/08/2008 And 06/30/2009			
Provider	**Total Claims**	**Processed Within 21 Days**	**Percent**
2nd II None Foundation	119	50	42%
Access Family Services, Inc.	8,692	8,681	100%
Agape Services, Inc.	203	203	100%
Alexander Youth Network	18,874	18,666	99%
Alliance Human Services, Inc	5,669	5,583	98%
Alliance Human Services/Rapid Response	168	168	100%
Anuvia Drug Court (formerly CDC Drug Court)	3,884	3,884	100%
Anuvia Prevention and Recovery Center, Inc.	3,615	3,571	99%
Autism Services of Mecklenburg County, Inc.	2,952	2,952	100%
Carolina's Rehabilitation	408	363	89%
Community Choices, Inc.	9,429	9,323	99%
Compass Adult Care, Inc.	21	21	100%
Comprehensive Community Care, Inc.	2,153	2,033	94%
ComServ, Inc	603	603	100%
Developmental Disabilities Resources, Inc.	18,469	18,467	100%
Easter Seals UCP of NC	13,059	13,057	100%
Easter Seals/SET	2,441	2,054	84%
Family First Community Services	28	18	64%
Family Preservation Services of NC, Inc.	35,507	33,647	95%
Family Support Services	6,141	6,141	100%
First Choice Community Services, Inc.	6,041	6,041	100%
Footprints Carolina, Inc.	7,235	7,235	100%

Goodwill Industries of the Southern Piedmont, Inc.	7,639	7,639	100%
Hilltop Comprehensive Care, Inc.	13	13	100%
Hinds' Feet Farm	747	747	100%
Hope Haven, Inc.	15,513	15,232	98%
InnerVision, Inc.	1,905	1,905	100%
LifeSpan, Inc.	6,184	6,173	100%
Matrix Mental Health Alliance, LLC dba CriSys	741	739	100%
McLeod Addictive Disease Center, Inc.	15,003	15,003	100%
Mecklenburg Open Door, Inc.	41,705	41,615	100%
Mecklenburg Open Door, Inc. - Recovery Solutions	4,154	4,066	98%
Mélange Health Solutions, LLC	92	0	0%
Mental Health Association in North Carolina, Inc.	410	410	100%
Nevins, Inc.	19,082	19,082	100%
Person-Centered Partnerships, Inc.	7,274	7,159	98%
Personalized Therapy, Inc.	47	47	100%
Primary Care Solutions, Inc.	1,633	1,631	100%
Professional Care Management, Inc.	163	163	100%
Quality Family Services, Inc.	6,693	6,287	94%
Residential & Support Services, Inc.	41,299	41,291	100%
RHA/Howell Care Centers, Inc.	7,154	7,154	100%
Skill Creations, Inc.	530	530	100%
Southeast Addiction Institute	1,020	1,020	100%
Southeast Addiction Institute Drug Court	3,495	3,495	100%
The Arc of North Carolina	33,364	33,356	100%
Thompson Child and Family Focus	550	544	99%
TrueVisions	5,925	5,925	100%
UMAR-WNC, Inc.	2,103	2,103	100%
United Family Services, Inc.	8	0	0%
Youth Homes, Inc.	3,007	2,975	99%
Total	**373,164**	**369,065**	**99%**

Payments Processed Between 07/08/2007 And 06/30/2008			
Provider	**Total Claims**	**Processed Within 21 Days**	**Percent**
2nd II None Foundation	95	72	76%
Access Family Services, Inc.	8,208	7,921	97%
Adult Care and Share Center, Inc.	134	134	100%
Alexander Youth Network	15,240	13,694	90%

Alliance Human Services, Inc	4,355	3,986	92%
Anuvia Drug Court (formerly CDC Drug Court)	1,310	1,310	100%
Anuvia Prevention and Recovery Center, Inc.	5,122	5,122	100%
Autism Services of Mecklenburg County, Inc.	2,629	2,629	100%
Carolina's Rehabilitation	440	193	44%
CNC/Access, Inc. dba Rescare Healthcare	6	6	100%
Community Choices, Inc.	7,164	7,014	98%
Comprehensive Community Care, Inc.	2,380	2,337	98%
ComServ, Inc	732	732	100%
CWOE dba Beatties Ford Rd Family Counseling	180	180	100%
Developmental Disabilities Resources, Inc.	13,893	13,889	100%
Easter Seals UCP of NC	12,380	12,080	98%
Easter Seals/SET	2,709	2,662	98%
Family Center, Inc.	495	495	100%
Family Preservation Services of NC, Inc.	35,062	33,424	95%
Family Support Services	6,897	6,896	100%
First Choice Community Services, Inc.	4,915	4,915	100%
Footprints Carolina, Inc.	7,165	7,129	100%
Goodwill Industries of the Southern Piedmont, Inc.	8,409	8,368	100%
Hilltop Comprehensive Care, Inc.	1,122	1,060	94%
Hinds' Feet Farm	68	68	100%
Hope Haven, Inc.	12,008	12,008	100%
InnerVision, Inc.	1,859	1,858	100%
LifeSpan, Inc.	8,382	8,321	99%
Matrix Mental Health Alliance, LLC dba CriSys	607	565	93%
McLeod Addictive Disease Center, Inc.	18,498	18,465	100%
Mecklenburg Open Door, Inc.	36,385	36,385	100%
Mélange Health Solutions, LLC	40	40	100%
Nevins, Inc.	15,399	15,399	100%
Omni Visions, Inc.	12	12	100%
Person-Centered Partnerships, Inc.	5,888	5,832	99%
Primary Care Solutions, Inc.	443	222	50%
Professional Care Management, Inc.	17	17	100%
Quality Family Services, Inc.	8,218	8,054	98%
Residential & Support Services, Inc.	39,880	36,229	91%
RHA/Howell Care Centers, Inc.	7,000	7,000	100%
Skill Creations, Inc.	652	621	95%
Southeast Addiction Institute	1,542	1,528	99%
Southeast Addiction Institute Drug Court	1,331	1,331	100%
Strategic Interventions, Inc.	12	12	100%

Successions, Inc.	6	6	100%
The Arc of North Carolina	32,139	31,966	99%
Thompson Child and Family Focus	1,840	1,783	97%
Timber Ridge Treatment Center, Inc.	6	6	100%
TrueVisions	4,670	4,657	100%
UMAR-WNC, Inc.	371	371	100%
Visions Residential Healthcare Services	5	5	100%
Youth Homes, Inc.	2,756	2,595	94%
Total Claims	**341,076**	**331,604**	**97%**

Payments Processed Between 07/08/2006 And 06/30/2007			
Provider	**Total Claims**	**Processed Within 21 Days**	**Percent**
2nd II None Foundation	998	934	94%
Access Family Services, Inc.	8,615	7,540	88%
Agape Services, Inc.	564	499	88%
Alexander Youth Network	10,868	9,820	90%
Alexander Youth Network of Lenoir	14	0	0%
Alliance Human Services, Inc	1,692	1,132	67%
Anuvia Prevention and Recovery Center, Inc.	878	874	100%
Arc Services, Inc.	340	339	100%
Autism Services of Mecklenburg County, Inc.	2,658	2,649	100%
Carolina's Rehabilitation	528	412	78%
CNC/Access, Inc. dba Rescare Healthcare	631	549	87%
Community Choices, Inc.	5,841	5,593	96%
Comprehensive Community Care, Inc.	3,123	3,122	100%
ComServ, Inc	724	724	100%
CWOE dba Beatties Ford Rd Family Counseling	95	95	100%
Developmental Disabilities Resources, Inc.	12,087	11,510	95%
Easter Seals UCP of NC	14,985	13,620	91%
Eliada Homes, Inc.	521	413	79%
Family Center, Inc.	1,053	797	76%
Family Preservation Services of NC, Inc.	28,981	22,624	78%
Family Support Services	9,138	8,581	94%
First Choice Community Services, Inc.	2,563	2,563	100%
Footprints Carolina, Inc.	4,845	4,798	99%
Golden Rule of Charlotte, Inc.	1,794	1,679	94%
Goodwill Industries of the Southern Piedmont, Inc.	12,681	12,274	97%
Guiding Shepherd Inc.	51	0	0%

Hilltop Comprehensive Care, Inc.	1,505	1,262	84%
HomeCare Management Corporation	51	26	51%
Hope Haven, Inc.	13,226	13,226	100%
InnerVision, Inc.	1,975	1,955	99%
Keystone Charlotte, LLC	723	303	42%
LifeSpan, Inc.	15,380	15,127	98%
Matrix Mental Health Alliance, LLC dba CriSys	384	375	98%
McLeod Addictive Disease Center, Inc.	14,637	12,910	88%
Mecklenburg Open Door, Inc.	28,126	28,048	100%
Mélange Health Solutions, LLC	102	101	99%
National Mentor Healthcare, LLC	158	118	75%
Nevins, Inc.	27,183	26,393	97%
New Hope Carolinas, Inc.	68	37	54%
Person-Centered Partnerships, Inc.	4,621	4,062	88%
Primary Care Solutions, Inc.	1,032	913	88%
Professional Care Management, Inc.	1,698	1,383	81%
Quality Family Services, Inc.	8,518	7,997	94%
R & G Youth Services, Inc.	705	601	85%
Residential & Support Services, Inc.	34,660	31,505	91%
RHA/Howell Care Centers, Inc.	7,620	7,175	94%
Scholars, Inc.	102	102	100%
Skill Creations, Inc.	555	512	92%
Southeast Addiction Institute	700	673	96%
Successions, Inc.	1,852	1,533	83%
The Arc of North Carolina	22,785	22,544	99%
Thompson Child and Family Focus	2,294	2,141	93%
Three Rivers Residential Treatment	250	145	58%
Timber Ridge Treatment Center, Inc.	12	8	67%
TrueVisions	2,568	2,508	98%
Turning Point Services, Inc.	132	132	100%
UMAR-WNC, Inc.	130	130	100%
Visions Residential Healthcare Services	54	54	100%
Youth Focus, Inc.	26	26	100%
Youth Homes, Inc.	2,666	2,576	97%
Total Claims	**322,766**	**299,742**	**93%**

Financial Management/Monitoring
(Limit to 6 pages)
The LME shall have internal controls and systems in place to ensure that all Title XIX Medicaid revenue and expenditures are accounted for separately from other funding sources.
☐☐ Provide a description of the LME's internal controls and systems in place to ensure that all Title XIX Medicaid revenue and expenditures are accounted for separately from other funding sources.
Mecklenburg LME will have in place a Finance Director with at least seven years experience managing progressively larger budgets. This Finance Director will oversee our internal financial management controls and systems. The LME will segregate all Medicaid funds from other funds for revenues and expenditures. It is anticipated this will be accomplished through the use of a special revenue fund under governmental accounting rules, utilizing an accrual basis of accounting. Multiple budget units will be established as necessary to account for service funds and administrative funds. Mecklenburg County has a detailed and flexible chart of accounts in which new revenue and expense accounts will be created as necessary. Once a contract has been awarded to a provider, the LME Financial Services division will code provisions of the contract to match specific revenue sources. Afterwards, the contract is encumbered and entered into the Advantage Financial System by separate revenue sources (by accounting lines). This ensures that payments are applied against the appropriate funding source.

The LME's information system allows for tight control of revenues and expenditures. Each funding source is set up as an "insurer." Enrollees are assigned a funding source (Medicaid, IPRS, Insurance, County, etc.) upon admission. This funding source has an effective date and an end date. It is updated as the enrollee's coverage changes. The enrollee's funding source is required and connected to authorizations as they are approved. Authorization numbers are required when submitting claims, therefore funding source is identified as claims are processed and paid. The funding source denotes how to post the expense to the general ledger. If the funding source for an enrollee changes during the span of an authorization, the funding source is adjusted. In the event claims have been paid prior to identifying a funding source change, claims are adjusted retrospectively.

To ensure that payment errors or irregularities are prevented or detected, the LME Financial Services division has multiple security levels for reviewing, keying, and approving provider invoices. The staff member who receives an invoice will audit, review and code it to correspond to the appropriate ledger account and ensure that payments go against the correct budget line. Once the coding process is complete, the invoice is then keyed into the Advantage Financial System and forwarded to another staff for final review and approval. These tasks are deliberately separate and are a benefit to the vetting process. With this arrangement, it is much more likely that benign errors or lack of documentation will be found. (See **Attachment 26** the Financial Policies and Procedures)

☐☐ Provide a description of the LME's process for calculating Incurred But Not Reported (IBNR).
The LME defines IBNR or "incurred but not reported" as the difference between potential outstanding claims and paid claims. Outstanding claim information comes in the form of authorized services for which no claim has been received, or claims that have been processed and approved but not yet paid. Historical data are also used to determine the estimated rate at which authorized units are used. Reports of IBNR are sorted by the LME at a number of levels: by provider, site, service, level of care, date spans, ad hoc reporting periods upon special request, age and disability area, etc.

The LME's software system, eCura is used for the collection and processing of authorization requests and claims and therefore, contains all information necessary to calculate an IBNR report.
This information is reviewed by our Core Operations Committee– *consisting of senior staff from Finance, Utilization Management, Provider Relations/Contracting, System of Care and Administration* – on a

weekly basis. This integrated approach is critical to the maintenance of our financial stability and would expand to include the management of the Medicaid monthly capitation.

☐☐ Provide a description of the LME's process to monitor and track monthly capitation payments to ensure service delivery can be provided throughout the contract year.
Within this description, describe the LME's budgeting process and methods to track actual expenditures against budgets. Describe the process as it relates to both Title XIX Medicaid and other funding sources.
The Mecklenburg LME has a proven record of responsible and accurate financial management. The information system (eCura) allows us to have very tight control around revenue and expenditures for each funding source i.e. Federal, State and County dollars. Each funding source is setup as an "Insurer" entity in our information system. Every enrollee can be linked to one or more insurers. That linkage includes an effective and expiration date as well as information about the benefits associated with each insurer. Every transaction that occurs for an enrollee (authorizations, claims, check printing, etc) is linked to a single insurer which allows us to control revenue and expenditures for each funding source. At any point in time, we can determine how much was authorized and paid for any funding source. Our overall financial exposure is easily monitored, tracked and analyzed. Additionally, this information is reviewed by our Core Operations Committee, consisting of managers from Finance, Utilization Management, Provider Relations/Contracting, System of Care and Administration, on a weekly basis. This integrated approach is critical to the maintenance of our financial stability and will expand to include the management of the Medicaid monthly capitation.

If awarded the contract, the Medicaid capitation and expenditures would be tracked as categorical funding sources i.e. elderly – aged & dual-eligible's; blind/disabled; families & children; and CAP-MR/Innovations. Budget targets would be established based on historical claims data including all covered levels of care e.g. inpatient, outpatient, community based, etc. Each category would be tracked and analyzed by:

- Unique consumers.
- Visits/Service Units.
- Unit Costs.
- Cost per Consumer.
- Visits/Services per 1000.
- Run Rates/Cost vs. PMPM.

This 'dashboard' would inform decision making at multiple levels including administrative, financial planning and adjustments, financial management and forecasting, provider profiling, and over/under utilization among others. Data management and reporting would also center on financial risk, exposure analysis as well as other predictive and trending modeling.

Budgeting Process:
The LME's fiscal year is July 1 to June 30. Budgets are established each year by the LME in accordance with the Mecklenburg County budget process. The budget for Title XIX Medicaid will be based on the established capitation in the contract with the Division of Medical Assistance. The budget for state and federal funding will be based on the allocation from the Division of MH/DD/SA Services. If the actual amount is not known at the time of budget development, budgets are based on projections for each funding source. The budget will then be adjusted accordingly which requires board approval. Multiple budget units will be established as necessary to account for service funds and administrative funds. In addition, Medicaid funds will be segregated from state and local funding. Mecklenburg County has a detailed and flexible chart of accounts in which new revenue and expense accounts will be created as necessary. All inbound dollars are tracked and identified as 'administrative' or 'service' and an additional 'risk reserve' fund would be created.

Budget monitoring and methods to track actual expenditures against budgets:
As noted previously, within each funding source budgets will be established by service category and population using historical data. Accruals will be made at the end of each month for revenue earned but not yet received and for expected expenditures related to claims not yet received (IBNR). The LME prepares and examines monthly reports to analyze financial performance. This analysis will include a comparison of budget to actual and unusual spending trends. By examining services rendered and the cost for those services and comparing this to the revenue received, this enables the LME to ensure that service delivery is provided to eligible consumers throughout the year.

Also as previously noted, the LME monitors provider service contracts and the utilization of federal, state, and county. The Core Operations Committee reviews authorization and utilization reports on a weekly basis. All new service contracts, changes to existing service contracts and termination of service contracts using State, County or Medicaid funds are reviewed and approved by the Committee. In addition, the LME reviews transaction activity for assessing under/over payment or denial of payments for any variance that could potentially impact fund availability or service delivery.

Provide a description of the LME's process in place to demonstrate that all third-party resources are identified, pursued, and recorded. All funds recovered by the LME from third-party resources shall be treated as income.

All network providers are contractually required to pursue third party resources and report collections to the LME. The LME's information system has the ability to store all third party resources as part of the coordination of benefits module. The application allows the LME to decide, per third party resource, whether to pend, deny or approve claims when the claim is received with no information about what the third party has paid. When a claim is received with information that a third party has paid any portion of the claim, the financial information is stored in the claim with a link to the third party resource it was associated with. Payment to the provider is automatically reduced by the amount the third party paid. Once the claims are processed and adjudicated, all data about the third party payment is stored and can be used for reporting. In the event third party coverage is discovered after claims have been processed, an adjustment to the payment will be made. The information can also be set up to take care of co-pays required by Medicaid, as is the current requirement for outpatient services.

Provide a description of how payments to providers by the LME shall be made on a timely basis, as required by section 11.2 of the contract.

The LME processes claims and payments on a weekly basis. Mecklenburg County has established a standard of 30 calendar days to pay providers, which is more stringent than the North Carolina prompt pay requirements. The LME has 21 days to process claims and associated documentation, at which point an explanation of benefits is generated and sent to the provider via an electronic 835 or a mailed hard copy. The explanation of benefits includes denied, pended and approved claims. Mecklenburg County Finance Department has 9 days to generate the payment upon receipt of the documentation. Prompt payment rates are monitored on a quarterly basis. Providers will be required to submit claims within 90 days from the date of service. Any claims received after this will be denied.

Provide a plan as to how the LME will set up and manage the risk reserve.

Mecklenburg County Finance will establish and maintain a restricted fund to account for the risk reserve on behalf of the LME. The account will hold the additional 2% capitation – *until the account balance reaches the 15% of the total annualized cost of the contract threshold established by DMA* – payment to the LME for the purpose of building the risk reserve and will be booked, listed and designated as such on the balance sheet. This fund will be managed and utilized according to the terms and conditions of the agreement between DMA and the LME. Also, as specified by DMA, any income from the investment of these funds will accrue exclusively to this account. As referenced earlier, Mecklenburg County is subjected to outside audit on an annual basis and this restricted fund will be part of that audit process.

Contractor Designated as a single PIHP
(Limit to 2 pages exclusive of formal agreements)
If other than a single LME applies, see the discussion in the Scope of Work and submit the following:
☐☐ Definition of the geographical area and the business relationships formulated to act as a single PIHP.
☐☐ Attached evidence of business affiliations and all formal agreements.
☐☐ Describe and submit evidence of all community stakeholders engagement (consumers and families, CFAC, provider network, community and county agencies) in submitting this RFA application to the State.
☐☐ Describe and demonstrate evidence of future and ongoing efforts to strengthen the collaborative partnerships with the LME operating a PIHP.

This requirement does not apply to Mecklenburg LME as we are applying as a single LME.

Enrollment and Disenrollment
(Limit to 1 page)
The waiver entity shall have policies and procedures for facilitating information exchange with the local department of social services regarding enrollee participation in the Innovations Waiver 1915 (c).
☐☐ Discuss the policies and procedures in place to facilitate the exchange of information with the local department of social services regarding approvals for participation in the Comprehensive and Supports waivers.

The MR2 prior approval process is integral to the determination of level of care for applicants to the Comprehensive and Supports Waivers. The prior approval process is coordinated by LME staff with the Murdoch Center who determines the appropriate level of care for prospective waiver recipients. Clinical staff employed by DMH/DD/SAS at Murdoch review completed MR2 forms, as well as psychological evaluations, for all new waiver applicants in the state and make the final determination of level of care.

- Once Murdoch clinical staff determines that the individual meets the ICF-MR level of care, the LME is notified via phone or fax of the prior approval number.
- The LME mails a copy of the approved MR2 to the appropriate DSS, and another copy of the MR2 to the local case manager within five days of receipt to ensure that services begin in a timely manner and for inclusion in the permanent record of the individual. The LME retains a copy for their files.

Individuals who have been identified by the LME and referred for waiver funding who are being transitioned from institutions must have a new MR2 completed by a physician or licensed psychologist. In addition, the MR2 must be signed by staff of the LME. Staff of the LME will obtain the current prior approval number from the ICF-MR facility and enter it on the MR2. As above, clinical staff of Murdoch Center review completed MR2 forms as well as psychological evaluations for all individuals transitioning from a state or community ICF-MR facility to the community and will make final re-determination of level of care.

- Once Murdoch clinical staff determines the individual continues to meet the ICF-MR level of care, the LME is notified via phone or fax.
- Murdoch Center mails the original remaining stamped copies back to the LME.
- The LME mails a stamped copy of the MR2 to the appropriate DSS with a letter explaining that the individual is transitioning from an ICF-MR facility to the Community or from CAP-C or CAP-DA to CAP-MR/DD. An additional stamped copy of the MR2 is sent to the case manager. The LME maintains a copy for their records.

The LME receives approval letters from Value Options for all initial plans of care and continued needs reviews for new waiver recipients. The LME submits the Plan of Care approval letter to the local Department of Social Services (DSS) with a copy to the case manager for the initial plans. (Upon receipt of the approval letter the local DSS representatives enters the CM indicator into the system for new Waiver participants.)

Implementation Plan
(Limit to 15 pages)
The LME applying to operate a PIHP shall submit a project implementation plan that demonstrates the capacity to implement the requirements specified in the RFA. For purposes of the Implementation Plan, use January 1, 2011 as the start date, which is six months following the announcement of selection, with the understanding that is contingent upon approval by CMS of the technical amendment that specifies the selected LME.

☐☐ For each of the clinical and administrative section function areas described above, provide an implementation plan with sufficient detail to clearly articulate tasks, time frames, and expected results for each of the RFA requirements identified.
☐☐ Provide an index to your policy and procedural manual and draft policies that will support the activities of a LME operating as a PIHP and that can be reviewed onsite.

Implementation Plan
Please see **Attachment 40**, an implementation plan which meets the requirements stated above.

Policies and Procedures Index
Below is an index to Mecklenburg LME's Policies and Procedures:

Authorization and Utilization Management Policies
- Administrative Denial Policy.
- Assessment of Adequacy of Provider Community.
- Availability and Communication with UM Staff.
- Consumer Eligibility Policy.
- Denial Determination Policy.
- Distribution of Medical Necessity Criteria.
- How and Where to Access Crisis Services Policy.
- Lack of Clinical Information Policy.
- Medical Necessity Exceptions Policy.
- Non-Medicaid Appeals Policy.
- Out of State Placement.
- Retrospective and Administrative Reviews.
- Screening, Triage and Referral Policy.
- Standard Time Frames for UM Decisions.

Client Records Policies
- Collection and Coordination of Information.
- Exchange of Information and Continuity of Care Policy.
- Records Retention and Disposition Policy.
- Special Protection of Protected Health Information.

Client Rights Policies
- Complaint Management.
- Consumer Choice Policy.
- Human Rights Policy.
- Referral of Complaints.

Confidentiality Policies
- Release of Confidential Information.
- Confidentiality and Protection of Consumer Information.

- Notice of Privacy Practices.
- Request for Restriction of Use of PHI.

Compliance Policies
- False Claims Act Compliance Policy.
- Reporting and Investigating Compliance Concerns.

Credentialing Policies
- Confidentiality of Credentialing and Recredentialing Process for LIPs.
- Credentialing LIPs.
- Provider Standards and Credentialing of Agency Providers.
- Ongoing Monitoring of Sanctions Policy.
- Quality of Care Review, Notification of Authorities and Appeal Process for Contractors (non-physicians).
- Quality of Care Review, Notification of Authorities and Appeal Process for Contractors (physicians).
- Re-credentialing Licensed Independent Practitioners.
- Results of Primary Source Verification Policy.
- Review of Performance Data.
- Site Visits for LIPs.

Consumer Safety Policies
- Incident Management Policy.

Contract Appeals Policy
- Administrative Contract Appeals.

Finance Policies
- Sliding Fee Scale Policy.
- Claims Recoupment for Medicaid Eligibility.
- Use of State Funds Room and Board for Medicaid-Eligible Children.

Monitoring Policies
- Local Monitoring Policy.
- Requesting Plan of Correction.
- Requesting an Exception to Community Support Enrollment Suspension.

Additional Policies
- Adolescent Transition to Adult Status Policy.
- LME Disaster Plan.
- Delegation Policy.
- Dissemination of Information to the LME Community of Providers Policy.
- Limited English Proficiency.
- Payment for Services to Family Members.
- Provider Compliance with MeckLINK Call Center Requirements.
- Provider Network Availability Standards.
- Request for Proposal (RFP) Policy.
- Representative Payee Services.
- Support for Provider Agency Education and Training Policy and Procedure.

Pending Lawsuits and Judgments
(Limit 2 pages)
☐☐ Submit a statement that there have been no legal actions taken against the LME applying to operate a PIHP in the past two (2) years and there are no judgments or other legal actions pending;
OR,
☐☐ If any legal action has been taken, or is pending, provide an explanation.

As of April 1, 2010, there are two legal actions pending. Both are employee relations issues.

1. GCMC074108; 3/13/07 is the date of claim. This employee alleges discrimination. No payment has been made to the plaintiff.

2. GCMC075326, 7/23/07 is the date of the claim. This employee alleges discrimination and harassment. No payment has been made to the plaintiff.