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### 7A.2.1 Executive Summary

***Together We Can Inspire Hope for a Better Life*** is our corporate vision. At Cenpatico, our experience is that recovery and resiliency can only be realized when consumers, family members, providers, stakeholders, State and County government and managed behavioral healthcare work collaboratively--*together*.

Our *only* business is managing behavioral health care for publicly funded populations. It is our focus. Cenpatico specializes in managing care for public sector behavioral health service delivery systems, including mental health and substance abuse treatment services. We currently manage behavioral health care for over 1.2 million consumers in nine states. Our business includes extensive experience serving the needs of underserved populations including persons with chronic mental illness, those with substance abuse disorders, older adults, and children with severe emotional disturbance. Our managed care model develops and supports consumer and best practice driven behavioral health service delivery systems that emphasize local community-based services. Our managed care model is consistent with the philosophy and values of the Iowa Plan. Our proposal offers comprehensive strategies for achieving the Iowa Plan's goals.

#### **Our vision for the Iowa Plan will result in system transformation that produces:**

- Expanded statewide access and capacity for covered and required services, including but not limited to:
  - Psychiatry, including telehealth expansion and consultations
  - Sub acute levels of care for step down after hospitalization or to avoid need for hospitalization
  - Crisis services, including mobile crisis teams
  - Peer support services for substance abuse and mental health recovery
  - Services to support specific high-needs populations in their communities, such as persons aged 65 and over, adults with severe and persistent mental illness, children with severe emotional disorders, pregnant or parenting substance abusing individuals, etc.
  
- Comprehensive integration and coordination of services, including but not limited to:
  - Physical health/mental health/substance abuse service integration
  - Coordinated services for children and families, including discharge planning from date of admission for children in PMIC
  - Allied systems coordination, including state and local agencies and other resources
  - Discharge, wrap around and crisis intervention planning for high needs populations with emphasis on decreasing readmissions
  
- Continuous data-driven quality improvement through use of expanded measurement of outcomes

The value we place on **consumers' right to direct their recovery** comes from our fifteen years of experience in this field. We recognize that consumers must guide their relationships with service providers and supports across service domains and our management strategies reflect the value we place on recovery principles.

Because our model is designed to be **locally focused**, our processes are adaptable to meet diverse needs *within* states or regions. We have been successful in using our managed behavioral health care model to meet the needs of consumers in large rural areas, utilize multiple funding streams, address cultural differences, provide increased support for high-needs populations, increase integration and coordination of services and improve overall quality of care.

Our model emphasizes **allied systems coordination**. Our solutions include structured processes for creating collaboration among other state and local entities, including formal and informal support resources, so that consumers have access to all the necessary supports for their recovery.

The **financial impact** of our model is that consumers get the appropriate level of support and services they need for their stage of recovery, creating more successful outcomes and resulting in less costly care over their lifetime.

**Our organizational structure and staffing model provide local control, while implementing integrated network, fiscal, clinical, quality and technology solutions to achieve system transformation for the Iowa Plan.**

Local control will start with the creation of Cenpatico Iowa, LLC, to manage the Iowa Plan. Cenpatico Iowa will have offices in each of six regions of Iowa, correlated to the IDPH defined service regions. Executive staff will be located in the Des Moines-area office. We will have quality, utilization management, intensive clinical management, care coordination, and provider liaison staff in each of the six regional offices. Our local staff, with leveraged support from Cenpatico's corporate resources, will implement a *recovery-oriented* service delivery system for the Iowa Plan that coordinates and integrates services provided by the Iowa Plan's Medicaid provider network and the IDPH-licensed substance abuse treatment provider network, as well as those medical health services provided to Eligible Persons. Iowa Plan network providers will be contractually required to implement processes that make *Voice and Choice* a reality for Eligible Persons in Iowa.

**Network and Fiscal Solutions** Our provider network plan is the key to achieving the departments' ultimate goal of a statewide recovery-oriented care system that matches each person's strengths, needs and choices with appropriate and coordinated services and supports. We are not a direct service provider, but our administrative role allows us to ensure the quality of direct services to Eligible Persons. Prior to go-live, we will develop fully contracted networks to serve Enrollees and IDPH Participants. Our focus is on clear contract expectations and a service delivery structure that supports integration and coordination of care. This focus produces a framework for achieving statewide capacity and access for required services and substance abuse services.

We will restructure the existing network to include Comprehensive Service Providers (CSP) for each region. A CSP is a locally focused multi-service agency that in addition to offering access to a full continuum of outpatient and waiver services, will function as a service coordination hub for high needs individuals. We will negotiate with existing Community Mental Health Centers (CMHC) and other multi-service agencies in the six IDPH regions of Iowa to develop at least two CSP per region. Our regionally focused network model will provide the structure to build statewide availability for required services; it starts by developing the strengths of existing local assets and focuses targeted resources to address specific local service gaps. In our initial assessment of the current delivery system, we found that many CMHC offered less than full continuum services with significantly limited services at many rural CMHC.

Our plan is to develop CSP that offer, develop capacity to offer, or have structured referral systems in place to facilitate access to a continuum of care that includes the following services: wraparound, Peer Support, in-home service delivery focused on rural access and capacity issues, telehealth remote site, 24 hour mental health stabilization, crisis intervention and management, prevention, Mobile Crisis Teams, Assertive Community Treatment teams, higher level and/or intensity outpatient services to address the existing gap between 24 hour level of care and traditional outpatient/community based services. Access for Enrollees to specialty services, such as substance abuse treatment, will be provided directly by appropriately licensed CSP or coordinated with independent providers in the region. CSP and other providers as appropriate will receive training for treatment team facilitators to support and enhance team based service planning, including joint treatment planning conferences. In addition, we will work with County Boards of Supervisors to request and encourage them to contract with CSP for Targeted Case Management services, in order to further streamline access and coordination of services. Comprehensive Service Providers will offer extended hours to include evening and weekend routine and urgent appointments, in order to expand access and to provide crisis services support.

We will facilitate the expansion of telehealth services for psychiatry through the use of telehealth-specific provider agreements and active recruiting of Iowa-licensed psychiatrists both in and outside of Iowa. We will pursue partnership with the University of Iowa School of Medicine's Department of Psychiatry to create solutions to gaps in psychiatry services for Iowa Plan Enrollees. We will recruit Iowa Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) to serve as telehealth remote site partners to further expand access across the State. We will also implement community focus groups to assess the value and impact for communities of potential expansion of covered telehealth services to include certain psychotherapy services.

We offer network strategies to increase integration of medical and behavioral health care. We will negotiate contracts with FQHC and RHC which have behavioral health services in place and/or to expand their services to include behavioral health screenings and basic services. Conversely, we will negotiate with CSP to expand their services to include general medical practitioners.

We will also negotiate with community hospitals and inpatient providers to develop partial hospital and other sub-acute programs to address the identified need for step down services. We will maintain an open panel; any eligible, appropriately licensed provider that executes a participating provider agreement and successfully completes credentialing will be able to participate in the network. This will ensure the greatest geographic access and allow for consumer choice of providers.

Expanding the support systems around individuals reduces inpatient admissions and greatly decreases the likelihood of readmission. The CSP will offer Enrollees a provider choice that simplifies access for those who require multiple services to meet their recovery needs. By building needed services and contracting in this way, we anticipate a cost shift of direct service costs from inpatient and residential services to outpatient and community treatment.

We will reimburse acute levels of care on a fee-for-service basis in order to properly account for and manage care for Enrollees admitted to inpatient and residential settings. IDPH fund capitated rates will be negotiated with licensed IDPH substance abuse treatment providers. In the second year of the contract, we will transition the CSP to a block payment methodology while retaining a fee-for-service system for non-CSP Medicaid providers, including Medicaid specialty providers and acute care facilities. Block payment reimbursement is a strategy that empowers larger multi-service providers in the overall care of those they serve. CSP receive lump sum payments by fund type each month and manage the dollars to cover services. CSP are accountable for their spending and are required to submit encounters for services to be equal to or greater than their contract amounts. The primary advantages to this payment strategy are that it improves care and outcomes by allowing the provider to coordinate waiver and wrap around services in relation to traditional outpatient services. The coordination of care is centralized with the CSP. It brings more of the right services to bear for each individual. It gives the providers flexibility in determining the right service mix for their communities, leading to better outcomes for each individual served.

Our CSP network model is ideal for allocation, distribution and accounting for provision of the community reinvestment funds. Of the monthly capitation amounts, 2.5% will be placed in the Community Reinvestment Fund. 70% of the Community Reinvestment Fund is allocated for member services, and we target the following areas for investment: crisis intervention and mobile crisis services; Assertive Community Treatment services; community re-entry from incarceration; consumer employment; certification program for peer support specialists; and addressing the behavioral health care workforce shortage, including developing specific Behavioral Health Certification programs in conjunction with local community colleges. 30% of the Community Reinvestment Fund is allocated for provider development and consumer/family education and outreach, and we will target outreach and education programs to increase awareness of behavioral health issues in order to reduce the stigma associated with behavioral health diagnoses.

**Clinical Solutions** Our utilization management program focuses on improving care through *correct* utilization, not emphasis on simply decreasing utilization/costs. As a result of ensuring access to the right care at the right time, cost efficiency is achieved. Our Utilization Management Guidelines for mental health services expand strict medical necessity criteria to encompass psycho-social necessity criteria. For substance abuse services we apply American Society of Addiction Medicine's 2<sup>nd</sup> Edition Revised Patient Placement Criteria (ASAM PPC-2R) which include psycho-social dimensions.

We will require prior authorization for 24 hour care that removes Eligible Persons from their home environment (including acute and sub acute inpatient, residential, and Medicaid substance abuse services in PMIC) in order to achieve real time monitoring of these most restrictive levels of care and to allow us to support discharge planning from the time of admission. Non-facility-based services do not require prior or concurrent authorization and will be retrospectively reviewed. Utilization Managers, Clinical Provider Liaisons and Clinical Quality Assurance Coordinators will apply the Utilization Management Guidelines and ASAM PPC-2R retrospectively for these services. Retrospective review will occur through a variety of strategies, including audits and specific profiling tools, designed to ensure optimal quality of care and appropriate utilization of services across the behavioral health service delivery system. Clinical review for outpatient and community based services will be conducted through post service profiling activities where data can be compiled, analyzed and acted upon in collaboration with the provider. Providers will receive regular clinical training in Evidence Based and Best Practices and utilization will be monitored for compliance with protocols and guidelines.

The overarching goal of our Intensive Clinical Management (ICM) program is to ensure that services are accessed in a timely and cost effective manner through early identification and appropriate consumer-driven service planning resulting in optimal recovery for high needs individuals. High needs populations include but are not limited to: adults with severe and persistent mental illness; children with severe emotional disorders; persons aged 65 and older; persons with co-occurring mental health/substance abuse/medical diagnoses persons whose recovery requires support from multiple agencies/systems; persons involved in the criminal justice, child welfare, or juvenile justice systems; and pregnant or parenting individuals with substance abuse disorders.

Our ICM program includes an initial screening assessment tool; a comprehensive assessment once admitted to the program; the development of care plans in conjunction with Eligible Person, their families, social support system and primary direct service providers; and referrals to appropriate providers and resources as necessary. ICM will regularly monitor Eligible Persons' progress in relation to their individual recovery goals as documented in the service/treatment plans. Coordination with other agencies and resources that enhance Eligible Persons' ability to access appropriate recovery support is an integral part of our program.

We will establish and operate a dedicated toll-free line where Eligible Persons can access crisis counseling, referrals and triage. The crisis line will be staffed by Iowa-licensed behavioral health clinicians or nurses including availability at all times of clinicians with specialized training in providing mental health and substance abuse services to children. All clinicians will receive initial and ongoing in-service training related to crisis intervention and verbal de-escalation techniques, assessing lethality and will receive regular updates regarding available services by county.

The limited number of child and adolescent psychiatrists available to provide treatment, more specifically medication management services for children and adolescents, is a prevalent issue across the state. We will implement our successful Psychotropic Medication Utilization Review (PMUR) program to address the need and will contract with Iowa-licensed child/adolescent psychiatrists to serve as consultants in the program. Since implementation last year of PMUR for Texas foster children, there has been a 13% decline in the number of foster children prescribed psychotropic medications overall and specifically a 74% decline in polypharmacy. We will recruit out-of-state child psychiatrists and offer incentives for obtaining Iowa licensure.

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## Specific Technology Solutions

We will bring an innovative product known as *Health Passport* to the Iowa Plan. The *Health Passport* features a secure web based application that houses data from various sources, including: demographic data, pharmacy data for the state's pharmacy benefits manager, immunization data from both the state's immunization registry and data from the primary medical provider, current and historical medications, environmental and medication allergies, behavioral health assessments, treatment summaries, service plans and crisis plans from the various behavioral health providers participating in the care of the consumer. Role-based accessibility options are available to registered service providers with appropriate processes in place to obtain required consents for release of confidential information when needed. This increased sharing of information promotes improved integration and coordination of services resulting in greater overall quality of care and cost efficiencies. Providers who currently use the *Health Passport* have found the tool helpful in coordinating care, and identified the ability to view a snapshot of the consumer's history and the issues covered with past clinicians as the most helpful feature. Second to that, providers also highlight reviewing the medication history as a useful tool in identifying previous treatment successes and failures.

For the Iowa Plan, participation in *Health Passport* will be offered to Eligibles on an opt-in basis in year two of the contract, with an intensive outreach and education campaign during the first year targeted at engaging Eligible Persons and service providers.

*Caring Voices* is another innovative program we will bring to the Iowa Plan, which has application for a variety of high risk populations, including some elderly Enrollees and some pregnant Enrollees with co-occurring mental health or substance abuse issues. We provide pre-programmed cellular phones to identify high needs Enrollees upon discharge to improve follow-up care after hospitalization. The phones provide a vital means of access to care for many consumers. Each telephone contains phone numbers used most by the Enrollee in their recovery such as their psychiatrist, therapist, CSP, CMHC, case manager, pharmacy, and may include care givers or community supports identified in the treatment and crisis plan for the Enrollee. This program has been well-received by consumers as a resource in our other markets, and our data collection and analysis has indicated up to 75% reduction in behavioral health inpatient readmissions for our *Caring Voices* participants.

## Quality Solutions

At Cenpatico our overall recovery, resiliency, results oriented philosophy of managed care is supported by our quality assurance performance improvement plans and our quality-focused policies and procedures. We have extensive experience in gathering data and have made data analysis central to our model of continuous quality improvement. Our organizational structures, including the local model proposed for the Iowa Plan, are based on interdependent relationships among quality, network management, utilization management and member services staff, with the quality assurance team providing both leadership and support for interdepartmental clinical quality processes. The quality team functions include auditing and monitoring of network providers' services and Cenpatico's internal care management processes, data collection and analysis, and communicating data analysis results to appropriate staff for implementation in specific training and corrective action planning with providers. The quality team, in collaboration with other departmental staff is also responsible for developing and implementing population-wide quality improvement activities in response to identified statistically significant deficits in both Cenpatico's internal care management processes and in network providers' quality of care.

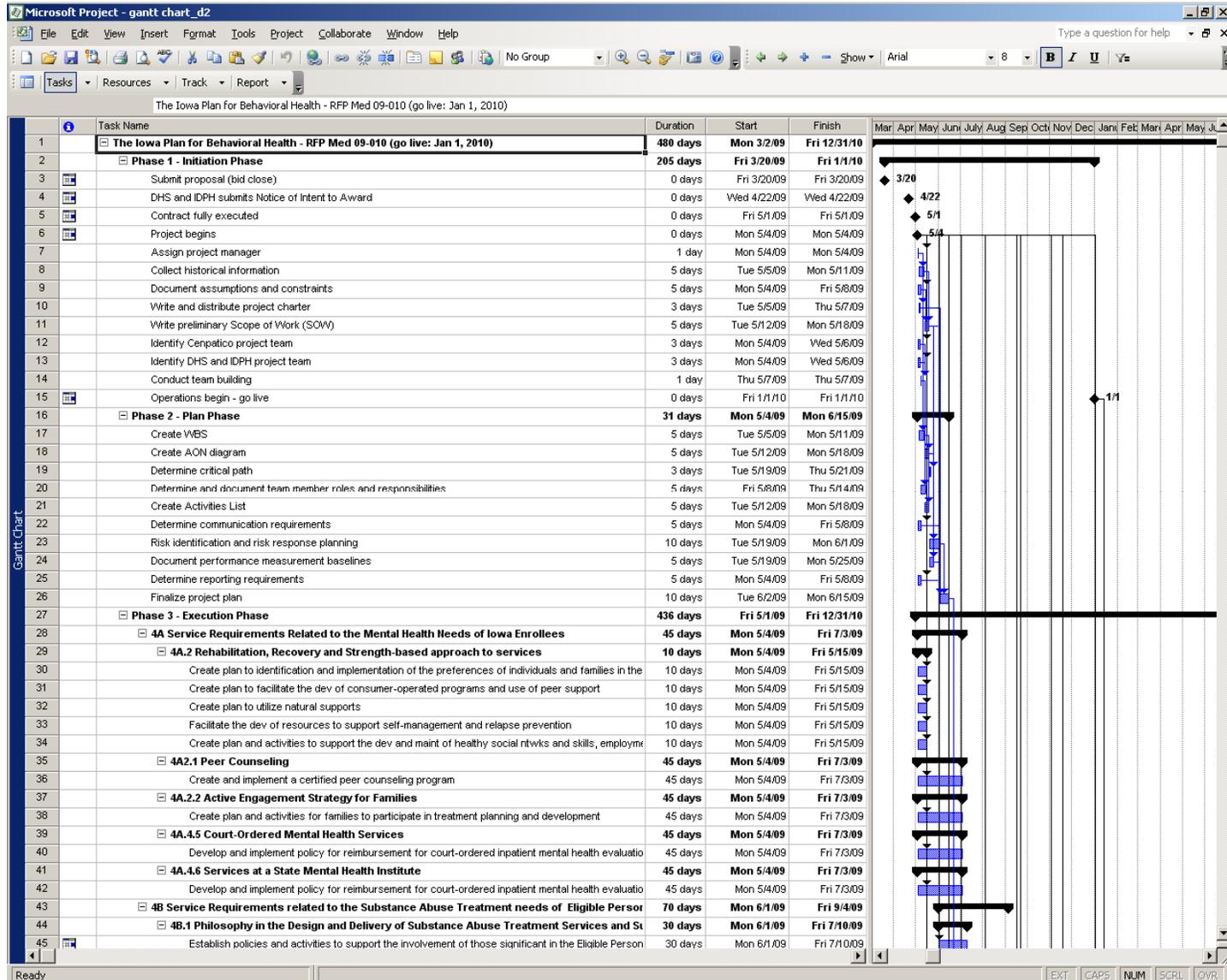
Our **Psychotropic Medication Utilization Review (PMUR)** initiative will work for Iowa as it maximizes opportunities to utilize pharmacy data to improve the quality of care. This initiative uses an automated **pharmacy claims analysis** process to identify consumers who are outside specific medication utilization parameters. The automated process is able to screen thousands of prescriptions, physical health and behavioral health claims on a monthly basis. Consumers who are identified as being "outside parameters" by

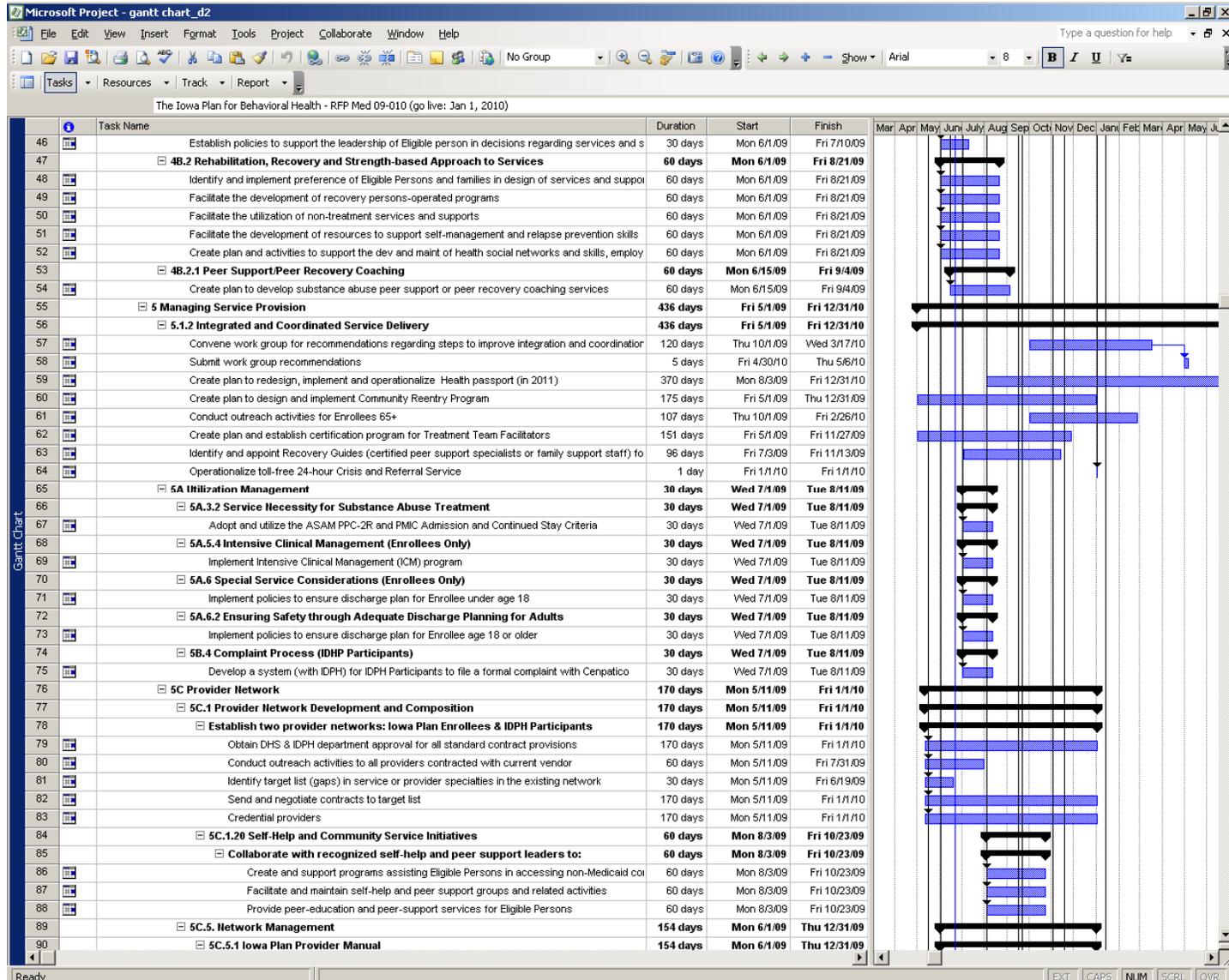
the automated screening process are reviewed by Cenpatico clinical staff. They obtain the most recent information regarding the member's diagnoses, medication regimen, response to treatment, copies of psychological evaluations, psychiatric evaluations and treatment progress notes. If this information reveals that an individual's medication is outside parameters, accepted practice, or is causing significant side effects, the case is forwarded for a formal PMUR. Cenpatico medical management triages the PMUR request to consultant psychiatrists who review the available information, and do peer-peer outreach with the prescribing physician. We have seen significant decreases in inappropriate psychotropic prescribing patterns since implementing this initiative in other markets.

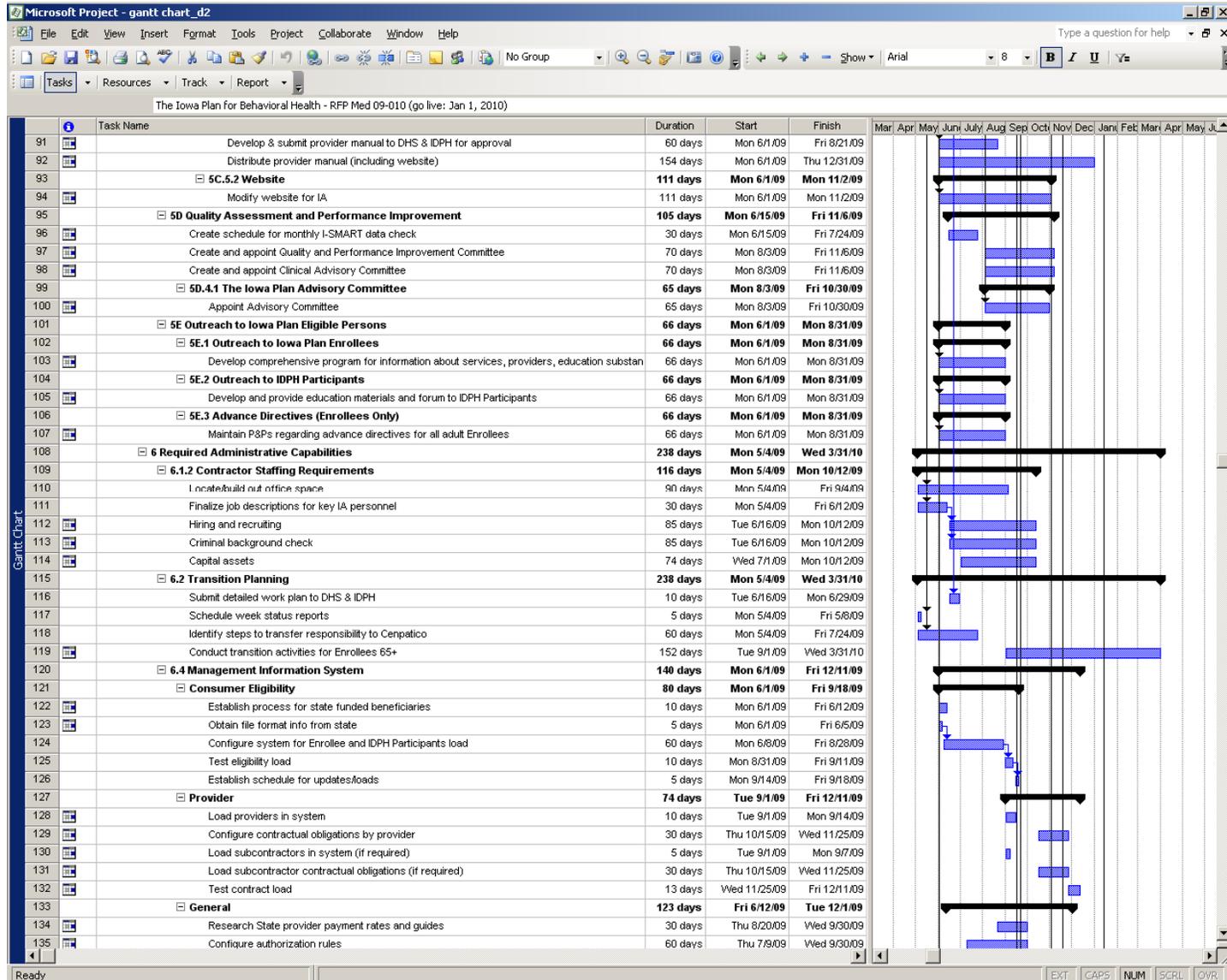
Another population wide quality initiative that we will offer the Iowa Plan is a preventative program for women who are pregnant or post partum. Our **Perinatal Depression Program** is a coordinated project between Cenpatico and medical health plan management organizations. The purpose of the program is to educate members in the perinatal period about the risks of depression, the signs and symptoms of depression, and to educate the member about accessing services for treatment of depression. Screening materials are distributed to members identified as pregnant or newly delivered. The screening tool utilized for this program is the Edinburgh Postnatal Depression Scale, which measures likelihood of prenatal or postnatal depression. Our Intensive Clinical Management and Care Coordination staff utilize these tools to identify early indicators of depression, and link Eligible Persons with services before they experience behavioral health crises. Our recovery, resiliency, results oriented philosophy of managed care extends to quality initiatives that allow for maximum impact, for prevention and early intervention for Iowa's Eligible Persons.

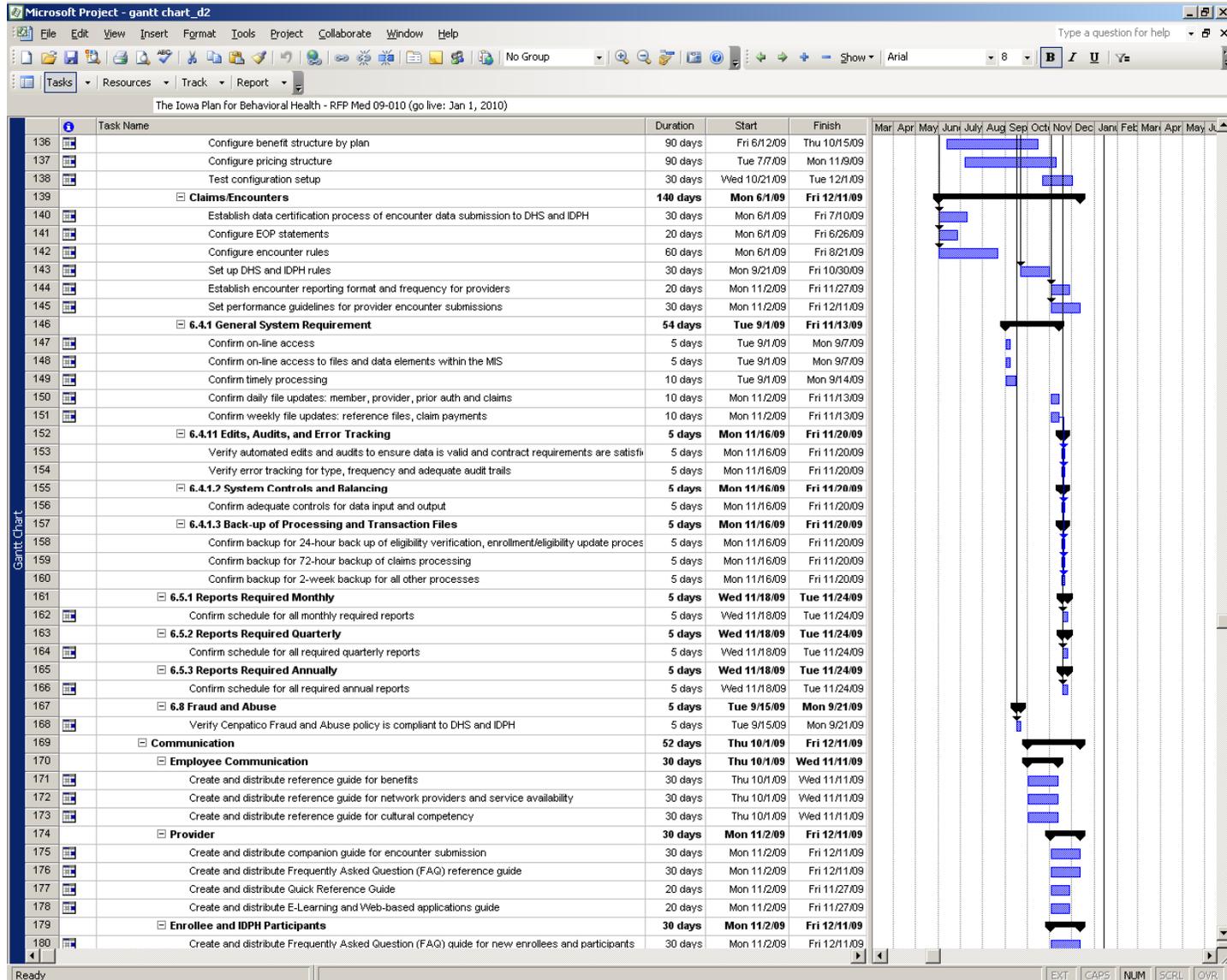
Cenpatico has made a deliberate and thoughtful decision in choosing to respond to the State's request for proposal for the Iowa Plan for Behavioral Health. Our primary goal in this proposal is to bring creative solutions that improve opportunities for Iowan's to receive care that supports their goals for recovery, empowers them to be active participants in their care, and enables them to live fulfilled lives in their communities. We believe that the foundation for this goal already exists in Iowa. Our regionally focused model will provide the structure to build statewide availability for services by developing the strengths of existing local assets and focusing targeted resources to address specific local challenges. To achieve this transformation we will avoid heavy handed management in favor of consensus building strategies with providers and communities, specifically seeking and applying guidance from consumers and families. Our proposal reflects our belief that consumers and their families can successfully recover from mental illness and substance use disorders, and that consumer-driven care is necessary for consumer recovery.

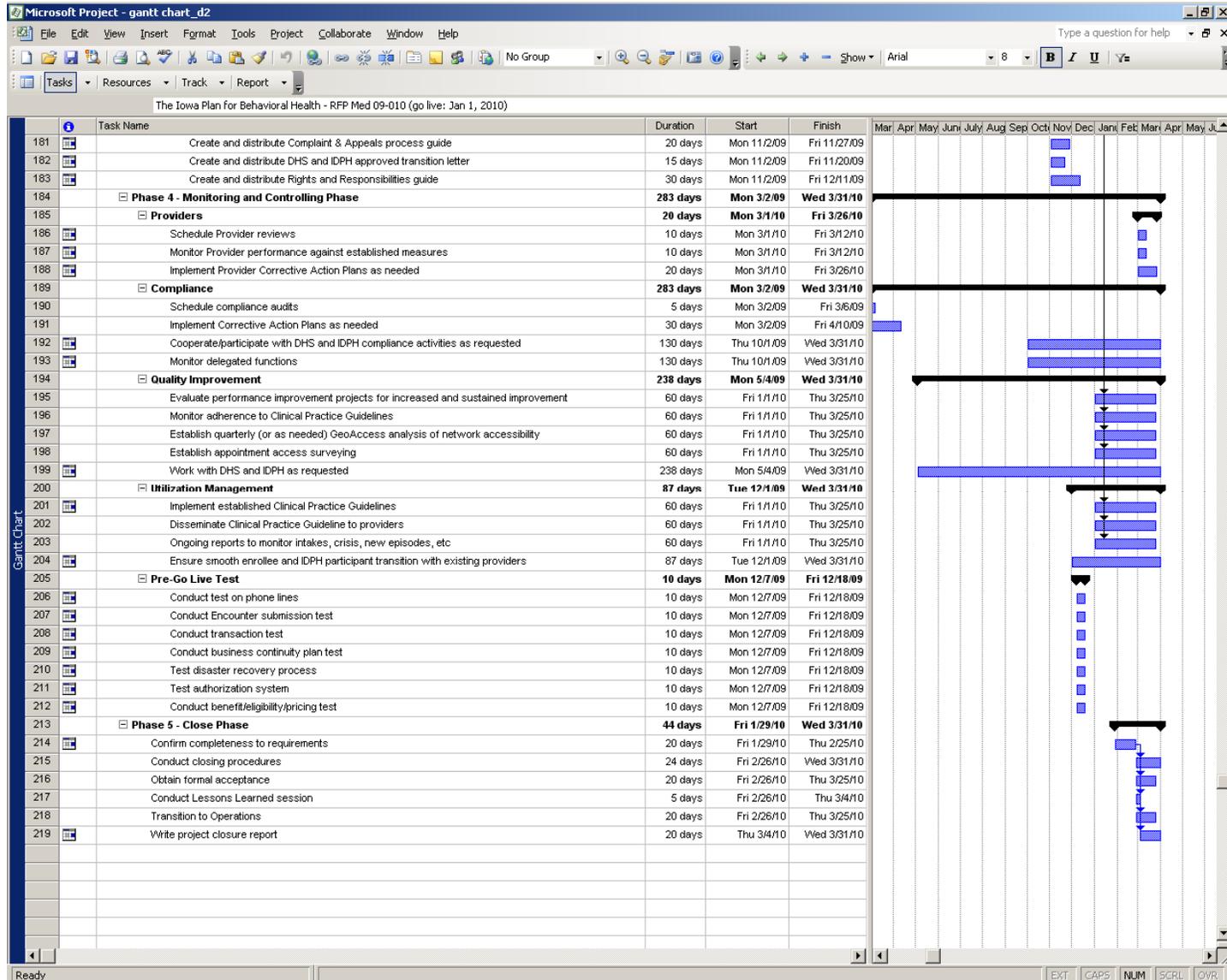
Cenpatico brings extensive implementation experience to the Iowa Plan. We undertake each new contract with an individualized locally oriented approach and dedicate sufficient knowledgeable and well-trained resources to provide compliance with all contract deliverables and individualized service. We currently manage fifteen contracts in nine states – all serving Medicaid and other publicly funded populations. Over the past four years, we have successfully implemented thirteen contracts – most with a shorter pre-operational implementation period than the eight months allowed in the Departments' schedule for implementing the Iowa Plan. Our implementation process accesses corporate wide resources and is supported through the utilization of standard project management principles, methodologies and techniques as established by the Project Management Institute (PMI). The following Gantt chart reflects our initial draft implementation plan for this contract.











### **7A.2.2 Enrollees 65 and Older**

**Describe the Bidder's experience in treating individuals aged 65 and older. Please provide information on:**

- **other states in which the Bidder provides or has provided such coverage;**
- **particular challenges the Bidder has encountered in serving this population;**
- **any recommended additions to the provider network to better serve those aged 65 and older, and**
- **a proposed transition plan to ensure continuity of care while enrolling the population into the Iowa Plan, including a communication plan.**

Cenpatico's recovery and resiliency programmatic approach for Iowa includes developing working partnerships with older Iowa Enrollees and community stakeholders to find solutions that best meet the needs of this population. Our experience developing collaborative partnerships and primary prevention programs for older adults in Arizona, and our work implementing programs to reduce readmission rates for the Aged, Blind, and Disabled population in Ohio provides us unique insight as to the needs of the older adult subset of the larger consumer population. We bring our experience with identifying and removing barriers, such as poor communication between medical and behavioral health providers; the ability to develop and implement innovative programming like suicide prevention and substance abuse awareness programs for older adults; and how to effectively manage transitions through general and targeted outreach and communication planning, to the Iowa Plan for Behavioral Health.

According to the Iowa Association of Area Agencies on Aging (AAA):

- There are currently 554,573 Iowans aged 60 and over, nearly 1/5 of the State.
- One out of every four households in Iowa is providing care for an older family member.
- Iowa Ranks 2<sup>nd</sup> in the nation in the percent of population aged 85 and older.
- Iowa ranks 4<sup>th</sup> in the nation in the percent of population aged 60 and over.

Meetings with community members and current program analysis tells us that in many areas of Iowa, the tools for community care for older adults exists, but need streamlined coordination across the multi-dimensional delivery system to increase access for more individuals. Through regional care coordination and innovative technologies, like our *Health Passport*, Cenpatico is uniquely positioned to maximize Iowa's existing supports and programs that enable older adults to live successfully in their communities. We will partner with agencies like the Iowa Department of Elder Affairs and Area Agencies on Aging to streamline coordination with programs such as Case Management Program for Frail Elders (CMPFE) and the Consumer Choices Option program, which allows older adults to receive flexible funds to design their personal care program. Through agency collaborations and community stakeholder coalitions, we will take action to augment or sustain effective community care for older adults.

### **Experience in Other States**

**Arizona:** Cenpatico serves the elderly population in Arizona and engages primary prevention programs for behavior change, increasing knowledge, and improving skills specific to elderly adults. These programs focus education and outreach efforts on older adults and their caregivers to improve awareness of available services in the community, understand signs of behavioral distress, and reduce the stigma many older adults have about getting help.

Cenpatico contracts with the local Area Agency on Aging, Pinal Gila Council for Senior Citizens (PGCSC), for suicide prevention services targeting older adult populations. SAPT funding is used for primary prevention to provide suicide prevention training to caregivers and gatekeepers and for the Ambassador program designed to create mobile community resources for seniors. The *Ambassadors* program was awarded the Center's for Substance Abuse Prevention (CSAP) *Service to Science* award. This Cenpatico funded program has become an evidence-based program meeting the criteria for SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). The Ambassador program recruits, trains and supervises community members to identify the needs of seniors in their communities to reduce depression and isolation and assist with access to care. By the end of 2008, 40 community members were actively

engaging in mobilizing their respective communities. An additional 17 Ambassadors are now trained and working closely with community stakeholders to reduce depression and isolation and improve safety and health factors by mobilizing community resources to meet the needs of older adults. An example of how this program has worked to mobilize community resources to benefit older adults is the *Home Alone* program. Ambassadors obtained *Home Alone* pendants and worked with local EMT, Fire, and Police departments to install them in the homes' of seniors. Local realtors donated lock boxes for the home owner's house keys. As a result, first responders can get into the house and assist the senior during emergencies.

For Iowa, we will support, develop, or implement suicide and substance use and abuse prevention programs for older adults keeping to the fidelity model of the *Ambassadors*. We will collaborate with Iowa's thirteen Area Agencies on Aging to train "Ambassadors" which will then train and work closely with Area Agency on Aging staff in implementing educational strategies that work towards increasing awareness regarding the risks associated with substance abuse, depression and suicidal behaviors. Such a model will ensure the caregiver, healthcare professional, and direct care staff for older Iowans are aware of the needs of this population and can then make an appropriate intervention.

**Ohio:** Cenpatico implemented a contract for serving an Aged, Blind and Disabled (ABD) population in multiple regions of Ohio in 2007. Older adults with behavioral health disorders were less likely to be engaged with outpatient care and experienced a high percentage of out-of-community placements as a result. Our clinical staff noticed traditional barriers such as stigma, misdiagnosis, and social isolation did exist, however, complex co-morbid medical issues, and poor coordination of services between physical and behavioral healthcare presented the biggest challenges. In response, we launched an **integrated model of Intensive Clinical Management (ICM)** to meet the challenges of older adult behavioral healthcare. The primary focus of this care management model is coordinating the complex needs and service matrix, through identification, assessment, education and collaboration with providers. In our model, specialized ICM staff work to address patterns known to be associated with older adults who have a severe and persistent mental illness including: high utilization of acute care and stabilization services, frequent readmission, high emergency room utilization, high pharmacy costs.

Through our local team of Intensive Clinical Managers and Care Coordinators' outreach to community providers, we have successfully coordinated across care systems by building relationships with community care agencies, facilities, and community mental health center (CMHC) staff to better identify and coordinate the overall care of Enrollees. Collaborative efforts to remove barriers to treatment such as, transportation needs; regular communications with acute care providers through emergency room reports and inpatient admission reports; and regularly scheduled **Treatment Team meetings** to discuss complex clinical issues of individual members, work to advance continued recovery for Enrollees and are the core of our integrated efforts with community providers.

**Lessons Learned:** Our experience with the older adults in Arizona and Ohio demonstrates that older adults with behavioral health disorders are less likely to utilize traditional outpatient care and often experience a higher percentage of out-of-community placements as a result. Barriers to service utilization include poor coordination between physical and behavioral healthcare for complex needs, stigma, misdiagnosis, and social isolation. When community-based care expands to include wrap-around services, in-home care, and peer support, out-of-community placements are reduced. We have learned from our experiences in Arizona and Ohio that the bringing the care, education, and information to the elderly is crucial to improving recovery outcomes. Natural supports and community caregivers such as peers, churches, senior center staff, and family members must be included in the care plans of older adults to improve access to care. This requires improved outreach and training to recognize signs and symptoms of behavioral health needs or crisis in older adults.

**Strategies for Improvement:** To best serve Iowa's older adult population, we will support Enrollee's ability to get the help they need, through ICM and our provider network, and we will implement strategies to

improve prescriber, physical, and behavioral health provider communications through integration, including community outreach, network strategies and use of *Health Passport*.

***Clinical Expertise:*** To ensure that expertise and experience with special needs of older adults will be available for the Iowa Plan, we will employ ICM staff to specialize in geriatric issues who will be the assigned clinical staff for Enrollees over 65 with high service needs, regardless of region. This specialist ICM will also provide in-house training quarterly, and as needed for all clinical staff. We are committed to identifying and addressing the behavioral health needs of an older adult population. We will support, develop or, implement programs in Iowa that utilize evidence-based practice for older populations and expedite routes to care in a behavioral health emergency.

For older individuals, care coordination activities such as discharge planning from an acute level of care or finding transportation to appointments, must be especially sensitive to issues of social isolation, continued community tenure, and stigma associated with mental illness. Our outreach activities for older adults will include but not be limited to:

- Proactive identification and outreach to elderly Enrollees with high utilization of medical or behavioral health services during the implementation process to assess need and appropriateness for ongoing ICM or CC follow-up.
- Individualized care planning with Intensive Clinical Managers and Care Coordinators acting as resources for community providers to bridge the gap between covered benefits and additional supports for positive outcomes like locating housing post-discharge or linking them with meals-on-wheels.
- Communicate discharge plans to primary medical provider and outpatient behavioral health providers
- Provide resources and referrals for service needs, or for prevention and early intervention programs.

***Health Passport:*** A primary concern in the care of older adults is medication complications or side effects caused by drug interactions. Improving prescriber access to medication regimens is an integrated healthcare mechanism that addresses this concern for Iowa’s older adult population. In Texas, we have partnered with Superior Health Plan and the Texas Health and Human Services Commission to bring an innovative integrated health, electronic solution to market called *Health Passport*. 6,120 physical health providers and 3,800 behavioral health providers currently use *Health Passport*. Though *Health Passport* was designed to serve the foster care market, this product demonstrates potential in serving all vulnerable populations with specific benefits for Iowans 65 and older.

*Health Passport’s* application for Iowa’s older adult population would reduce potential for inappropriate prescribing patterns and possible exposure to dangerous side effects that the elderly are more likely to experience as physical health specialists and behavioral health specialists will have quick access to pharmacy data to check for possible drug interactions. *Health Passport* will act as a secure electronic, web-based repository for behavioral health assessments, crisis, treatment, and service plans that have been done so that current providers can continue the plan of care. Providers can upload psychological evaluations, pharmacists can enter prescription activity, and physical health doctors can add current lab activity all to the Enrollee’s *Health Passport* so that services are not duplicated or undermined. Immunizations, medications, and drug allergies are part of *Health Passport*. The psychiatrist seeing an older Enrollee who recently experienced a physical health crisis can view the medications prescribed by doctor’s treating a heart condition and can coordinate psychotropic prescriptions to make care as integrated and seamless as possible.

*Health Passport* is an “opt-in” web-based application that allows for role-based access designated by the individual consumer. Enrollees may choose their level of participation with this comprehensive database that allows for recording all enrollee contact and demographic information, as well as referral request and follow-up information. Once the Enrollee “opts-in” they continue to maintain control over which providers and care givers have access to their care information. Additionally, the information is layered, allowing for example

the psychiatrist and cardiologist to see only prescription and diagnosis information, while the Enrollee elects for their Targeted Case Manager to have access to their complete database. Health Passport functions as a repository that allows multiple agencies to record and track Enrollee information while allowing the individual to maintain control over access.

***Psychotropic Medication Utilization Review:*** In addition to our *Health Passport*, we will utilize specific psychiatric consultations for the older adult Enrollee population in Iowa. Iowa, like many other states faces a shortage in psychiatrists and medication management services. Compounding this problem for the older adult population is a lack of prescribers with specialized training in psychotropic management for the elderly. We faced a similar shortage of special population psychiatrists in Texas and implemented our **Psychotropic Medication Utilization Review (PMUR)** program to help address this need. The primary function of the program is to ensure quality of care for Enrollees prescribed psychotropic medications by contracting specialty psychiatrists who can provide consultation to behavioral or physical health prescribers in underserved areas. Since implementing the *PMUR* process in Texas we have seen decreases in polypharmacy due to physician awareness of and improved compliance with quality and clinical practice guidelines.

In Iowa, we will utilize pharmacy data with our automated pharmacy claims analysis process allowing us to identify older adults whose medication regimen is outside specific medication utilization parameters. In circumstances where medication regimens are outside the parameters, and there is evidence of inappropriate prescribing, we initiate a Quality of Care (QOC) review, and facilitate the Enrollee obtaining a second opinion or care with a new provider. Since implementation last year of *PMUR* for another high needs population, foster children, there has been a 13% decline in the number of foster children prescribed psychotropic medications overall and specifically a 74% decline in polypharmacy. This program will bring similar success in promoting medication safety for older adults in Iowa.

***Caring Voices:*** A primary barrier to care for older adults is social isolation. For older adults with higher service needs, not having regular means of communication to schedule appointments or make contact with case workers is a barrier to recovery. When this barrier is identified for older persons discharging from an acute care setting our *Caring Voices* program can help. Cenpatico has piloted *Caring Voices* in our Ohio market with the ABD population as a way to increase the high risk older adult's ability to get the reach out for the help they need. *Caring Voices* is a pre-programmed cellular phone given to an Enrollee in their discharge toolkit to improve follow-up care after hospitalization by providing vital access to care by offering a pre-programmed cell phone to the consumer at discharge. The telephone contains phone numbers that are used most by the Enrollee in their recovery such as their psychiatrist, therapist, CSP, primary care physician, case manager, pharmacy, and may include care givers or community supports identified in the treatment and crisis plan for the Enrollee. This program has been well-received by consumers as a resource. Since program implementation, the impact on consumer recovery is evidenced by a 75% reduction in behavioral health inpatient readmissions for our *Caring Voices* participants in Ohio and we believe this program will be beneficial to Iowa's older adult population as well.

***Training for Stakeholders:*** We propose increasing training and education across communities for the safety of the older adult Enrollee. Our training program will include volunteers and staff in the Senior Centers utilized by Enrollees. We will provide trainings and outreach through our Member Services Department. Our Interagency Liaisons will perform outreach activities and trainings with local agencies on aging and senior centers. To improve safety and resiliency for older Enrollees in the community, our education and training will extend to PCPs, EMTs, mail carriers, utility workers, religious volunteers, and first responders, and other concerned community members on identifying behavioral health symptoms specific to an older population, barriers and routes to care.

Cenpatico stresses the importance of education and skill development of not only the Enrollee but of the community through contracting with providers to facilitate the education and skill development of community partners and the Enrollee, in a natural environment (neighborhoods, trailer parks, libraries, senior

centers, churches, VFW halls). Local stakeholders and support personnel are trained to facilitate groups that will provide information on topics, (depression, suicide prevention, alcohol abuse, prescription drug abuse), vital to the prevention, early intervention and treatment of behavioral health issues prevalent in the elderly. We also use the media (public radio announcements) and community events to promote awareness and education.

### **Specific Recommendations for Increasing Network Capacity for Older Adults**

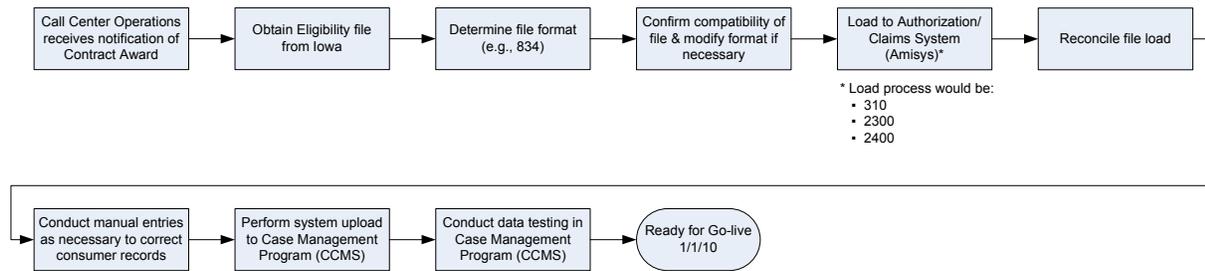
- **Expand array of reimbursable home-based services** to include assessment/evaluation, ongoing therapy services, family counseling, and medication management services for those behavioral health providers willing to provide services in home-based settings
- **Expand opportunities for community based services (waiver services) for older adults by creating Comprehensive Service Providers (CSP)** that act as centralized locations for a greater range of community based services.
- Expand older adult **Peer and Family Support Specialists staff with specialized training in risks and strategies to care for older adults**. These staff will work in community prevention programs like the **Ambassadors**, as well as CSP, and other community-based modalities. Our peer and family trainings will be individualized for Iowa, and consistent with National models such as the Georgia Peer Support Specialist Training and the DBSA Peer Support Training.
- Address the behavioral healthcare workforce shortage by **providing resources for Iowa community colleges to develop a Behavioral Health Basic Certificate program and an Advanced Certificate program**. These certificate programs prepare students for careers as behavioral health technicians, case managers, parent aides, peer support, family support, family advocates, respite care workers and paraprofessional staff. Specific training courses will focus on older adult populations. This workforce development supports Iowa's recovery model.
- **Contract with Iowa Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)** which have behavioral health services in place at their locations and/or negotiate expansion of their services to include behavioral health screenings and basic services.
- Engage FQHC and RHC to serve as remote site partners for Enrollees to receive services via **telehealth** in an effort to expand consumer access across the State.

### **Transition of Enrollees to the Iowa Plan**

We will address this item in two parts: Part one describes the technology and data process to transition exiting Enrollees' data to our technology systems. Part two addresses the transition of the Enrollees themselves to Cenpatico management.

**Part one:** Technology and data process: Once we receive notification of contract award, our Call Center Operations Manager will submit a request for the eligibility file (e.g. 834). Then we will confirm the compatibility of the file and make any modifications to the format if necessary. We load the data onto our authorization/claims system (AMISYS) and reconcile the file load. We then conduct any manual entries, if necessary, to correct any Enrollee records and perform a system upload to our case management program (CCMS). Finally, we conduct data testing in CCMS to be ready for the go live. The diagram below demonstrates the process flow to transition existing Enrollees' data to our technology systems:

### Enrollee Transition Process Flow



**Part two:** Transition of elderly Enrollees to Cenpatico: Our goal is to reduce barriers to care and make the transition transparent for the older adult with no disruption to their services. Critical for continuity of care is expedited contracting for providers that work with or specialize in care to older adult populations. Our Network Management team will prioritize contract negotiations with these providers to ensure continuity of care for older adults. Additionally, our staff will be trained and familiar with services offered through provider agencies and able to assist Enrollees in connecting with the right services for their needs. To ensure this happens requires **both general and targeted communication plan for outreach and education** to the older adult population.

**Our general communication and education plan** will include outreach and communication with Enrollees and community members that have most frequent contact with elderly Enrollees through the use and in cooperation with the local senior centers, churches, older adult living communities, libraries, hospice programs, hospitals, and pharmacies. We will have public notice posters and fliers designed with imaging and print type marketed toward an older population. Notices will explain key dates and information about the transition, and will include our Iowa toll-free number, local office address, and website for obtaining further information. Our staff will work with communities that have higher populations of older adult Enrollees to coordinate community education sessions. These education sessions will be led by our Communications Specialist, and open to Enrollees, caregivers, and other stakeholders to provide direct access to Cenpatico staff for questions or concerns and an provide opportunity to build relationships between this special population and Cenpatico.

**Our targeted communication and education plan** will focus on Enrollees (65+) identified as having a history of high service utilization for either medical or behavioral health services. For these older adults, in addition to the general education opportunities outlined above, our Intensive Clinical Managers (ICM) will make outreach calls and send introduction letters to build a rapport with this community and let enrollees know who they can contact with service coordination questions. At this point of contact, our ICM staff will conduct a needs assessment to determine appropriateness for continued follow up in the ICM program. The ICM will also assist the individual with any service coordination needs at this time. Should this Enrollee need continued ICM follow up, the older adult Enrollee will be assigned to our Intensive Clinical Manager that specializes in older adult care.

**Throughout the transition,** we will conduct several rounds of direct mail campaigns with letters and documents to explain who we are and when the transition is occurring. Direct mail and welcome letters will be presented in easy to read font and style, will present the details of the transition process, and outline the services we offer. We will also include our welcome kit with information specific to older adults that will include: the toll-free number to our customer service center, *Health Passport* information, a resource card describing all the local community resources available, and a medical log to aid the Enrollee in tracking their medications and doctors appointments. All communication activities will be planned and scheduled in advance with any documents or communication determined appropriate by DHS and IDPH. Further, we will

use community meetings at locations convenient and accessible to the older adult population and their care givers, to share information and get feedback as appropriate.

### **7A.2.3 Coordination and Integration of Services**

**a) Describe what strategies the Bidder would employ to ensure the coordination and integration of service delivery for Eligible Persons who receive services through the Iowa Plan. In particular, please describe how the Bidder will improve integration of services for:**

- **Eligible Persons with concurrent mental health and substance abuse conditions**
- **Eligible Persons with concurrent medical and mental health and/or substance abuse conditions;**
- **Eligible Persons with mental health and/or substance abuse conditions who are involved with the adult correctional system;**
- **Enrollees with concurrent mental health needs and mental retardation, and**
- **Eligible Persons with mental health and/or substance abuse conditions who are involved with the child welfare/juvenile justice.**

**Include background information, research data, and your experience in other states on how best to structure coordination and integration. Describe lessons learned and how they will be applied in Iowa.**

### **Systemic Transformation Approach and Goals**

Cenpatico has extensive experience tailoring service coordination across diverse populations and communities. We start by learning the strengths and deficits of the current service delivery system. While researching the Iowa Plan service delivery system, we heard from stakeholders that the current system is complex and fragmented. At present, coordination and integration efforts appear to be problem- rather than strengths-based, compartmentalized, and do not comprise true systemic coordination of a community based system of care and services. In addition, the rural counties in Iowa present an environment of specific challenges in which to coordinate and integrate services due to geographic distance barriers and variance of service availability.

Cenpatico proposes a multi-pronged approach that builds on the successful components of the current system and implements specific strategies aimed at effecting system transformation. System transformation will result from multi level coordination across Iowa State Departments, Divisions, and Agencies (including corrections, child welfare, aging, disabilities, etc), counties and their Central Points of Coordination, community resource agencies, consumer advocacy organizations, peer support providers, professional service providers, natural supports and other identified recovery-oriented community resources. This approach supports achievement of the following goals:

- Reduce fragmentation and inefficiency in the existing delivery system;
- Improve quality of care and service delivery within a framework of recover and resiliency principles while containing costs; and
- Increase outreach to, and opportunities for, Eligible Persons to participate in decisions which impact how the service delivery system functions.

Our approach to achieving these goals includes a staffing model that provides interdepartmental support for achieving optimal integration and coordination of services. While our Clinical Department staff for the Iowa Plan, including Utilization Managers, Intensive Clinical Managers, and Care Coordinators will work to coordinate services for individual Eligible Persons on a case-by-case basis, our overall model for the Iowa Plan utilizes the Quality, Network Management and Member Services Departments to address system improvements from a more macro perspective. Our Iowa Plan Director of Network Management, along with the Clinical Provider Liaisons designated for each of the six (6) regions, will work to enhance and expand the current provider network to support improved integration and coordination of services through negotiated contract requirements as well as provider training, monitoring, and technical assistance. Our Iowa Plan Member Services Director will take the lead in developing and implementing a strategic plan to fully engage Eligible Persons and their families in the process of transforming the Iowa Plan behavioral health services delivery system in ways that best support the recovery of Iowans. The Director will be supported in these outreach and engagement activities, as well as in implementing feedback from Eligibles and their families,

by the Member Services Department staff, including the Recovery & Resiliency Advisor, Family Advisor, Interagency Liaisons (IAL), Communications Specialist, and Grant Writer. In addition, specific Member Services Department staff, including IAL, will work with other system agencies/entities to ensure that consumer feedback is implemented in all efforts to improve integration and coordination of services. Toward this end, the Member Services Director will be responsible for the development and implementation of an allied service coordination plan to address service coordination across systems. The Grant Writer will work with providers, community resource and advocacy agencies, consumer owned businesses and peer supports to identify and access available additional funding to strengthen recovery oriented services for Iowa Plan Eligibles. Finally, our Quality Director, supported by Clinical Quality Assurance Coordinators located in each of the six (6) regions, will collect and analyze data to assess and recommend changes that may be implemented within any department in order to improve overall outcomes for Eligibles.

## **General Strategies for the Iowa Plan, Cenpatico's Background and Related Experience**

### ***Asset Mapping***

For the Iowa Plan, appropriate Member Services and Network Management staff, in partnership with the Recovery Advisory and Clinical Advisory Committees, will implement Asset Mapping in order for us to fully determine the scope of the existing services delivery system as the basis for expanding and enhancing it. Asset Mapping is a process that can be used in any community and is an effective strategy for involving all of a system's stakeholders in helping to bring about improvements in a community's service delivery system. This process draws upon the work of John P. Kretzmann and John L. McKnight, described in their book "*Building Communities From the Inside Out: A Path toward Finding and Mobilizing a Community's Asset*"<sup>1</sup> and provides a structured approach to comprehensive data gathering, including information on all existing formal and informal services and resources available in each service area, building relationships to broaden local involvement, developing and implementing a shared vision and plan for strengthening the community, and leveraging outside resources to support local activities.

### ***Comprehensive Service Providers***

Cenpatico's vision for the Iowa Plan Provider Network includes a regionally-focused statewide system of Comprehensive Service Providers (CSP) as we have found this to be an effective network design for greater systemic coordination of recovery services. We use this model to support a community-based system of service delivery that is able to provide and coordinate waiver and wrap around services not typically offered by independent providers or more limited outpatient agencies. In addition, CSP allow consumers to receive coordination and integration of service with greater ease of access as one agency provides most services and is the central point for coordinating services needs with other resources. The provider network also includes independent providers and other agencies in order to ensure the greatest geographic access and to allow for consumer choice of providers. The CSP offers a provider choice that simplifies access for consumers who require multiple services to meet their recovery needs.

In Iowa, we will negotiate with existing provider agencies and support collaboration among providers to develop two Comprehensive Service Provider agencies within each of the six IDPH regions. It is our expectation that we will begin the negotiating process by exploring the interest of the Community Mental Health Centers in each area to expand or collaborate among themselves to create CSP. While CSP may serve any Eligible Person, they will provide comprehensive integrated programming and service coordination specifically intended to better serve Eligibles who are identified as having the highest needs for support for their recovery. High-needs individuals include, but are not limited to:

- Eligible Persons with concurrent mental health and substance abuse conditions
- Eligible Persons with concurrent medical and mental health and/or substance abuse conditions

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<sup>1</sup> Kretzmann, J. & McKnight, J. (1993) *Building Communities from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets*. The Asset-Based Community Development Institute, Institute for Policy Research. ACTA Publications.

- Eligible Persons with mental health and/or substance abuse conditions who are involved with the adult correctional system
- Enrollees with concurrent mental health needs and mental retardation
- Eligible Persons with mental health and/or substance abuse conditions who are involved with child welfare/juvenile justice systems
- Eligible adults with severe and persistent mental illness
- Eligible children with severe emotional disorders and their families
- Eligible children in out-of-home placements
- Eligible Persons age 65 and older in out-of-home placements
- Eligible Persons at risk for out of home placement
- Eligible children and their families involved with multiple State agencies
- High utilizing individuals
  - Eligible Persons that are receiving an array of behavioral health and/or substance abuse service simultaneously; or
  - Eligible Persons with multiple acute hospitalization readmissions

The CSP will provide, administer and coordinate the majority of services that high-needs Eligible Persons require for support of successful recovery. Acute care and specialty services will be available through local hospitals, Mental Health Institutes, Community Mental Health Centers, or other contracted independent providers/groups available locally. If the CSP is missing certain services or provider types, Cenpatico will work with the CSP to implement a plan to develop the service, recruit the provider type, or collaborate with other providers to address the service gap. We will work with the CSP to implement referral systems and business agreements among CSP and other local providers/resources to ensure integration and coordination of all services. We will support expansion of Assertive Community Treatment (ACT) team activities for Iowa through community reinvestment funds. We will negotiate contracts with CSP to provide ACT team services to the high needs individuals for whom they are offering services.

### ***Health Passport***

*Health Passport* provides a vehicle for information exchange among providers and functions as a foundational tool for integration and coordination of services. Cenpatico, doing business as Integrated Mental Health Services, worked with Superior Health Plan and the Texas Health and Human Services Commission to bring an innovative product known as the *Health Passport* to serve the foster care population in Texas in April 2008. Approximately 30,000 children are served through the foster care system in Texas. *Health Passport* is currently used by 6,120 physical health providers and 3,800 behavioral health providers. *Health Passport* is web based and does not require users to have product-specific software. *Health Passport* is not a full electronic medical record – it contains summarized data such as service plans, EPSDT screenings, behavioral health assessments, medication, vaccinations, and historical and current treatment summaries, rather than complete records with progress notes, physician notes, etc. It is a primary tool for ensuring communication of key information among all members of the multidisciplinary service team.

*Health Passport* is readily adaptable for Iowa Plan Eligible Persons to coordinate and integrate services and pertinent data among multiple behavior health and physical health providers for high needs Eligible Persons. Upon receiving approval from the Departments, we will form a steering committee with membership reflecting a cross section of relevant stakeholders (Eligibles and their families, behavioral health and medical providers, advocates, state and local government agencies, etc) to review the current *Health Passport* features and determine what modifications would best serve Eligible Persons in the Iowa Plan. We envision that initially the *Health Passport* will be implemented to serve high needs Eligible Persons and be administered via the CSP system. We will develop an implementation plan that operationalizes use of *Health Passport*, including processes and procedures for:

- Identifying and engaging medical, behavioral health, and substance abuse treatment service providers;

- Outreach and education to Eligible Persons, including obtaining informed consent for sharing information to be included in the *Health Passport* among specific service providers;
- Extensive and ongoing provider training and technical support; and
- Collaborating with appropriate state agencies to access and update pharmacy data.

We anticipate readiness to roll out an Iowa Plan *Health Passport* across all CSP in year two of the contract, 2011. In compliance with federal and state privacy requirements, the program will be offered on an “opt in” basis for both providers and Eligible Persons. However, we will implement robust outreach, education and engagement efforts to support the use of this tool to improve integration and coordination of services.

### ***Team-Based Service Planning***

We will build on the Iowa Plan’s current Joint Treatment Planning concept, and will utilize the CSP network structure to facilitate the process. We draw upon our experience in other states, such as our Arizona Team-Based Service Planning experience, which is grounded in the philosophy that coordination and integration of services should occur for each consumer based upon the following principles:

- **Strength and Needs-Based Planning.** Based on the initial and ongoing strength-based assessment, the service plan is customized to creatively reflect the person’s unique culture and individual and familial strengths in addressing the person’s mental health and/or substance abuse conditions and other support needs.
- **Consensus.** All team members strive to reach consensus, recognizing that consumer choice ultimately drives the service plan.
- **Jointly Established Service Plans.** For consumers with criminal justice, child welfare, MRDD or other significant multi-system involvement, a jointly established service plan is developed and collaboratively implemented.
- **Natural and Informal Supports.** Membership of service planning teams includes representatives of natural and informal community based supports.
- **Collaboration.** Collaboration is sought from other involved family members, agencies and community resources. The team strives to promote connections with all the appropriate supports the community has to offer rather than limiting the service plan to covered benefits.
- **Crisis Stabilization and Crisis Intervention Planning.** The team works to identify and develop strategies to resolve urgent health, safety and security needs and to prevent or mitigate crisis situations.
- **Cultural Competency.** The team process, from the assessment to the facilitation of team meetings and the provision of services, is designed to be culturally competent and linguistically appropriate, and based upon the unique values, preferences and strengths of the person, involved family members, and the community.

## **Population-Specific Strategies, Background and Related Experience**

### ***Eligible Persons with Concurrent Mental Health and Substance Abuse Conditions***

There is an increasing prevalence of individuals with co-occurring mental health and substance disorders (Minkoff & Cline, 2004)<sup>2</sup>, and it is common for these consumers to have poorer outcomes and higher costs in multiple system domains. Our approach to the coordination and integration of services for Iowa Plan Eligible Persons with concurrent mental health and substance abuse conditions includes a specialized team-based service planning process that ensures competency of service providers relevant to this particular combination of conditions. This approach is derived from our experience in Arizona, our most

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<sup>2</sup> Minkoff, K. & Cline, C. (2004). *Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-occurring Disorders*. Psychiatric Clinics of North America, Volume 27, Issue 4, Pages 727-743

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comprehensive contract, where our efforts include monitoring, feedback and offering incentives to ensure that substance abuse services are conducted in a manner consistent with the following principles:

- Services that support recovery through ongoing monitoring, feedback and re-engagement into treatment based on the consumer's changing needs over time.
- Services that treat the family as a unit and that include the family in the recovery process.
- Services that include assessment for co-occurring mental health conditions and physical disabilities or diseases.
- Services that include, as appropriate, a focus on returning the individual to the workforce or meaningful daily activity.
- Services that provide physician oversight of medical treatments (e.g., methadone, medications, and detoxification), to ensure that services are rehabilitative in focus and directed to long-term recovery management.
- Services that ensure coordination and continuity between behavioral health service providers and natural supports.
- Services that are delivered by staff competent to assess and treat substance use disorders in individuals and families.

In Iowa, we will also negotiate network provider contracts with the three substance abuse treatment providers (Center for Alcohol & Drug Services, Jackson Recovery Services, and Employee and Family Resources) that are currently offering pilot projects for Culturally Competent Substance Abuse Treatment. We will explore with each provider the outcomes of the projects and assist in developing sustainability plans for successful projects. We will assist Eligible Persons being served by these projects in receiving behavioral health screenings when indicated and offer CSP based coordination of services. Culturally Competent Substance Abuse Treatment Project service providers will be included on joint treatment planning teams.

### ***Eligible Persons with Concurrent Medical and Mental Health and/or Substance Abuse Conditions***

As part of the proposed CSP Provider Network model, we will develop specific programs to offer onsite general medical services to Eligible Persons with concurrent medical and mental health and/or substance abuse conditions. We will offer these programs in at least one CSP per region within the first year, with a goal to expand this service to all CSP by the second year of the contract. To achieve these goals, we will develop and implement a comprehensive outreach program geared to engage primary care physicians or other general practitioners who provide medical services to Iowa Plan Enrollees through the HMO, MediPASS, or FFS reimbursement systems. The underpinning of these strategies includes our experience providing integrated medical-behavioral health service planning in other states, including to Ohio high-needs consumers and in piloting full service wellness programs which include medical care onsite in Arizona CSP locations. Based on our continuous research in order to stay current in this area, Cenpatico embraces an overall managed care philosophy grounded in an understanding of the value of integrated medical and behavioral health care. It is this understanding of the efficacy of medical-behavioral health integration that we bring to the Iowa Plan. A brief survey of the significant evidence in the literature that consumers with complex co-occurring conditions tend to experience poorer outcomes despite higher costs for care includes:

- A study at the University of Washington, Seattle, found that increased depressive symptom severity was correlative to decreased diabetic medication regimen compliance and poorer diet (Ciechanowski, Katon, & Russo, 2000).<sup>3</sup> Decreased adherence to the medical treatment regimen can and does result in potentially more costly medical interventions, as the patient may suffer more severe complications of the

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3 Ciechanowski, P.S., Katon, W. J., & Russo, J. E. (2000). Impact of depressive symptoms on adherence, function, and costs. *Archives of Internal Medicine*<sup>160, 3278-3285</sup>.

illness. Further, obesity, an additional risk factor in diabetes, is more prevalent among individuals with a psychiatric disorder (Newcomer, 2006).<sup>4</sup>

- Cigarette smoking, with its attendant medical health risks, is far more common in people with a psychiatric disorder -- as high as 88% for patients diagnosed with schizophrenia and 60% for those with bipolar disorder, as compared to the general population, where the rate is less than 25% (Kalman, Morisette, & George, 2005).<sup>5</sup>
- In a comprehensive study using Medicaid data sets, researchers compared prevalence rates for eight medical disorders among adults with psychotic and substance abuse disorders, adults with psychotic disorders only, adults with substance abuse disorders only, and adults with neither psychotic nor substance abuse disorders (Dickey, Normand, Weiss, Drake, & Azeni, 2002).<sup>6</sup> The medical disorders considered in the study were: diabetes, hypertension, heart disease, asthma, gastrointestinal disorders, skin infections, malignant neoplasms, and acute respiratory disorders. The results indicated that those with psychotic disorders had significantly higher prevalence rates for all eight medical disorders. Those with co-morbid substance abuse and psychotic diagnoses had the highest prevalence rates for five of the medical disorders: heart disease, asthma, gastrointestinal disorders, acute respiratory disorders, and skin infections.

We will use the state provided pharmacy data to improve integration and coordination of care for Eligibles with dual medical and behavioral health diagnoses via *Health Passport* and Psychotropic Medication Utilization Review (PMUR) programs. *Health Passports* will include pharmacy data, both medical and psychiatric, in order to increase communication and coordination among multiple prescribers to improve outcomes for Eligible Persons with concurrent medical and mental health and/or substance abuse conditions. In addition to improving clinical outcomes for consumers, this strategy is also a means of addressing increasing pharmacy costs for psychiatric medication, both as a specific category and as a percentage of total pharmacy costs. Prescription drug costs continue to rise. In 2001, of the 25 prescription drugs with the highest retail sales, eight were psychotropic. Antidepressants had the highest retail sales for any single category (\$12.5 billion) and accounted for the largest share increase from 2000 to 2001 (Huskamp, 2003).<sup>7</sup> Given the complex interaction of behavioral health disorders with medical disorders, and the fact that many PCP, pediatricians, and other medical specialists are often the prescribers of psychotropic medications, this is an area where increased integration and coordination of services can positively impact outcomes for consumers and improve cost efficiency. While increasing communication of pharmacy information among relevant providers via the Passport, we also bring to the Iowa Plan our experience implementing PMUR programs to further improve quality and integration of services. For example, we implemented PMUR for our Texas foster care population and in the past ten months there has been a 13% decline in the number of foster children prescribed psychotropic medications overall and specifically a 74% decline in polypharmacy. The revised prescribing patterns are the result of improved compliance with quality and clinical practice guidelines achieved through feedback to prescribers from Cenpatico medical directors and physician advisors based on our analysis of pharmacy data.

### ***Eligible Persons with Mental Health and/or Substance Abuse Conditions who are Involved with the Adult Correctional System***

Here again, we continue to enhance and expand existing services for Iowa Plan Eligible Persons. From our preliminary research in preparing this proposal, we are aware of two existing projects in Iowa that we will

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<sup>4</sup> Newcomer, J.W. (2006) Medical Risk in patients with bipolar disorder and schizophrenia. *Journal of Clinical Psychiatry*, 67, 25-30.

<sup>5</sup> Kalman, D., Morisette, S.B., & George, T.P. (2005). Co-morbidity of smoking and patients with psychiatric and substance abuse disorders. *The American Journal on Addictions*, 14, 106-123.

<sup>6</sup> Dickey, B., Normand, S.T., Weiss, R.D., Drake, R.E., & Azeni, H. (2002). Medical morbidity, mental illness, and substance abuse disorders. *Psychiatric Services*, 53, 861-867.

<sup>7</sup> Huskamp, H. (2003). Managing psychotropic drug costs: will formularies work? *Health Affairs*, Sept/Oct, 84-96.

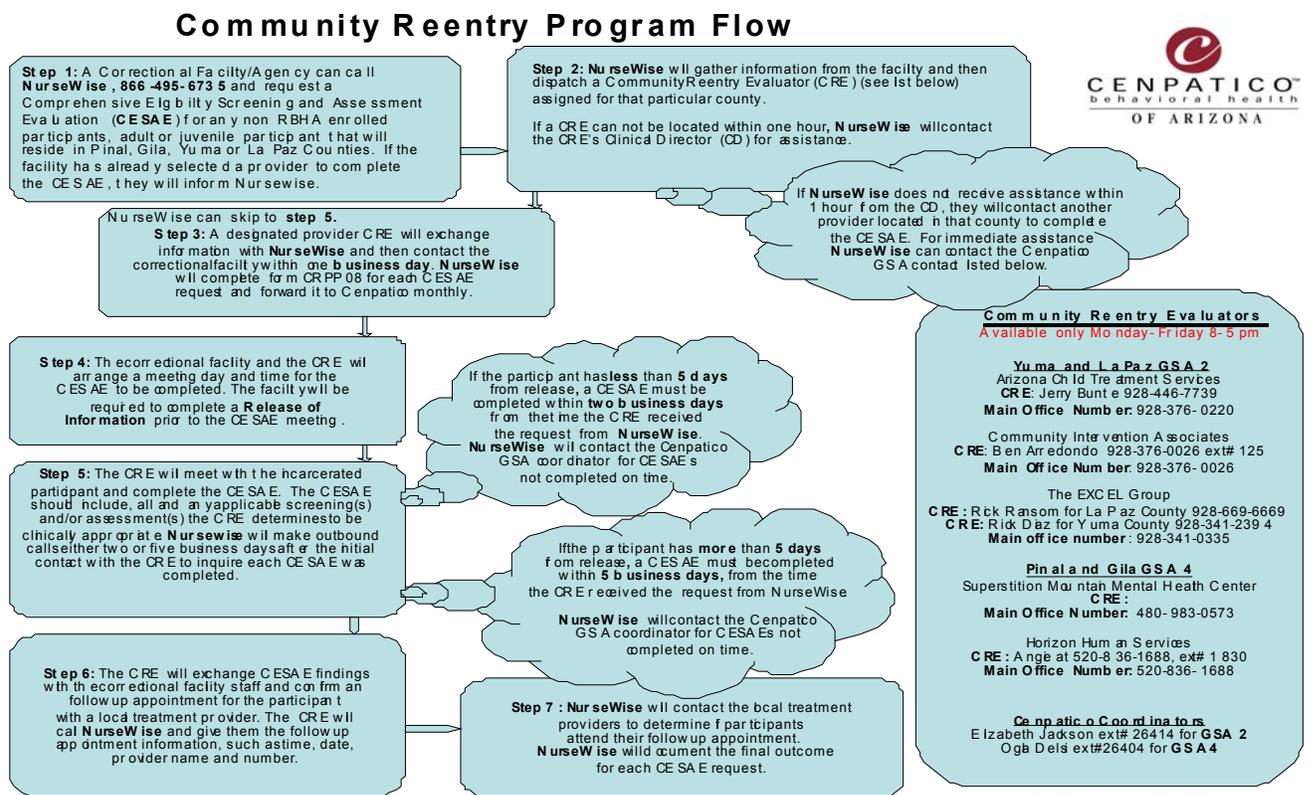
build upon to promote coordination and integration of services for Eligible Persons with mental health and/or substance abuse conditions who are also involved in the adult correctional system:

**Family Drug Court** uses a comprehensive approach to treating substance-abusing parents, while maintaining the goal of reuniting the family. These courts attempt to ensure that the children have immediate access to the appropriate services necessary to build stronger family units while the parents are in family drug court and the parents continue to receive support and monitoring after the treatment is complete. In those communities in which Family Drug Courts are present (Wapello, Polk, Linn, Scott and the Sioux Tri-County area- Woodbury, Cherokee and Ida counties, and the counties serviced by the Upper Des Moines Opportunity, Inc in Northwest Iowa) we will work with the Drug Courts on behalf of Eligible Persons to assist in the timely access to services. Individualized joint treatment plans for these individuals will include input from and collaboration with the family drug court program.

**The Jail Treatment Program** provides substance abuse treatment to clients during incarceration and after release from jail in Polk, Woodbury, and Scott Counties. As we develop the Iowa Provider Network we will negotiate contracts with the three treatment agencies that are involved in this program (United Community Services, Inc., Center for Alcohol and Drug Services, Inc., and the Jackson Recovery Centers) so that potentially Eligible Persons are informed of post-release resources. We will work with the appropriate substance abuse treatment program to assist in the timely access to services upon release from jail and also to offer service planning and coordination services to provide support for sustained recovery.

In addition, we propose using community reinvestment funds to implement in Iowa a **Community Reentry Program** that we are currently piloting in two geographic service areas (GSA) in Arizona. This program allocates funding to specified treatment providers to coordinate with county jails and prison facilities to complete behavioral health evaluations for incarcerated individuals who are nearing their release dates. The evaluations determine what types of services the individuals are eligible to receive and will need upon their release into the community and facilitate coordination of services post release. The program is implemented in collaboration with NurseWise, a Centene nurse help line, which facilitates access and tracking to ensure individuals move through the process and gathers outcome data.

The flow chart below describes the program as implemented in the Arizona service delivery areas:



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***Enrollees with Concurrent Mental Health Needs and Mental Retardation***

Cenpatico's CSP Provider Network model will provide coordination and integration services specific to meet the needs of Enrollees with concurrent mental health needs and mental retardation. Our team based service planning process will involve Division of Mental Health and Disability Services to develop a jointly established and collaboratively implemented service plan. Such plans will be individualized to emphasize Enrollees ability to exercise their own choices about the amounts and types of services received and provide recovery based services that build on the individuals' strengths and abilities.

Cenpatico experience in this area includes utilizing Specialist MH/MR staff to intervene on behalf of high needs individuals whose services are not being provided or coordinated appropriately. Intervention can involve sitting in on child/family or adult team meetings to guide discussion and service delivery across both the mental health and developmental disability systems. We also provide case specific technical assistance to either mental retardation providers or behavioral health providers relative to applicable state/federal statute, policy, and guidelines, community resources, cross-system processes or individual diagnoses and best practices (relative to either mental health or mental retardation and/or Developmental Disability). In addition staff provide training overviews of the mental health or mental retardation and/or Developmental Disability systems to Cenpatico staff and both mental health providers and MR/DD provider staff.

***Eligible Persons with Mental Health and/or Substance Abuse Conditions who are Involved with the Child Welfare/Juvenile Justice System***

In working with children and families that are part of the child welfare or juvenile justice system, our experience is that a team engagement model is most effective for coordination across systems that are involved with the child and family. In Iowa we propose to build on the existing DHS Division of Children and Family Services use of the Family Team Decision Making (FTDM) model and utilize our specific experience in Texas serving foster children, and in Arizona serving children and families via Child and Family Teams (CFT).

Similar to the Iowa FTDM model, in Texas we instituted weekly meetings with the Department of Family and Protection Services to review any child that has identified placement barriers. In addition to State Office staff, these meetings also include caseworkers, parents, DFPS Supervisors, regional placement staff, Child Placing Agencies, providers, foster parents, and others to strategize placement and treatment alternatives. These meetings have proven to be extremely beneficial in coordinating care, but most important is the opportunity for all entities serving the child to come together as a team to build rapport and eliminate barriers.

In many states including Texas, we learned that care was often fragmented due to multiple funding sources and programmatic requirements. We quickly identified that that this fragmentation has different impacts across the diverse regions of Texas. To address these issues, we implemented a regional model for managing foster care with offices in seven areas of the state. Within each region we have staff who know the nuances of the service delivery system within that region providing service coordination, utilization management, service management, discharge planning, as well as training and consultation to address the diverse needs of each area; this is similar to our proposed CSP network model for Iowa. In Iowa, we will facilitate communication between all of the systems and entities involved in the child's life utilizing strategic relationships between CSP and Cenpatico service coordination staff and processes.

Also similar to the Iowa FTDM model, a CFT is defined as a group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems such as Child Welfare or Juvenile Justice System, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the

family in providing for the child, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child. By implementing CFT facilitation training with network providers, we increased the number of functioning CFT from 615 in January 2008 to 1135 in December 2008.

#### **7A.2.4 Rehabilitation, Recovery, and Strength-Based Approach to Services**

- a) Describe the Bidder's experience in providing behavioral health services through a recovery-oriented approach and detail the model that the Bidder would implement under the Iowa Plan to promote this approach to care, recognizing the priority that the Departments are placing on effecting change in this area during the Contract period. The description should specifically address what approach it will take with respect to:
- Contractor interactions with Eligible Persons;
  - service system planning and design, and
  - provider adoption of a rehabilitation, recovery and strength-based approach to services.

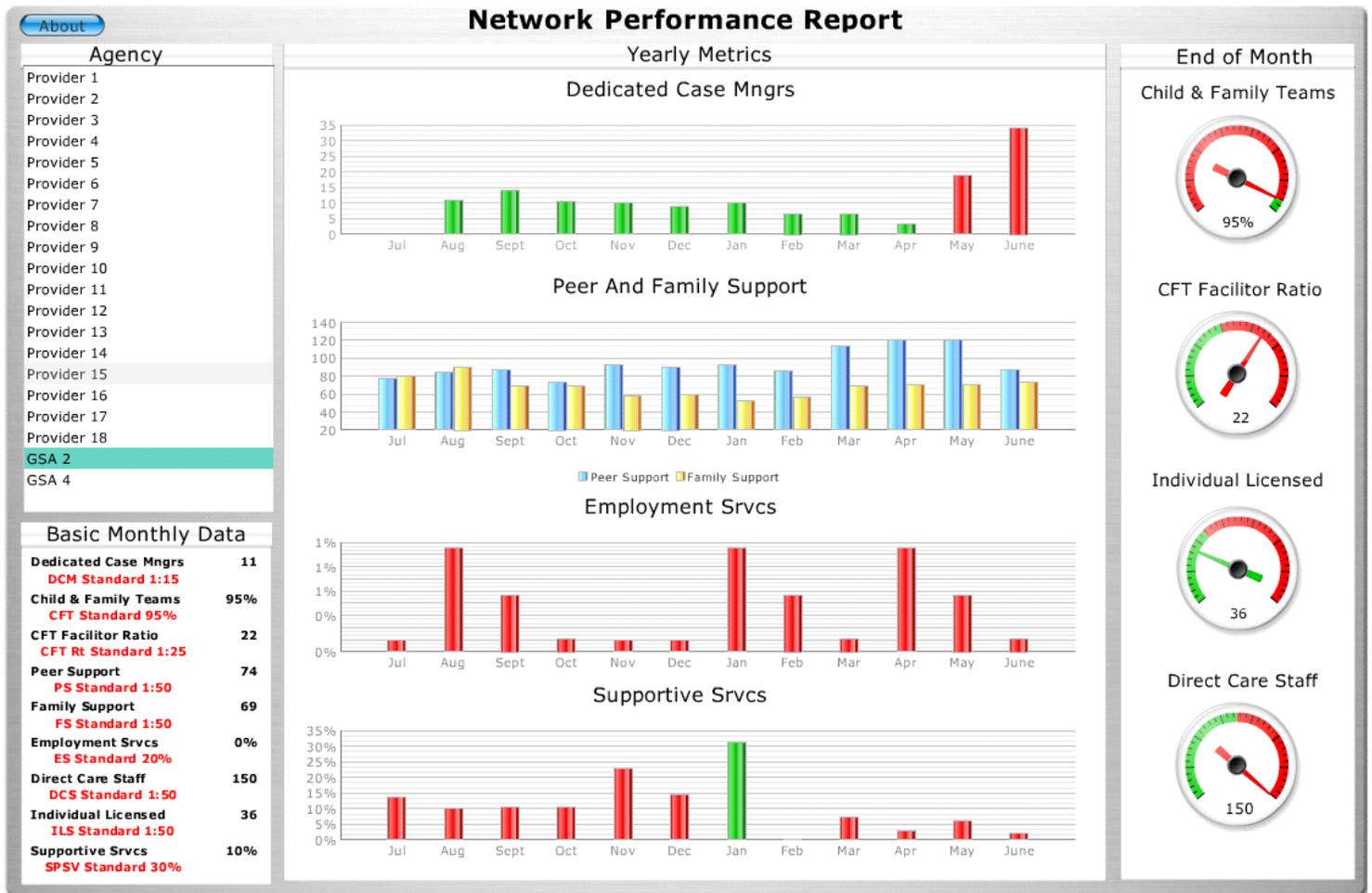
**Experience in Providing Services through a Recovery-Oriented Approach:** Cenpatico is experienced in transforming systems to support a recovery-oriented approach to care. From our experience in other contracts, we have learned that transforming a behavioral health services delivery system to fully embrace recovery and resiliency involves a fundamental change in the culture of provider organizations and the system of care. A recovery based model maximizes consumer and family influence in the design, development and management of the system, creation and implementation of consumer-driven service planning, delivery of services and the creation of new services. It also involves a fundamental change in beliefs and behaviors, on the parts of providers and consumers, about their roles in recovery. In our experience, this shift from provider to facilitator of recovery and from consumer to the engineer of the recovery process often involves role re-training for both providers and consumers. Our model begins this transformation on day one.

Our best example of how we work to transform our markets from traditional acute care and outpatient care models toward a community based, recovery-oriented system of care is in our Arizona market. Here we found that changing the service delivery model required more than just changing available services, it required a change in provider to consumer relationships. To facilitate this change at the **beginning of the implementation** we convened a *transformation team* of Cenpatico staff, provider stakeholders, consumers, community members, and State employees to build the coalition we needed to change attitudes about service delivery to encompass recovery principles. With feedback from the transformation team, we developed a provider coaching program to incentivize development and appropriate use of quality community based services, including 24/7 wrap around services, employment services, housing support, peer support, family support, peer-run businesses and life skills supports. We implemented our provider coaching program with **strong leadership, training, provider incentives, coaching, monitoring, auditing, and enforcement actions.**

Strong leadership requires that Cenpatico employees are trained on, and exemplify, the principals of our recovery and resiliency model of care. Educating our staff on evidence-based practice, strengths-based approach to care coordination, and the importance of natural supports within the community sets an example to our provider community and ensures consistency across system interactions. Staff education begins early in the implementation, but is a continual process to ensure high quality care for Eligible Persons. After our staff were trained in Arizona, they provided **training** workshops for CEOs and senior leadership from provider agencies that focused on changing attitudes toward care and implementing a recovery-oriented approach from the top down. We then held strategic workshops for stakeholders, therapists and mid-level managers that emphasized techniques and strategies for a recovery oriented delivery system. Recovery and resiliency principles were promoted at every meeting and compliance actions were explained in terms of recovery and resiliency goals. All Cenpatico and provider staff were trained in recovery and resiliency principles and were coached to reinforce these principles throughout their daily activities and all interactions with consumers, families, and other stakeholders.

After training Cenpatico staff, provider leadership and community members, the evidence of a shift in provider and consumer culture began to emerge. To ensure that changes in care toward recovery and resiliency principles continued, we established provider and agency **contracts with clearly defined program and service delivery requirements** that support recovery and resiliency. Examples of requirements include the employment of peer support staff, Child and Family Treatment Teams, and implementation of evidence-based practice. Our Clinical Provider Liaisons monitor performance on these and other indicators throughout the contract period with provider profiling to maintain provider commitment to recovery and resiliency principles.

**Our Network Management department has at-a-glance network and provider profile data on key recovery and resiliency oriented quality indicators using the dashboard graphic below.**



Our experience both at the corporate level and at a local market level has demonstrated the value and insight gained from inclusion of consumers and families members as decision makers on committees and as employees within our organization. **Fundamental to a recovery and resiliency model, empowerment and employment support the process of improving outcomes.** Person and family-centered practice empowers individuals to participate in their own recovery and recognizes the critical value and role of family members in treatment success. We have a rich history developing Enrollee and family centered programs and services including:

- Child and Family Teams
- family-centered substance use treatment programs

- wrap around services and
- family reunification programs

Recognizing the importance of care that is responsive to the individual and cultural needs of Eligible Persons and their families, our model emphasizes the need for flexibility in service delivery. We achieve service responsiveness through meaningful involvement of Eligible Persons and families that is sensitive to their needs through:

- involving consumers, parents and families in Cenpatico's governance and administration on boards and committees
- our staffing model design which includes employing Enrollees and family members as well as emphasizing extensive training for all staff on cultural and recovery and resiliency values
- Consumer and Family Councils and focus groups which provide regularly scheduled and ad hoc forums for stakeholder feedback and influence in program monitoring and development
- involvement in quality assurance, provider training, certification, assessments
- continually measuring meaningful Enrollee and family involvement throughout the service delivery system

**Contractor Interactions with Eligible Persons:** Our interactions with Eligible Persons focus on facilitating the process of recovery and assuring quality care through direct feedback from all Eligible Persons and their families. As Cenpatico is not a direct service provider our role is to provide appropriate service referrals, education, technical support, oversight, and monitoring of the delivery system. Our goal is to ensure providers and the greater service delivery system improves the likelihood of recovery for Eligible Persons. Strategies for achieving this goal are outlined below.

***Community Feedback Forums:*** During implementation and throughout the contract period, we actively seek feedback from Eligible Persons through community forums. In Iowa, we will implement quarterly community forums in each of the six regions. These forums provide an opportunity for Eligible Persons, family members, and community stakeholders to interact with Cenpatico staff, learn more about services and benefits in their area, and to provide us with first-hand information about service deficits and potential program improvements. As needed this information will lead to focus group meetings to address specific topics for the community or to develop quality improvement initiatives for Cenpatico.

***Consumer and Family Advisory Councils:*** Through our community forums we will recruit Eligible Persons, family members and peers to take part in a more formalized feedback opportunity by developing and maintaining Consumer and Family Advisory Councils. These councils, facilitated by our Recovery & Resiliency Advisor and Family Advisor, will provide an opportunity for review quality data related to specific quality initiatives.

***Consumer Run Program Evaluation:*** We will contract with a consumer-operated organization to operate an independent Ombudsman program and to conduct Eligible Person and family member interviews to assess program effectiveness and identify areas for improvement. Peer administered interviews allow Eligible Persons and their families to share insight about the quality and effectiveness of care they have received, provider program adherence to the principles of recovery and resiliency, and shields their identity to providers. Interviews will be structured and assessed using a tool developed by Cenpatico and approved by the Recovery Advisory Committee. Results of the assessment will be included in profiling reports given to providers by their Clinical Provider Liaisons. Results will also be available on our website as a tool for Eligible Persons and their families for choosing their preferred provider.

***Customer Service and Crisis Lines:*** We will operate a **toll-free Iowa customer service line** for obtaining service referrals, requesting benefits information, speaking with clinical staff, and accessing the Grievance and Appeals Process. The toll-free customer service line is available 8 am to 5 pm, Monday through Friday.

Additionally, we will provide an **Iowa Crisis Line 24/7/365** to serve as a safety net for all persons living in Iowa. Crisis Line staff will assess individual needs and deploy Mobile Crisis Teams, Emergency Responders, or schedule urgent or follow-up appointments as appropriate. All customer service and crisis line representatives are trained in recovery and resiliency principles and are monitored monthly through silent-call monitoring to ensure service quality.

### **Model for the Iowa Plan**

***Service System Planning and Design:*** We will apply our experience in developing solid systems that support recovery and resiliency to the Iowa Plan by improving access to, and careful coordination of, an effective network of support and rehabilitation services. Our clinical team will facilitate and participate in developing **Joint Treatment Planning** teams for person-centered recovery planning that includes mental health professionals, case managers, community supports, peer and family support staff. This can best be accomplished by the centralization of care coordination functions for persons with high needs. To achieve centralization of care coordination functions, we will establish a regional system of care. Our regional Comprehensive Service Providers, crisis system, peer run businesses, and comprehensive array of independent treatment providers will expand rehabilitation, recovery, and strength-based services state-wide.

Our regional model creates an organizational structure that supports the integration of services, ensures the effective training of providers and stakeholders, facilitates the development of new programs and services, monitors quality performance and ensures providers adopt a rehabilitation, recovery and strength-based approach to services. Cenpatico will be structured to provide the following functions:

1. establish and maintain an effective provider network
2. conduct psycho-social necessity reviews and provide authorizations for acute care services
3. deliver family and person-centered Intensive Clinical Management services
4. provider training
5. program and service development
6. quality assurance
7. conduct provider audits
8. implement a project management strategy to facilitate system integration.

***Comprehensive Service Provider Agencies:*** During contract implementation, we will negotiate with CMHC and larger provider agencies to establish at least two Comprehensive Service Providers (CSP) in each region. **Comprehensive Service Providers (CSP) are a regionally-focused statewide system** that will provide greater systemic coordination of recovery services. In our Arizona service delivery areas, which are almost entirely rural, we use this network model to ensure that Eligible Persons receive coordination and integration of service with greater ease of access as one agency provides most services and is the central point for coordinating services with other agencies, individual providers, and community resources. Additionally, this model supports a true community based system of service delivery that is able to provide and coordinate waivers and wrap around services not typically provided by independent providers or more limited outpatient agencies. Comprehensive Service Providers will be required to employ peer and family support staff and provide a full array of supportive and rehabilitation services to assist persons to live successfully in the community.

***Crisis Care:*** We will develop **regional crisis services to provide community based mobile crisis team services** and ensure rapid access to behavioral health services with the goal of maintaining people in the community. The crisis providers will interface with local first responders and emergency rooms to meet the needs of local residents. Eligible Persons and stakeholders have **access to mobile crisis teams and emergent care through our centralized Crisis Line**. The crisis staff will dispatch and track the regional mobile crisis teams, maintain daily bed availability data, and when appropriate immediately connect Eligible Persons or providers with Utilization Managers. Crisis line staff will provide daily reports to Care Coordination staff for follow-up care and service planning.

**Peer-Operated Businesses:** Supported employment is an evidence-based practice for severely mentally ill individuals. To support this aspect of rehabilitation, we will develop peer-operated businesses in each region. The peer run businesses will provide a network of recovery support services for peers living in the communities. Services offered may include transportation services, peer support services, recovery centers, community reentry centers, supported employment, and crisis stabilization services.

**Choice of Providers:** Our vision for the Iowa Plan includes a broad array of independent providers and other agencies as well as CSP in order to ensure the greatest geographic access and to allow for consumer choice of providers. While the CSP model provides greater systemic coordination of recovery services that simplifies access for consumers who require multiple services; access to independent providers allows consumers flexibility and ensures opportunity for choice.

**Utilization Management:** To ensure coordination of our service model, Cenpatico will employ a team of Utilization Managers (UM); Intensive Clinical Managers (ICM) and Care Coordinators (CC), who will assist with discharge planning, facilitate crisis planning and help treatment teams keep people in the community. Through analysis of historical utilization in various regions and predicted experiences, we have developed a comprehensive clinical management model designed to provide ample coverage to the entire Iowa service area. Our teams of Utilization Managers, Intensive Clinical Managers, and Care Coordinators trained in rehabilitation, recovery and strength-based approach to services will be located throughout the six IDPH regions. The UM will oversee the authorization of all out-of-home placements, and begin the discharge planning process for all persons seeking or receiving out-of-home care. Utilization Managers facilitate, recommend, and support the use of evidence based practices related to employment, substance use disorders, chronic mental illness, wrap around services, direct support services, housing, motivational interviewing and peer and family support services. The UM will refer all Eligible Persons that seek or receive out-of-home care for follow-up by ICM or CC staff based on the individuals risk or needs assessment. Each of these staff are trained in, and responsible for, ensuring service plans are developed in support of the individuals' recovery goals.

In addition, each Care Coordinator develops an assigned area of expertise to aid in assertive interventions for care planning and discharge planning. As subject matter experts on the development and availability of housing programs, employment services, and support programs for adults with chronic mental illness, the **Care Coordinators will ensure that support resources are being accessed and utilized appropriately to reduce reliance on higher levels of care.** Care Coordinators work in tandem with Utilization Managers to assist in finding and gaining access to all relevant services for consumers needing acute care discharge plans, and/or for consumers needing wrap around services to increase community tenure and avoid out-of-home placement.

**Provider Adoption of a Rehabilitation, Recovery and Strength-based Approach to Services:** Provider adoption of a rehabilitation, recovery and strength-based approach to services must be supported through staffing, contracting, training, mentoring, coaching, quality improvement, compliance monitoring, enforcement, incentives and funding. A culture of recovery and resiliency will be promoted in Iowa through the strategies described below.

**Our organizational staffing model is designed to support a provider culture of recovery and resiliency** in Iowa and build collaborative relationships with providers. By employing key staff roles that have primary responsibility for developing provider commitment to rehabilitation, recovery, and strength-based approach to services with our provider network and community support providers, we provide a mechanism for early adoption and continual improvement of a recovery-oriented service delivery model.

**Recovery & Resiliency Advisor and Family Advisor:** Critical to shaping provider attitudes about rehabilitation, recovery and strength-based approaches to the service delivery system is setting an example. Employing consumers sets the example for consumer involvement and is a tangible demonstration of our

belief that recovery is possible. Our Member Services Department includes employment opportunities for Eligible Persons and family members. We will employ an Iowa consumer or former consumer in the position of Recovery & Resiliency Advisor and an Iowa family member as the Family Advisor. Together they lead the Recovery Advisory Committee and provide technical assistance to providers in the development of Peer and Family Support services.

The Recovery & Resiliency Advisor implements the **Annual Stigma Reduction Plan** for outreach and education to Iowa communities. Developed through collaborative meetings with Eligible Persons family members, advocates, and community stakeholders, our Stigma Reduction Plan will seek opportunities to support or develop Iowa programs through community reinvestment funding that work to reduce the harmful impact of stigma on recovery and resiliency. The Plan will spell out action steps to increase awareness about and reduce the impact of stigma related to mental illness, and substance use disorders. To augment our Stigma Reduction campaign the Recovery & Resiliency Advisor and Family Advisor will conduct outreach and education forums in Iowa communities about mental illness, substance use disorders, recovery-oriented care and the effects of stigma. These forums are a valuable opportunity to share information and obtain feedback and recommendations for continued improvements to outreach programs and the larger service delivery system.

**Director of Network Management:** The Director of Network Management supervises the Clinical Provider Liaison team, oversees provider training, and manages network and program development through the Network Management Plan. The Team includes Clinical Provider Liaisons and a Provider Relations Specialist. The Plan includes measurable objectives and timelines for the advancement of network characteristics that promote a rehabilitation, recovery and strength-based approach. These objectives include establishing a benchmark for the number of Peer Support Staff and Family Support staff employed by the Comprehensive Service Providers, number of Consumer and Family Operated Businesses, benchmarks for the percentage of services that are delivered by peer and family support staff, wrap around services, and ACT team capacity.

Providers are required to submit monthly staffing reports to allow Cenpatico to maintain up-to-date information regarding adequacy of the Network and review progress toward employing appropriate numbers of peer and family support staff. Deficiencies are reported to Clinical Provider Liaisons to provide technical assistance and support corrective action as appropriate. The Network Management Plan addresses all levels of care (including crisis services), programs, best practices and practice guidelines. The Director of Network Management oversees all provider training programs and ensures all system components and programs maximize consumer and family influence and embrace recovery and resiliency principles.

**Clinical Provider Liaisons:** The Clinical Provider Liaisons offer technical assistance and mentor provider agencies related to recovery and resiliency. These staff members will be Iowa licensed Masters' level clinicians as they will be partnering with provider agencies to implement and improve evidence-based practices and strategizing on reducing barriers to care. Our Iowa Clinical Provider Liaisons will meet with treatment teams and agency managers to deliver guidance in the development and implementation of recovery-oriented services. They offer specialized training and work to emphasize the collaborative nature of Cenpatico and all network providers. Additionally, Clinical Provider Liaisons will conduct fidelity audits related to key components of a rehabilitation, recovery and strength-based approach. These audits will ensure that services are provided in accordance with recovery and resiliency principles, providers employ peer and family support staff as reported, providers utilize peer and family support staff effectively, and that providers effectively solicit consumer and family influence in the operation of provider agencies and the delivery of services. Fidelity audits by Clinical Provider Liaisons follow-up on the maintenance of providers' recovery-oriented services to ensure effective implementation of recovery principles and evidence-based practices and use of tools to improve outcomes. The Provider Liaisons will partner with the Recovery & Resiliency Advisor and Family Advisor to provide technical assistance and support to Consumer Operated Businesses.

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**Monitoring Quality:** Cenpatico’s approach to recovery and resiliency principles will be reinforced through contract requirements and oversight, as well as through internal quality and performance improvement activities. **Our goal is for Eligible Persons to have access to and utilize the most appropriate services for their stage in recovery, so they can recover sooner and stabilize within the community, resulting in fewer traumas to self, and less costly care over their lifetime.** This responsibility touches each of our departments, but is always a function of monitoring quality in the development and transformation of behavioral health delivery systems.

Our model for Iowa includes elimination of prior authorization requirements for most levels of care. To maintain a high level of quality without prior authorization requires additional initiative on the part of the managed care organization to find new strategies for quality accountability. Our quality monitoring strategy for Iowa will include clear contract expectations, quality improvement audits, quality of care reviews, provider process improvement work plans, performance monitoring, and monitoring consumer engagement.

**Clear Contract Expectations:** The Cenpatico recovery and resiliency model prescribes and requires under contract that providers adhere to rehabilitation, recovery and strength-based principles. Contract requirements include the required employment of peer and family support staff, provision of clinical supervision, and continuing education to peer and family support staff working in Consumer and Family Operated Businesses, adherence to Cenpatico prescribed staff training regarding recovery and resiliency, incentives for the employment of peer and family support staff, and enforcement actions, including sanctions for non-compliance with recovery principles and contract requirements. Contracts require the employment of engagement activities and motivational interviewing to foster adherence to treatment in a respectful and supportive manner. Comprehensive Service Providers are required to offer recovery and resilience support to consumers and families 24 hours a day, 7 days a week, 365 days a year. They are required to maintain teams of peer and professional staff to ensure availability of wrap around services at all times in the community.

**Quality Improvement Audits and Quality of Care Reviews:** Cenpatico will conduct quality improvement audits and quality of care reviews to monitor the delivery of services in accordance with principles of recovery and resiliency. Audits of each provider agency are conducted at least twice a year and results will be published for public review. Process improvement projects are undertaken to address system issues that interfere with the adherence to recovery and resiliency principles. We will analyze all complaints received by Cenpatico and conduct Quality of Care reviews as indicated to assess the quality of service delivery in the Network and ensure consumers and families receive appropriate services. In addition, fidelity audits will be conducted to ensure programs support recovery and resiliency. The consumer and family led Recovery Advisory Committee analyzes system reports related to recovery principles; including, complaint data, utilization reports, access to care reports, provider profiles, and make recommendations to the Executive Director.

**Provider Performance Improvement Work Plans:** Cenpatico utilizes a corrective action methodology to foster improvements in the system and adherence to recovery and resiliency principles. Providers will be issued corrective action letters for non-compliance with contract requirements and failure to adhere to recovery and resiliency principles. These corrective action letters require the provider to develop a work plan to address the issue identified in the corrective action letter. Each corrective action is recorded on an individualized Provider Performance Improvement Work Plan. Our Clinical Provider Liaisons work with providers to ensure maintenance of performance benchmarks over time by providing training and technical assistance to enhance provider performance. Clinical Provider Liaisons track and report on corrective action steps identified in the Work Plan at least twice a month or more often as necessary. When collaborative correction efforts are unsuccessful disciplinary actions, up to and including sanctions, may result.

**Performance Monitoring:** Cenpatico will track delivery of services through a monthly analysis of encounters. Trends in service mix are analyzed to determine progress in advancing recovery and resiliency principles. We establish benchmarks for the delivery of direct support and employment services. Data

comparing provider progress toward required benchmarks is shared with providers on a monthly basis. Dashboard reports measuring key system indicators of progress in the implementation of recovery and resiliency principles are given to providers. These reports include process measures such as staff ratios, service mix, access to care and outcome measures such as consumer and family satisfaction, employment, criminality, homelessness, delinquency, success in school. These data will also provide the basis for conducting provider profiling.

***Monitoring Consumer Engagement:*** Engaging individuals with mental illness or substance use disorders involves making contact with the person rather than with the diagnosis or disability. It takes building trust and attending to the person’s stated goals and needs. Cenpatico will partner with providers to develop capacity for a range of services in addition to clinical care.

We will require provider agencies to conduct effective consumer engagement. Effective consumer engagement includes having the means and capacity to go where the consumer is rather than insisting the consumer goes to the provider. Provider agencies can improve effective engagement when they employ staff with first hand experience in recovery to provide wrap around and in-home services. Provider contracts will include placing staff in locations throughout the county to assist in the early stages of engagement. Provider contracts will include “no eject/no reject” language that prevents providers from refusing to provide services or discontinuing services to at risk and entitled populations. In addition, providers will not be allowed to close at risk and entitled persons without the consent of the Cenpatico. Providers will be required to maintain engagement activities to at risk consumers in support of recovery and to protect the consumer and the community. We will monitor engagement activities to ensure they support recovery and resiliency principles through quality of care reviews and quarterly chart audits.

***Cenpatico Sponsored Training:*** Cenpatico will provide extensive training activities that educate or support the principles of recovery and resiliency via live training and electronic learning opportunities. Our Clinical Provider Liaisons work with providers by giving training and technical assistance to enhance provider performance and develop rehabilitation, recovery and strength-based approaches to service delivery that emphasize evidence-based practices. Our Recovery and Resiliency Advisor and Family Advisor will give trainings to providers and other community stakeholders on recovery and resiliency concepts, anti-stigma issues, peer support, and other behavioral health topics identified by the community.

Additional opportunities for training that supports rehabilitation and recovery for Eligible Persons includes but is not limited to:

- ***Rehabilitation and Service Planning Training***
- ***Motivational Interviewing Training***
- ***Supported Employment Training***
- ***Readiness to Work Assessment Training***
- ***Vocational Assessment Tool Training***

We will also provide training through our web based e-learning system at no cost to providers, consumers, family members, and other community stakeholders for topics regarding recovery and resiliency, anti-stigma, cultural competency, and more. These trainings are easily accessible and would be beneficial to those in more rural areas who have access to a computer.

**Cenpatico has experience creating out-of-the box solutions to consumer employment needs such as working with web-based employment organizations.** Cenpatico has leveraged the resources of *Linkages* in Arizona to streamline the process of assisting employers to obtain federal tax incentives to employ persons with disabilities and provide on-line recruiting opportunities for consumers. We will bring this opportunity to Iowa and support consumers in meeting their employment goals through the implementation of a web-based employment service and the use of job developers.

**Web-Based Employment Service:** Cenpatico contracts with a web-based employment organization, *Linkages*, to streamline the process of assisting employers to obtain federal tax incentives to employ persons with disabilities and provide on-line recruiting opportunities for consumers. This service matches employers with consumers seeking employment. *Linkages* reaches out to employers and educates them about the advantages of employing persons with disabilities. *Linkages* employs a job developer who recruits employers in Iowa to participate in the program. The Job Developer will educate employers about the advantages of employing persons with disabilities, assist them in enrolling in the program, and ensure the ongoing enhancement of the hiring process for employers.

*Linkages* will provide businesses with:

- Motivated employees who are dependable and dedicated and have skills and work experience encompassing a variety of occupations, from manual labor to professional and trade positions.
- Training, support, and education for both the employee and the employer through participating rehabilitation providers.
- Information about disabilities, reasonable accommodations, ADA requirements, and the vocational rehabilitation system.
- Tax credit information that may help businesses benefit even more from hiring qualified individuals.

***We understand the challenge of developing comprehensive services in rural communities with limited funding opportunities. To facilitate early adoption and commitment to rehabilitation, recovery, and strength-based care, Cenpatico's plan includes incentives to providers, a grant writer to help programs find additional funding for non-covered services, use of Recovery Guides to assist with consumer outreach, and extensive assistance in the development and implementation of supported employment programming.***

***Incentives:*** We will incentivize providers through service code rate increases and quarterly financial incentives for the delivery of peer support, family support, direct support services and employment services. Additional incentives will be linked to hiring Peer Counselors, Family Support staff while also including consumers on boards and committees within their organizations. We will also offer incentives to encourage consumer and family member participation in the Cenpatico Recovery Advisory Committee in support of recovery and resiliency.

***Grant Writing:*** Since 2005, Cenpatico has been granted over \$4.2M in grant revenues. Our Iowa Grant Writer will assist provider agencies and consumer operated businesses to pursue grant funding to enhance and support the service delivery system in Iowa. We have experience identifying other financial resources to help support recovery and resiliency and meet the needs of communities. Routine identification of potential grant fund resources have a proven track record of finding grant funding for needed programs and services in our delivery areas. Cenpatico assisted a contracted prevention agency in applying for and receiving Children's Behavioral Health funds allocated from the Arizona State legislature to provide a teen leadership development program on the Maricopa Ak-Chin Nation. The youth have planned community educational activities and public awareness campaigns to increase knowledge and awareness of the risks of self destructive behaviors and activities. In FY 2007/2008 2,389 individuals were reached through these efforts.

***Employment of Recovery Guides:*** Recovery Guides are Certified Peer Support Specialists or Family Support Staff who have received additional training, provided through Cenpatico, in using their recovery experience to model and mentor other Eligible Persons as they develop and implement their personal recovery and treatment plans. Our Clinical Provider Liaisons and the Recovery and Resiliency Advisor will train providers in the effective use of Recovery Guides to assist persons in preparing for work. The guides can share their personal experience of recovery and help motivate other consumers to overcome or manage their mental illness and seek employment and self-sufficiency. The Recovery Guides assist consumers in regaining a sense of purpose and control over their lives. They educate team members about the importance

of vocational and rehabilitation services, engage consumers in meaningful paid and unpaid activities, assist consumers in assessing rehabilitation interests, serve as a resource manager for the treatment team, and outreach persons who are not engaged.

***Implementation of an Employment Work Plan:*** Our CSP will be contracted to develop and maintain employment support services and programs. Our Interagency Liaison specializing in supported employment will provide technical assistance to enhance the delivery of employment services geared toward supporting recovery and assisting persons to regain a sense of purpose, gain control over their lives and live successfully in the community. The Interagency Liaison is responsible for the development of the Employment Development Plan and monitors the implementation of the Plan. We will use our experience in Arizona to assist us in designing an Employment Work Plan tailored to meet the needs of consumers in Iowa. We will encourage and support consumers in the pursuit, acquisition and maintenance of employment and ensure employment is an essential part of treatment through: 1) the implementation of an Employment Work Plan, 2) employment of recovery guides, 3) employment training, 4) program development and 5) technical assistance.

***Resource Centers and Rehabilitation Programming:*** Providers will be contracted to develop resource centers, equipped with computers, internet access, pre-employment resources and assistance to facilitate readiness for employment. The centers will develop volunteer programs, job shadowing experiences and day labor programs. These providers will also be expected to develop and maintain rehabilitation programs and curriculum that include, orientation to the world of work, job awareness, work exploration, benefits counseling, meaning and the value of work, stress management, appropriate work behavior and the consequences of adverse behavior, and conflict resolution. This would be a great opportunity for a consumer operated business and we will work with DSHS to explore this possibility.

***Technical Assistance:*** Our staff are available on-site and via teleconference for technical assistance and support. Our Clinical Provider Liaisons will provide technical assistance to providers in support of establishing employment programs, measuring consumer readiness to work, and helping consumers prepare for employment. Interagency Liaisons will support our non-contracted community agencies in technical assistance related to programs and services that support recovery and resiliency in the community. Our Recovery and Resiliency Advisor and Family Advisor are available to provide technical assistance for peer services or for any program wishing to expand their understanding of service delivery from the Eligible Person or family member perspective.

#### **7A.2.5 Person-Centered Care**

**a) Describe the Bidder's philosophy of how best to involve Eligible Persons in the planning of their care. The description should include:**

- **how the Bidder intends to ensure Eligible Person and, as appropriate, family members, participation in treatment planning, and**
- **a description of any instances in which it employed such strategies with each of these populations under other contracts, with documentation of any related measurements of effectiveness.**

The focus of our managed care model is recovery-oriented, person-centered care. Effective involvement of Eligible Persons and family members in service planning starts with system-wide understanding and dedication to the core principles of recovery and resiliency. We believe that people can and do recover from mental illness, and that they know best what services and strategies will support their recovery. We will build on the Iowa Plan's current Joint Treatment Planning concept utilizing our experience with *Team-Based Service Planning* to provide a built-in mechanism for supporting providers with consumer and family inclusion. We will incentivize our providers to encourage the hiring of Peer and Family Support Specialists to support and model recovery principles and act as a resource to all stakeholders on how to achieve person-centered care. Cenpatico will further support Eligible Persons, families, communities and providers by offering trainings on integrating a recovery and resiliency model into treatment planning. Finally, we will

monitor provider use of these strategies through quarterly chart and fidelity audits to protect the rights of Eligible Persons and their families to quality care that puts the person first.

Cenpatico will establish and maintain a provider and service delivery system that meaningfully involves Eligible Persons and family members in treatment planning. We will continue to seek the influence and participation from consumers and their families during our quarterly community forums where we can develop new opportunities for Eligible Person and family involvement in the recovery process. We will engage, encourage, and monitor involvement through strategies outlined below.

***Expanding the Peer Workforce:*** In order to facilitate the effective inclusion of Eligible Persons and family members in treatment planning and service delivery, we will facilitate provider employment of Peer and Family Support Specialists who act as natural supports, resources for Eligible Persons as they develop their plan, and model recovery for both the provider and consumer community. We have found that the inclusion of family support and peer support staff in the provider workforce transforms the system, teaches providers the importance of including Eligible Persons and family members as equal partners, and empowers Eligible Persons to make their voice heard throughout the treatment planning process.

As part of our commitment to expanding the peer workforce in Iowa, Cenpatico will employ Iowa consumers and family members in the roles of Recovery and Resiliency Advisor and Family Advisor. The Recovery and Resiliency Advisor will provide guidance to staff and network providers in support of recovery and resiliency from the consumer perspective, and take an active role in recruiting consumers and family members as Peer and Family Support staff. The Family Advisor will be a trained Peer Support Specialist hired from the community to offer particular guidance on involving families in recovery. This position will help train and advise staff, providers, and consumers and families in recovery principles and the employment of consumers. Both positions will report to the Director of Member Services, and will be involved in all of Cenpatico's initiatives towards community and consumer relations and outreach.

Cenpatico will provide educational outreach, technical assistance, and financial incentives to providers for employment of consumers and family members. We will also adapt and provide curricula and trainings for Iowa to prepare Eligible Persons and family members to be certified as Family Support and Peer Support staff. Train-the-trainer Family Support and Peer Support modules will be made available to develop the peer and family workforce in the provider community. These peer and family trainers enhance the peer workforce as they will deliver ongoing education and support for provider and community agencies on recovery and rehabilitation topics, including person-centered treatment planning and care.

***Creating Recovery Guides:*** Recovery Guides are Certified Peer Support Specialists or Family Support Staff who have received additional training, provided through Cenpatico, in using their recovery experience to model and mentor other Eligible Persons as they develop and implement their personal recovery and treatment plans. The guides can share their personal experience of recovery and help motivate other consumers to overcome or manage their mental illness and seek employment and self-sufficiency. The Recovery Guides assist consumers in regaining a sense of purpose and control over their lives. They educate team members about the importance of vocational and rehabilitation services, engage consumers in meaningful paid and unpaid activities, assist consumers in assessing rehabilitation interests, serve as a resource manager for the treatment team, and outreach for persons who are not engaged in care. We will encourage peer staff to obtain this additional training to be certified as Recovery Guides. Upon completion of their training and certification as Recovery Guides, peer staff will be empowered to assist Eligible Persons and family members in being full participants in the development and implementation of the individualized treatment plans. These Recovery Guides will provide Eligible Persons and family members the support and confidence to be strong advocates for their participation in the provision of care. They will demonstrate that recovery is possible and help Eligible Persons, family members and providers recognize the hope of recovery.

**Flexible Funding:** As part of a person-centered model, programs like Iowa’s Consumer Choices Option offer Enrollees choices for how and where their care is delivered. By allowing individuals more flexibility in how money is spent on their care, individuals gain responsibility for planning and controlling certain service options that may increase their ability to stay in their communities. In the first contract year, we will develop a coalition to explore how Cenpatico can effectively support flexible funding programs that best benefit Iowa Plan Enrollees. It is our goal to support and augment best, or promising, practice programs as deemed appropriate by community stakeholder consensus.

**Team-Based Service Planning:** In our Arizona market we have increased the number of children engaged in team-based service planning (CFT) from 40% to 95%, thus improving our ability to monitor consumer and family involvement in service planning. In Iowa, we will utilize the framework of the current Joint Treatment Planning Conferences to monitor functional improvements and ensure meaningful involvement in the treatment planning process. Based on our success in Arizona with the similar concept, Child and Family Teams (CFT), we will further develop *team-based service planning* through our Comprehensive Service Providers in each region. These specialized treatment planning teams will focus on improving outcomes for Eligible Persons and ensure meaningful involvement of consumers and families in the treatment planning process. Our Clinical Provider Liaisons will monitor the treatment team process by conducting team observations utilizing the Treatment Team Observation tool, which will provide information to guide technical assistance and support to the Treatment Team facilitators. The tool will measure multiple indicators including consumer and family involvement and perception of involvement in the service planning process.

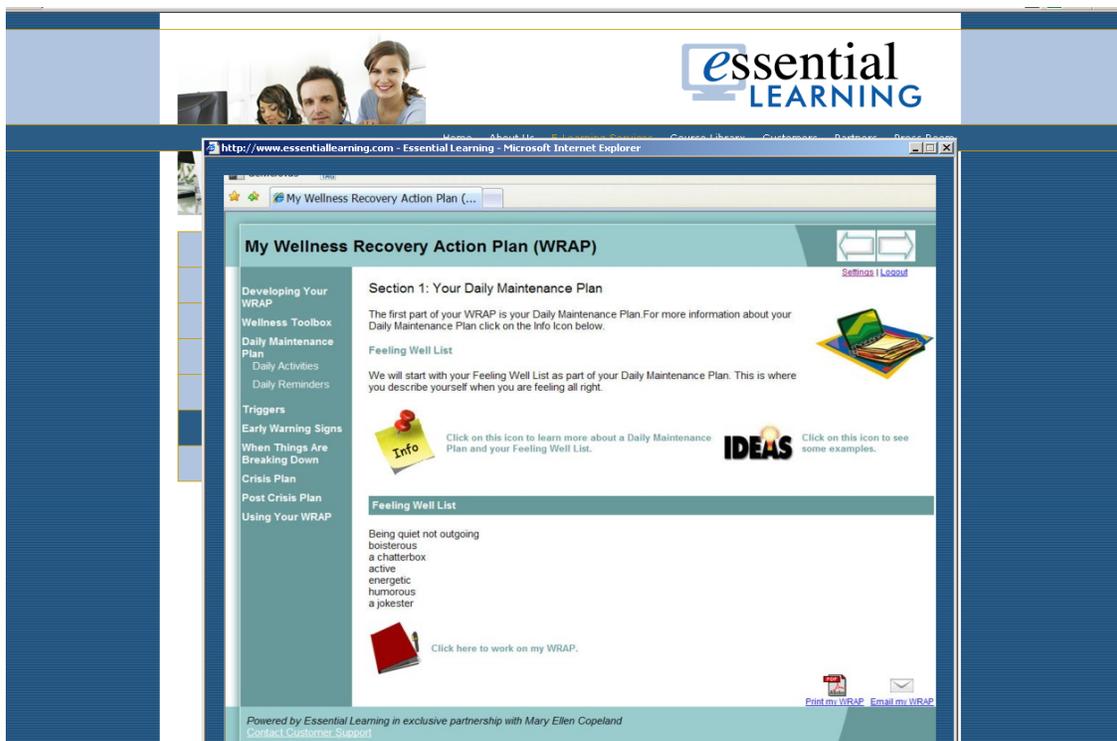
**Establishing a Certification Program for Treatment Team Facilitators:** Cenpatico will support expanded team-based service planning and improve treatment team outcomes by implementing a certification program for Treatment Team facilitators. Maintaining an adequate workforce of fully trained and certified Treatment Team facilitators will enhance person-centered service planning, and through our Treatment Team Observation tool, we will be able to monitor meaningful involvement of consumers and families in service planning. Treatment Team facilitators can be Eligible Persons, family members, case managers, therapists, primary care physicians, or other stakeholders. Facilitators are responsible for ensuring Treatment Team meetings occur at intervals appropriate to the individual’s recovery and as indicated in their service plan. Additionally, they must work to involve appropriate stakeholders and support system participants on the team, ensure Eligible Persons are meaningfully involved in the service planning process, and ensure consensus and understanding for all participants with the resulting service plan.

We will train and certify Treatment Team facilitators to ensure facilitators of team-based service planning have learned group facilitation skills specific to treatment teams, understand principles of consumer-led service planning, and know how to apply rehabilitation, recovery, and strength-based approaches to care and service planning. Facilitator training modules will include: consumer engagement, cultural competency, principles of recovery, consumer-led service planning, community supports, employment, crisis planning, and team facilitation. By training and certifying facilitators, we will be able to ensure competency levels are achieved for all persons leading treatment teams. Training will be available through e-learning, and candidates must achieve a passing score on all training modules for certification.

**Information, Training and Technical Assistance:** Our experience in Arizona demonstrated the importance of training and technical assistance during system transformation. We developed training plans that included contractually obligated trainings to ensure all providers received adequate training for consumer and family involvement in care planning, cultural competency, and evidence-based practices. Our staff provided on-going technical support and trainings as requested by providers and as indicated by performance audits. For Iowa, our Network Development staff will provide courses in how to complete effective service plans and how to include persons and family members in service planning. These courses will also be available to Eligible Persons, family members, community representatives, and stakeholders through our Member Services Department staff.

**Eligible Persons and Families:** We will provide information and technical assistance to consumers, family members and service providers in the development of consumer-driven service planning. Technical assistance is provided by our Recovery and Resiliency Advisor, and Family Advisor. Education and awareness are supportive strategies that help develop consumer-driven services for consumers and their families. Community forums are one way in which Cenpatico works to inform the community, and learn from the community. Cenpatico has successfully utilized consumer and family forums in Arizona and stakeholder forums in several states. These forums have provided opportunities to reinforce expectations for maximizing consumer influence in the treatment planning process and provide us direct feedback about consumer and family member perceptions of the involvement of family members in their care. We will use these forums to educate and inform consumers, families and providers about opportunities to expand meaningful consumer involvement in service planning.

Our brochures, fliers and posters will communicate educational activities and will spotlight the merits of consumer-driven service planning. Our staff will coordinate with and monitor contracted providers to ensure that information sharing with consumers and family members on consumer-driven, person-centered service planning occurs. Information and activities to learn about consumer-driven service planning will be available at locations that consumers and their families may frequent, including but not limited to peer-operated service programs, provider offices, state and county offices, consumer conferences, and advocacy organizations. Many of these efforts will be led by the consumers and families themselves through peer and family support staff working in the community.



We will also make available training regarding consumer-driven service planning to consumers, family members and stakeholders and other community members through our web-based e-learning system, Essential Learning. Community members will have free access to training and information on the Essential Learning website. This site is available through a link on our website as well. We will also work with consumer operated organizations to ensure they have computers available with internet access to facilitate the training and sharing of this important information. We will assist with grant writing to help the organizations obtain computer hardware and access to internet services.

**Providers:** We will conduct extensive training for Iowa providers on the efficacy of consumer and family involvement in service and recovery planning, consumer rights, cultural competency, and natural supports. These are the same types of trainings that Cenpatico staff will be required to participate in to foster a recovery and resiliency environment at the managed behavioral healthcare level and throughout the service delivery system. The Recovery and Resiliency Advisor and Family Advisor will provide training with assistance of the Member Services Department team, and in some cases augmented by our Clinical Provider Liaisons. We will offer live training, webinars and e-learning modules to maximize opportunities to learn. Information about consumer-directed service planning and services will be shared with providers on a regular basis. We will build on our experience to develop a culture that consistently delivers consumer-directed services. The Consumer-Driven Services Expansion Team will work closely with providers to successfully recruit, effectively employ and maintain Peer and Family Support Specialists.

**Contract Requirements:** Our experience in Arizona demonstrates that the swiftest method to achieving wide-scale adoption of a person-centered approach that values recovery and resiliency is through contract requirements for service type and care. For Iowa, we will prescribe in contract that providers adhere to recovery and resiliency principles including maximizing consumer and family involvement in service planning. Contract requirements further include the employment of peer and family support staff, provision of clinical supervision, and continuing education to peer and family support staff, adherence to Cenpatico trainings regarding recovery and resiliency, incentives for the employment of peer and family support staff, and enforcement actions, including sanctions for non-compliance with recovery principles and other contract requirements.

**Onsite Fidelity Audits:** Our Clinical Provider Liaisons will conduct fidelity audits related to key components of recovery and resiliency, including consumer leadership and family involvement in service planning. We have utilized this process in Arizona to monitor provider adherence to best practices, and have received praise for the program's success. Our fidelity audit tools are now being adopted for all Regional Behavioral Health Authorities in Arizona. For the Iowa Plan, our fidelity audits will include a review of organizational charts, interviews with provider staff involved in the service planning process, interviews with managers and leadership within the agency, review of program descriptions, and "spot" audits of charts. The findings will be reported to providers in writing with summary data presented to the Recovery Advisory Committee, the Clinical Advisory Committee, and the Departments' appointed Advisory Committee for review and recommended action. Findings that do not meet standards will result in a Corrective Action Letter. The Clinical Provider Liaison will include findings in the Provider Performance Improvement Work Plan and monitor the Plan twice a month to ensure the Plan is being executed. The process will include re-checks and ongoing consultation conducted by the Provider Liaison staff to ensure continuous improvement.

**Clinical Chart Audits:** Clinical chart audits will be conducted quarterly by the Quality Assurance staff. We successfully employed clinical chart audits in Arizona to identify areas for provider development and programmatic improvement. Clinical chart audits for Iowa will include an analysis to ensure that service planning is consumer-led, and the assessment, service planning and treatment process are aligned with recovery and resiliency principles. Corrective Action Letters will be written to providers who fail to meet minimum standards. Service Plans will be audited to assure consumers' recovery goals and "family vision" are included in Individualized Service Plans and that the service planning process was consumer led. The audit assures all members of the consumer's identified treatment team participate in the development of the service plan. Service plans and crisis plans will also be audited to be sure they are individualized, indicate an awareness and appreciation of the person's culture, and advances the person's recovery. The Plans will be audited to assure they contain clear quality of life outcomes, as desired by the consumer and include at a minimum goals related to education, employment and self directed care.

The results of the quality audits will be tabulated, trended and reported to the Recovery Advisory Committee, the Clinical Advisory Committee, and the Departments' appointed Advisory Committee via our Quality

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Assurance and Performance Improvement Committee. The Committees have the authority to review the results and direct appropriate action to correct any deficiencies.

***Consumer Run Satisfaction Assessments:*** Consumer and Family Run Organizations will be sought out, and contracted with, for conducting quarterly face-to-face interviews with consumers and family members. The purpose of peer administered interviews is to allow for more objective feedback regarding consumer and family perceptions about the quality of care they have received and adherence to the principles of recovery and resiliency. Scores will be given to providers by their Clinical Provider Liaison, and posted on our website as a tool for consumers and their families for choosing their preferred provider. Providers will be expected to score above a prescribed benchmark. In conjunction with Eligible Persons, family members, and community stakeholders we will develop a rating tool that measures meaningful consumer, parent and family member participation in the provider Network, including meaningful participation in service planning. The tool will be used to determine the level of provider commitment to consumer participation, and survey the range of activities available for consumer participation.

The Recovery and Resiliency Advisor will oversee the quarterly assessment of consumers and family member perception of Cenpatico's performance in increasing meaningful consumer, parent and family involvement and influence in service planning as well as shaping the greater service delivery system. In addition, we will work with all provider agencies to measure the level of consumer and family participation in their organizations. The Recovery and Resiliency Advisor will submit the results of this assessment to the Quality Assurance and Performance Improvement Committee quarterly.

This assessment tool will be developed in collaboration with Iowa Eligible Persons, family members, and other community stakeholders upon contract award. This assessment will measure criteria including but not limited to the following:

- Do programs and services clearly identify the purpose and methods for including consumers, parents and family members at different levels of the organization, including service planning?
- Are policies in place to make sure that consumer, parent and family member feedback is used to improve programs and services and modify service plans?
- Are the leaders of the organization responsible for consumer and family participation in service planning clearly identified and accessible?
- Do policies explain how staff is educated regarding consumer and family member involvement and participation in service planning?
- Are resources available to support consumer and family member inclusion in strategic planning and reviews of the programs and services offered?
- Do programs demonstrate how consumer and family member participation is a key part of programs?

***Utilization Management Staff Review of Service Plans:*** Our Utilization Management team including Utilization Managers, Intensive Clinical Managers, and Care Coordinators will be trained by our Corporate Recovery and Resiliency Advisor on recovery and resiliency principles and interventions. Trainings are designed to help Cenpatico staff adopt a leadership attitude towards promoting recovery and resiliency principles for Eligible Persons, their families, and providers. Our Iowa clinical staff will receive trainings to include: the efficacy of consumer and family involvement in service and recovery planning, consumer rights, cultural competency, and involving natural supports in recovery planning. On-site trainings will be supplemented by regular staff train and re-train activities as well as e-learning modules including person-centered service planning.

Utilization Management staff coordinate with first responders, inpatient facilities, emergency rooms, jails and detention facilities to ensure the effective coordination of crisis services and assist stakeholders in working effectively with consumers. Providers are required to submit any crisis plans, WRAP plans, or

Advanced Directives to Cenpatico within two working days of completion. The documents are entered into our internal CCMS database, and *Health Passport* when appropriate, which are accessible 24 hours a day, 7 days a week, and 365 days a year through our crisis line staff. The documents allow us to facilitate a crisis response that is individualized to the recovery goals and expectations of the consumer. Access to this information provides valuable individualized information to the crisis team, allowing them to tailor an intervention that helps keep consumers safely in the community and supports their recovery goals. It is critical that this information reflects the wishes and involvement of Eligible Persons and family members. Utilization Management staff will review these documents to ensure consumer and family members have been meaningfully involved in the creation of the plans. UM staff will work with providers to correct individual plans with deficiencies, and will report trends to Quality and Network departments for appropriate corrective action planning.

***Technical Assistance and Corrective Action:*** Results of the quality assurance audits, fidelity audits and consumer and family interviews are reported to the Iowa Plan Advisory Committee appointed by the Departments as well as the Quality Assurance and Performance Improvement Committee (QAPI). Clinical Provider Liaisons will provide twice monthly technical assistance to providers to enhance scores and conduct spot checks to determine if corrective actions are effective. Ongoing performance will be monitored through focused audits and failure to improve scores may result in additional action, including sanctions. Consumer-led service planning that supports recovery and resiliency principles is central to the health and well being of our consumers.

**Implementing Person-Centered Care in Arizona:** We have learned that increasing consumer and family involvement in service planning requires training, technical assistance, coaching, monitoring, auditing, and re-checking on progress and enforcement action. Service planning among Cenpatico providers in Arizona improved dramatically as we implemented the aforementioned strategies. Provider performance related to consumer and family member involvement in service planning has improved from a low of 72% to a high of 94% in recent audits conducted by Cenpatico Quality staff in Arizona.

Through our emphasis on rehabilitative services such as supported employment and consumer empowerment, we have successfully facilitated contracted providers employment of peer and family support staff. Currently in our Arizona market we now have 78 peer staff and 37 family support staff working in our Network.

Our partnerships with providers, consumers, family members and community stakeholders resulted in the development and implementation of expanded mental health self-help and peer support group programming at the Transitional Living Center (TLC), a contracted provider with locations in Yuma and Casa Grande, Arizona. With Cenpatico sponsorship TLC became a peer-run Community Service Agency. Through this partnership, TLC has implemented peer-based psychiatric rehabilitation recovery support services for people recovering from substance abuse disorders in the area. "Peers" must participate in the Recovery Empowerment Training Program and become certified before being eligible to provide services. Peer Support services are initiated when there is a reasonable likelihood that it will benefit an Eligible Person's functioning and facilitates recovery within the community. Eligible Persons are provided Peer Support services in community environments such as homes, workplaces and other settings. Peer support is targeted towards persons with a serious and persistent mental illness or substance abuse. Peer support services include individual support and counseling with a trained peer who is able to share their own recovery story. Peer support services may also include service coordination and advocacy activities in addition to rehabilitative services.

The program emphasizes "dealing with life on life's terms," identifying skills to address the personal, vocational, familial, legal and social consequences of addiction. TLC currently offers a regular program of peer-based recovery services including peer-led support groups, individual peer support and mentoring, a peer-led resource connector program, life skills classes and workshops, alcohol and drug-free social and

recreational activities, and a drop-in center. This program also includes workshops developed in response to needs identified by peers.

**b) Provide the names, telephone numbers and email addresses of two references who can be contacted to confirm the effectiveness of the Bidder's performance.**

**References:**

Program	Name	Title	Phone	E-Mail
Quality Management Operations, ADHS/DBHS	Carolyn Dempsey	Performance Improvement Specialist	(602) 364-4644	<a href="mailto:dempsec@azdhs.gov">dempsec@azdhs.gov</a>
ADHS/DBHS	Dr. Laura Nelson	Deputy Director	(602) 364-4558	<a href="mailto:laura.nelson@azdhs.gov">laura.nelson@azdhs.gov</a>

**7A.2.6 Covered Services, Required Services, Optional Services**

**a) Describe the Bidder's strategy to ensure statewide capacity for required services**

Cenpatico offers a multi-pronged approach to ensuring statewide capacity for covered services that includes immediate recruitment of the existing network providers, restructuring of the existing network to include Comprehensive Service Providers (CSP) for each region, and specific strategies to increase capacity. We will begin immediate recruitment of mental health and substance abuse treatment providers contracted with the current vendor for network participation upon award. Focusing our initial contracting efforts on these providers will ensure continuity of care for Eligible Persons already in care upon the implementation date. We will simultaneously negotiate with Community Mental Health Centers (CMHC) and other multi-service agencies in the six IDPH regions of Iowa to develop at least two CSP per region.

***Restructuring the Network:*** In our initial assessment of the current delivery system, we found that many CMHC offered less than full continuum services with limited services at most rural CMHC. Our plan is to develop **Comprehensive Service Providers (CSP)** that offer, or develop capacity to offer, a continuum of care that includes the following services: wraparound, Peer Support, in-home, telehealth remote site, 24 hour mental health stabilization, crisis intervention and management, prevention, higher level and/or intensity outpatient services to address the existing gap between 24 hour level of care and traditional outpatient/community based services. Access for Enrollees to specialty services, such as substance abuse treatment, will be provided directly by appropriately licensed CSP or coordinated with independent providers in the region. Cenpatico's network will comprise all eligible behavioral health and substance abuse provider types, not just CSPs.

CSPs will provide a full-continuum of covered and required traditional outpatient and waiver services and programs under the Iowa Plan for Eligible Persons that are identified by Cenpatico as high-need. High-need is defined as, but not limited to:

- SPMI adults
- SED children
- Children that are in out of home placement
- Geriatrics in out home placement
- Eligible Persons at risk for out of home placement
- Children involved with multiple State agencies
- Dual Diagnosis Eligible Persons
- Eligible Persons unable to maintain recovery without multiple supports
- Eligible Persons who need additional supports to maintain compliance with their medication treatment
- High utilizers
  - Eligible Persons that are receiving an array of behavioral health and/or substance abuse service simultaneously; or
  - Eligible Persons with multiple hospitalizations

Our CSP network model will address the needs of high-need Eligible Persons and address existing provider availability and accessibility issues, by introducing services, programs, or provider specialties not previously offered within a reasonable driving time. If the CSP is missing certain services or provider types, we will work with the CSP to implement a plan to bring the service or recruit the provider type to address the service gap. If this cannot be accomplished, we will identify local resources to use as referral sources for that particular service or provider type. A coordinated referral system between the CSP and local resources ensures an integrated delivery system of treatment.

Acute care and specialty services will also be available through local hospitals, MHIs, CMHCs or other contracted independent providers or groups available locally. We will also negotiate with community hospitals and inpatient providers to **develop partial hospital programs to address the identified need for step down services**. We will maintain an open panel; any eligible, appropriately licensed provider that executes a participating provider agreement and successfully completes credentialing will be able to participate in the network.

An important feature of our CSP model is the emergency and urgent care program. Cenpatico will partner with the CSP to offer an integrated crisis service delivery system; with 24/7 emergency and urgent care services in their catchment area for all Eligible Persons, not just high-need. The CSP will act as the receiving center for Eligible Persons in crisis and will accept walk-in cases as well as those referred from Cenpatico's Crisis Line, Mobile Crisis Teams, and emergency first-responders. CSP will be contractually required to meet emergent and urgent access standards (within 15 minutes of presentation and within one hour of presentation, respectively) which will help reduce unnecessary ER admissions. The regional CSP model will provide an expanded safety net for communities and improve access to care for individuals.

As a key provider in our network, and in an effort to integrate the delivery of services to Eligible Persons across the board, we will contractually require the CSP to:

- partner with local resources/businesses to implement service booths or satellite offices where a need for a specific service of provider specialty type is identified;
- offer extensive case management services for high need Eligible Persons to ensure that their PCP, as appropriate, is connected, engaged and actively participating in the Eligible Person's behavioral/substance abuse treatment plan; and
- ensure Eligible Persons are receiving the most clinically appropriate services to meet their unique/individual needs and supports a recovery-based model of care.

In addition to implementing a CSP model, any eligible, appropriately licensed provider that executes a participating provider agreement and successfully completes credentialing will be able to participate in the network.

**Monitoring Network Capacity:** While researching the Iowa Plan service delivery system, we heard from stakeholders that the current system is complex and fragmented. In addition, the rural counties in Iowa present an environment of specific challenges for coordination and access to care due to geographic distance barriers and variance of service availability. Cenpatico will monitor network accessibility and availability throughout the network build using the following means:

- Continually monitor network accessibility in GeoAccess using the Iowa accessibility standards.
- Ensure contracted providers comply with the appointment access standards set forth in the IAC.
- Monitor feedback obtained through consumer satisfaction surveys.
- Monitor out of network claims paid, and target those out of network providers for recruitment.

Cenpatico conducted an initial GeoAccess analysis and determined that there are no accessibility gaps from a mileage/travel time perspective for the following types: Community Mental Health Center locations, Psychiatrists, Nurses and Physician Assistants, Psychologists, Counselors/Social Workers, Targeted Case Management providers and Prevention Service Agencies. The current vendor's network analysis using the same software netted the same results as evidenced in the "Quality Improvement Report - April 1, 2008-June

30, 2008". **While this analysis demonstrates that a provider of each type is within a reasonable distance, it does not demonstrate if there is a sufficient number of each provider type available to render services.** We will implement density analysis to identify gaps in sufficient number of each provider type.

**Specific Strategies:** In order to address identified service or provider specialty gaps such as lack of community based services and inpatient step-down care (IOP an PHP services), we will increase network capacity and bring access to a greater number of services that maintain Eligible Persons in their communities, though both traditional and innovative means. Our Network Management department will implement the following strategies to increase access and service mix for rural and underserved communities:

- Implement and reimburse certain psychiatry (evaluation and medication management) services through the provision of telehealth as a covered benefit and method of treatment across the State to include reimbursement for the facility fee (Q3014 billing code).
- Utilize stakeholder focus groups, advisory committee feedback, and Department approval to build consensus for telehealth services and potentially expand covered telehealth services to include certain psychotherapy services.
- Contract with Iowa Federally Qualified Health Centers and Rural Health Centers with behavioral health clinicians on staff; where this has not yet been explored, we will negotiate this option to expand access to behavioral health services in rural and underserved areas.
- Engage FQHCs and RHCs to serve as remote site partners for Eligible Persons to receive services via telehealth in an effort to expand consumer access across the State.
- Expand reimbursable home-based services to include assessment/evaluation, ongoing therapy services, family counseling, and medication management services for those behavioral health providers willing to provide services in home-based settings.
- Contract with specific CSP to develop or expand Intensive Outpatient and other step down services where gaps are identified.
- Incentivize inpatient service providers to develop Partial Hospitalization programming and Level I sub acute services.
- Contract providers in bordering states that meet the licensing and accessibility requirements.
- Use community reinvestment funds to expand services with priority for increasing waiver and step down services as the priority for supporting recovery.

**We have experience addressing network deficiencies in new markets.** Recently we implemented a telehealth program for the Texas STAR Health (Foster Care) program. Psychiatric services in rural counties were limited and Eligible Persons, particularly those under the age of eighteen, did not have access to local psychiatrists. The physicians were either booked for months, only accepted referrals for Eligible Persons age eighteen and older, or were not in the immediate service area. To overcome these issues, we partnered with Mental Health and Mental Retardation centers (organizations similar to Iowa's Community Mental Health Centers) in areas identified through GeoAccess reporting to be without adequate access. Many of the centers had technology in place to provide telehealth services, however the provision of psychiatry services through this method was not billable under the program. We received approval from the Texas Health and Human Services Commission to develop and implement the program. **To-date Cenpatico has 11 centers contracted for to provide telehealth services.**

As the behavioral health vendor for Bridgeway Health Solutions (a long term care managed health organization in Arizona), we identified many area nursing homes that were not equipped to manage behavioral health issues with their patients. When Eligible Persons' behavioral health issues escalated, most nursing homes would send the Eligible Persons to the ER and unfortunately, would not readmit them back to the nursing home once they were stabilized. Many of these Eligible Persons were placed out of their community, far away from their families and support systems. **We implemented a training program** with nursing home staff to teach them to appropriately and effectively de-escalate behavioral health issues. This

included looking for signs that lead to outbursts and methods to overcome and address these issues before they became unmanageable. At present, we are training staff at three nursing homes in the Yuma area. In addition to this type of training, we are working with the local nursing homes, behavioral health agencies and the local medical center to develop better ways to meet the needs of the elderly.

**b) Describe any additional existing service gaps, by region, which the Bidder has identified in preparing this proposal, and the basis on which the Bidder has made this determination. Describe how the Bidder would address those gaps and provide an implementation timeline showing the dates for the introduction of any new services that the Bidder would provide, by region.**

**The Bidder shall minimally address:**

- **Level I Sub-acute Facility services delivery**
- **24 hour mental health stabilization services, noting that past attempts to do so for the Iowa Plan have not proven successful, and**
- **Substance abuse peer support/recovery coaching.**

Our gap analysis to date is based on our initial research, outreach to providers and advocates, and review of the data provided with this Request for Proposal. One of the largest service gaps across all regions is psychiatry. The vast majority of Iowa's psychiatrists are located in the central region (Des Moines metro area) and in one county in the south eastern region. We combine density analysis with GeoAccess time/distance analysis, and use Asset Mapping strategies to determine gaps in services. The Asset Mapping process inventories the strengths and assets of a community, highlighting their interconnection which in turn demonstrates how those assets can best be mobilized.<sup>8</sup>

During 2008 we collected data from providers/advocates via a mailed survey. We met with community stakeholders in Iowa to obtain their perspective on the adequacy of local service systems. We heard from substance abuse providers in the Northwest Region who lack available beds for detox services. Children's service providers in multiple regions confirmed a lack of psychiatrists. Providers statewide told us of the difficulty in locating Peer Support programs in the rural communities. We heard from many CMHC about the challenge of finding appropriate step-down care for individuals discharging into rural communities.

Based on these interactions in Iowa and our experience in other states, we believe our model for regional Community Service Providers (CSP) outlined above will be a successful strategy for increasing access to a broader array of community-based services such as wrap around and peer support. Additionally, this model offers the opportunity to partner with provider agencies to develop the most needed services in the area.

To further our analysis and understanding of service gaps in Iowa, we will meet with all current **Level I Sub acute** providers in each region upon contract award to determine utilization patterns and establish capacity for unmet needs. During contract negotiation for IDPH services, we will identify and contract for additional regional resources to meet unmet needs for sub-acute services. The determination for additional services will be made after feedback from Eligible Persons and other community stakeholders to ensure a complete understanding of the programmatic and specific service needs of each region.

Cenpatico has reviewed the available documented history of the attempts at initiating **Emergency stabilization services**. Based on this review, we will incentivize CSP to develop emergency stabilization units. Upon approval from community coalitions and successful contract negotiations with regional CSP, we anticipate operationalizing emergency stabilization units during the first contract year (2010). Following further analysis of utilization patterns and the current assets of the areas, our preliminary roll-out plan would start with the Northwest, North Central, and Northeastern Regions of Iowa, and then focus efforts on the Southern regions of the state. Should CSP or other providers develop capacity for emergency stabilization quickly, we will offer financial or programmatic oriented incentives, monitor their technique, and partner with them to share their success with other locations throughout the state.

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<sup>8</sup> Northwest Regional Educational Laboratory. Retrieved at: <http://www.nwrel.org/nwreport/dec98/article8.html>

From the information we have gathered thus far, we believe Iowa would benefit from investment in Mobile Crisis Teams to provide service to those in rural communities and to bridge the gap between crises and care. To this end, we propose expansion of crisis intervention and mobile crisis services. In addition to contracting with the existing Mobile Crisis Team providers (including Heartland Family Services in Council Bluffs and Behavioral Health Resources Golden Circle in Des Moines), **we will develop or expand integrated crisis services programs at each CSP. Services will include at least one Mobile Crisis Team per region** – increasing the number of Mobile Crisis Teams statewide from two to six. Mobile Crisis Team providers are not required to be CSP, though collaboration between all providers for integrated crisis services will be contractually required.

During our learning tour of Iowa, we spoke to many providers across the state who were not currently providing **substance abuse peer support/recovery coaching**. We believe that peer-support services are a necessary component of a recovery and resiliency oriented Network and will contractually require implementation of peer-support and recovery coaching in coordinated service plans. We are creating a certification program for peer support providers in order to expand peer support services. This training curriculum will be a forty hour training consistent with National models such as the Georgia Peer Support Specialist Training and the DBSA Peer Support Training, and will be readily adaptable to meet Iowa’s needs. In addition, we are creating a twenty-four (24) hour Train-the-Trainer curriculum which will also be adapted for Iowa communities. We will implement these trainings quarterly for each region for the first year of the contract, and then re-assess the training schedule going forward based on need for additional peer support staff.

<b>Cenpatico Timeline For Service Implementation</b>			
<b>Service</b>	<b>Analysis Start Date</b>	<b>Date for Initial Development</b>	<b>Implementation</b>
<b>Asset Map, Density Analysis, GeoAccess</b>	November 2008	May 2009	January 2010, On-going
<b>Recruit Current Service Providers</b>	2008	May 2009	December 31, 2009
<b>Negotiate Regional CSP</b>	2008	May 2009	December 31, 2009
<b>Level I Sub acute</b>	May 2009	January 2010	June 2010
<b>Emergency stabilization services North</b>	May 2009	January 2010	June 2010
<b>Emergency stabilization services South</b>	January 2010	June 2010	December 2010
<b>Recruit IA Licensed Telehealth Providers</b>	May 2009	August 2009	December 31, 2009
<b>Recruit FQHC/RHC for Integrated Service Delivery</b>	May 2009	August 2009	December 31, 2009
<b>Expanded Mobile Crisis Team</b>	August 2009	January 2010	June 2010
<b>Peer Support Specialist Training, (Quarterly in each Region)</b>	2008	June 2009	January 2010
<b>Substance Abuse Peer Support/Recovery Coaching</b>	2008	June 2009	January 2010

**c) Describe the process by which integrated mental health services and supports will be authorized for Enrollees and who will be allowed to authorize them. Include any parameters that would be implemented to guide the authorization of integrated services and supports. The Bidder should provide examples of any past experience with the provision of such services.**

**Integration of services is a priority for care, and so our management processes including those for authorization are designed to promote and support ease of access for all Eligible Persons.** For this

reason, we do not require prior authorization for initial access to care for all lower levels of care including integrated mental health services and supports. As there is no prior authorization required, clinical review for outpatient and community based services will be conducted through post service profiling conducted by our Quality Coordinators. Post service profiling includes chart audits to gather data that can be compiled, analyzed and acted upon in collaboration with the provider. To further promote integrated care we will not require prior authorization for non-psychiatric providers performing behavioral health care services, though we do require that they notify Cenpatico prior to submitting claims to ensure streamlined claims processing. Our CSP model will work to encourage integrated care by contracting with primary care physicians and substance abuse specialists to provide services in the CSP locations. These integrated services will not require prior authorization, but will similarly be monitored through post service chart audits and profiling.

***Integrated Services, Indiana:*** Cenpatico has partnered with *Health Link*, a Federally Qualified Health Center (FQHC) in Indiana, for the provision of integrated behavioral health and physical health services. *Health Link* now offers behavioral health assessment services on-site through a licensed clinical social worker. As services are often referred from on-site providers, prior authorization requirements would have been a barrier to care. For this reason, we offer this service option with no prior authorization for service. We have recently contracted with a nearby CMHC to offer primary care services, also with no prior authorization requirements. The success of this service option has opened the door for negotiation with other Indiana FQHC and CMHC for integrated care.

**Only the highest levels of care will require authorization.** These services include those provided in a 24-hour facility including: inpatient, residential, and sub acute. Utilization Managers (UM) authorize services for these higher levels of care. Utilization Managers are Iowa licensed, Master’s level clinicians or RNs. Adverse Determinations that result in a denial or termination of services are sent to either our Iowa Plan Clinical Director or their designated Peer Reviewer for case review. This Peer Reviewer must hold a current Iowa license and be qualified to review the requested level of care. We assign peer reviewers based on specialty match to ensure a child psychiatrist will review care requests for children, an ASAM certified Peer Reviewer is selected for substance abuse requests, etc. Authorization determinations are made using the approved utilization guidelines and criteria, which will implement true psychosocial necessity criteria for Iowa. Utilization decisions are made in a fair, impartial and consistent manner following criteria based on treatment efficacy and outcome research with annual input and review by practicing clinicians. Utilization review decisions follow currently accepted behavioral health care standards and take into account special circumstances that may warrant deviation from the norm stated in the guideline.

Cenpatico will not use a prior authorization process to shape provider behavior, but will instead partner with our provider organizations to measure outcomes, consumer satisfaction and to promote evidence-based, family-centered and recovery oriented best practices. Through contract negotiations, we will seek to expand integrated service options in physical health and behavioral health settings. Cenpatico expects to offer incentives during year two of the contract, post-profiling, to providers that demonstrate positive outcomes and strong efforts to incorporate best practices and recovery principles. We may also offer financial incentives, which will be calculated as a percentage of the block payment, for provider organizations to develop peer-run services, Mobile Crisis Teams, and other innovative solutions that address gaps in service provision in their regions.

**d) Describe how the Bidder will incorporate evidence-based practice into its management of the Iowa Plan and how that will impact the services offered through the Iowa Plan during the term of the Contract.**

Cenpatico is committed to promoting the use of evidence-based practices for Eligible Persons covered by the Iowa Plan. We facilitate the use of best practices in all our markets and are committed to educating, monitoring, and incentivizing the use of evidence-based practices in Iowa. In Arizona we have effectively encouraged and developed the use of evidence-based practices through our Best Practice Committee. We will adapt this strategy for the Iowa Plan to promote and adopt evidence-based practices statewide.

Our Best Practice Committee meets quarterly to review evidence-based, research based, consensus-based and emerging best practices. The Best Practices Committee includes the Cenpatico consumer staff, cultural expert, and representatives from the quality and network departments, as well as provider agency representatives, consumers and family members. The committee reviews best practices and recommends adoption of best practices. Work groups are established to review best practices, gather research data, review costs, summarize the findings and make recommendations to the Best Practices Committee. The work groups include Cenpatico staff, providers, stakeholders, consumers and family members.

The next step is to assess need and recommend allocation of resources for implementation of endorsed Best Practices. Once the best practices are approved through our Quality department processes and adopted, the Network Operations department creates a Work Plan to direct and oversee implementation. We monitor to ensure fidelity to the Best Practice guidelines throughout the implementation. Semi-annual fidelity audits are conducted once a Best Practice has been fully implemented and reached the fidelity threshold. Implemented Best Practices are monitored over time to measure effectiveness in achieving the desired outcomes. The results are analyzed via our Quality processes and recommendations are made for enhancements or changes to improve outcomes if needed.

Best practices we have implemented in other markets include: Recovery and Resiliency, Contingency Management, Motivational Interviewing, Supportive Employment, Matrix Model Treatment, Wrap Around-Meet Me Where I Am Model, the Child and Family Team Model, Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, Family Psycho-education, Integrated Treatment for Co-occurring Disorders, Illness Management/Recovery, Multisystemic Therapy (MST), Therapeutic Foster Care, and Functional Family Therapy (FFT).

We utilize SAMHSA Tool Kits when available to conduct fidelity audits and monitor provider fidelity compliance. When Tool Kits are not available, we create fidelity audit tools to assess provider fidelity to best practices. All Tool Kits and Cenpatico created fidelity audit tools require service be delivered in culturally competent and appropriate manner consistent with the recovery and resiliency principle of person centered planning.

Implementing best practices is a multi-dimensional process that requires sensitivity to the culture and values of communities. From our experience in other states, we know that successful roll-out of best practices requires the participation of many entities within the behavioral health system. We would propose to build upon the work done by Iowa Consortium for Mental Health, the University of Iowa, and the Children's Mental Health EBP workgroup to further identify, promote, train and monitor outcomes of Evidence Based Practices for Iowa consumers. We will utilize the EBP already identified by Iowa as well as introducing services rated by SAMSHA as Evidence Based Practices.

Cenpatico will identify programmatic priorities and incorporate evidence-based practices for the specialty populations included in contract based on historical utilization data. Throughout the life of the contract, we will analyze quarterly provider chart auditing and quality monitoring activities to determine areas of focus. Identified specialty populations that will take priority in EBP roll-out include:

- Adults with Severe and Persistent Mental Illness.
- Children with Severe Emotional Disturbance.
- Adults and Children with Substance Disorders.
- Adults and Children with Dual Disorders.

In addition we would propose the introduction of trauma informed care including the use of Trauma Focused Cognitive Behavioral Therapy for children who have experienced trauma, including children within the child welfare population.

### Best Practice Timeline For Adoption And Implementation

Evidence Based Practice	Review Start Date	Date for Recommendation from BPC*	Implementation Date
<b>Peer Support Services</b> “Peer Support allows consumers who have experienced a mental illness to provide support for other consumers who are dealing with similar experiences.” <sup>9</sup>	October 1	November 1	January 1
<b>Integrated Dual Disorder Treatment (IDDT)</b> “The Integrated Dual Disorder Treatment (IDDT) model that improves the quality of life for people with co-occurring mental and substance use disorders by integrating substance abuse services with mental health services. IDDT helps people address both disorders at the same time—in the same service organization with the same team of treatment providers.” <sup>10</sup>	October 1	November 1	April 1
<b>Collaborative Care Models</b> “Integrated health care model in which physical health and mental health providers partner to manage the treatment of mild to moderate psychiatric disorders and stable severe psychiatric disorders in the primary care setting.” <sup>11</sup>	October 1	November 1	April 1
<b>Child and Family Team</b> Child and Family Teams plan, coordinate, and monitor the combination of agency services and community or natural support services needed by children with complex challenges and needs, and their families. Team members are chosen by the family from individuals that are important to the child and/or are involved with the child and their. The CFT meets with the child and the family to set goals and plan services. Team members partner with the family to develop an individualized plan based on what the child and the family wants and needs. <sup>12</sup>	October 1	Recommend for immediate adoption for Iowa Plan.	January 1

\* BPC refers to the Best Practice Committee. Best Practice Committee reviews evidence-based, research based, consensus-based and emerging best practices. The Best Practices Committee includes the Consumer Advisor, Clinical Manager, Provider Development Administrator, Quality Improvement Administrator, provider agency representatives, consumers and family members. The committee reviews best practices and recommends adoption of best practices to the Quality Assurance and Performance Improvement Committee (QA/PI).

<sup>9</sup> The Washington State Peer Support Counselor Training Program-Washington Institute; in partnership with DSHS/Mental Health Division. Retrieved on-line:

<http://depts.washington.edu/washinst/Consumer%20Voice/Peer%20Support/Peer%20Support%20Services%20Intro.htm>

<sup>10</sup> Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE). IDDT. Retrieved on-line: <http://www.ohiosamiccoe.cwru.edu/about/index.html>

<sup>11</sup> Hogg Foundation for Mental Health. Retrieved on-line: [http://www.hogg.utexas.edu/programs\\_ihc.html#what2](http://www.hogg.utexas.edu/programs_ihc.html#what2)

<sup>12</sup> Arizona Department of Health Services. Available from: <http://www.azdhs.gov/bhs/provider/defs/cft.pdf>

### Best Practice Timeline For Adoption And Implementation

<b>Recovery and Resiliency</b> Practice of care that promotes the principles of recovery and resiliency: Strength-based, not symptom or illness-based; Self directed; Individualized and person centered; Empowering; Holistic; Peer supported; Involves society’s respect for the rights of the individual; Involves individual courage, responsibility and hope in achieving and sustaining recovery; and Using the individual’s natural supports will be the norm rather than the exception. <sup>13</sup>	October 1	Recommend for immediate adoption for Iowa Plan.	January 1
<b>Wraparound Milwaukee Model</b> Practice of wraparound services designed to address the multiple needs of youth who cross juvenile justice, child welfare, and mental health system lines, and is coordinated through a public managed care organization. This approach offers care that is tailored to each youth. <sup>14</sup>	October 1	November 1	January 1
<b>Permanent Supportive Housing Model (PSH)</b> “Emphasizes the ability of people with serious mental illnesses, and people with other serious and long-term disabilities, to live successfully in homes of their own in the community. PSH refers to integrated permanent housing linked with flexible community-based services that are available when needed, but are not mandated as a condition of getting or keeping the housing. The PSH model is based on a philosophy that supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible and available services that meet each consumer’s changing needs.” <sup>15</sup>	October 1	November 1	April 1
<b>Supportive Employment</b> “Supported Employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Supported employment programs are staffed by employment specialists who have frequent meetings with treatment providers to integrate supported employment with mental health services.” <sup>16</sup>	October 1	Recommend for immediate adoption for Iowa Plan.	January 1
<b>Psychiatric Rehabilitation Model</b> “Psychiatric rehabilitation works to help individuals with chronic mental illness to develop the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support.” <sup>17</sup>	October 1	November 1	April 1

<sup>13</sup> Oregon Department of Human Services. Available from: <http://www.oregon.gov/DHS/addiction/publications/recovery-resil-policy.pdf>

<sup>14</sup> Kamradt, B. 2001. Wraparound Milwaukee: Aiding Youth with Mental Health Needs. Washington, DC: Office of Juvenile Justice and Delinquency Prevention (OJJDP), April 2001. Available from: OJJDP, [www.ojjdp.ncjrs.org](http://www.ojjdp.ncjrs.org)

<sup>15</sup> Arizona Health Futures. January 2008. *Grayland: Housing for People with Serious Mental Illness in Maricopa County*. Available From: [http://www.slhi.org/publications/issue\\_briefs/pdfs/ib-2008-January.pdf](http://www.slhi.org/publications/issue_briefs/pdfs/ib-2008-January.pdf)

<sup>16</sup> Substance Abuse and Mental Health Services Administration. Evidence-Based Practices: Shaping Mental Health Services Toward Recovery; Supported Employment. Available from: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

<sup>17</sup> Rossler Wulf. Psychiatric rehabilitation today: an overview. *World Psychiatry*. 2006 October; 5(3):151-157. World Psychiatric Association. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1636112>

### Best Practice Timeline For Adoption And Implementation

<b>Assertive Community Treatment Model (ACT)</b> “The goal of ACT is to help people stay out of the hospital and develop skills for living in the community. Assertive community treatment offers services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day.” <sup>18</sup>	October 1	Recommend for immediate adoption for Iowa Plan.	January 1
<b>Motivational Interviewing (MI)</b> “Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence towards symptoms and circumstance.” <sup>19</sup>	October 1	November 1	January 1

e) **Should the Bidder anticipate that it will elect not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, describe services that it will not provide.**

Cenpatico does not anticipate any objections to provide, reimburse for or provide coverage of any counseling or referral service on moral or religious grounds.

#### **7A.2.7 Organization of Utilization Management Staff**

- a) **Describe the Bidder’s proposed organization of Utilization Management Staff. The description should include:**
- **The number of Utilization Management staff which the Bidder proposes, their credentials and expertise, and the rationale behind the number and mix of expertise the Bidder has determined would be necessary**
  - **A discussion of what the precise roles of each of the different types of Utilization Management staff would be:**
    - **The way in which the Bidder proposes to ensure maximum coordination between Utilization Management staff and local service delivery systems, and**
    - **The method by which the Bidder would ensure continuity of Utilization Management for Eligible Persons who make frequent use of the delivery system**

**Number of Staff, Qualifications and Rationale:** Cenpatico’s clinical utilization management program is comprehensive and designed to support the provision of recovery-oriented, consumer-driven quality care. Fifty-one staff positions will be dedicated to administration, supervision, and direct provision of utilization management functions, including intensive clinical management and care coordination. The organization and location of staff will support a regionalized approach to managing care while expanding uniformity and best practices throughout the state. The 99 counties in Iowa vary in cultural perspectives, and range from rural to urban environments. Our research indicates that currently there is significant variance in the continuum of services offered from region to region. Since there is such diversity of resources and needs by geographic region, we plan to locate Utilization Management staff throughout the state. The table below includes the proposed number of each staff position, required credentials and experience, and distribution of staff across six regional offices – one located in each IDPH region.

<sup>18</sup> Substance Abuse and Mental Health Services Administration. Evidence-Based Practices: Shaping Mental Health Services Toward Recovery; Assertive Community Treatment. Available from: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

<sup>19</sup> National Registry of Evidence-based Programs and Practices (NREPP) a service of the Substance Abuse and Mental Health Services Administration. Available From: <http://www.nrepp.samhsa.gov>

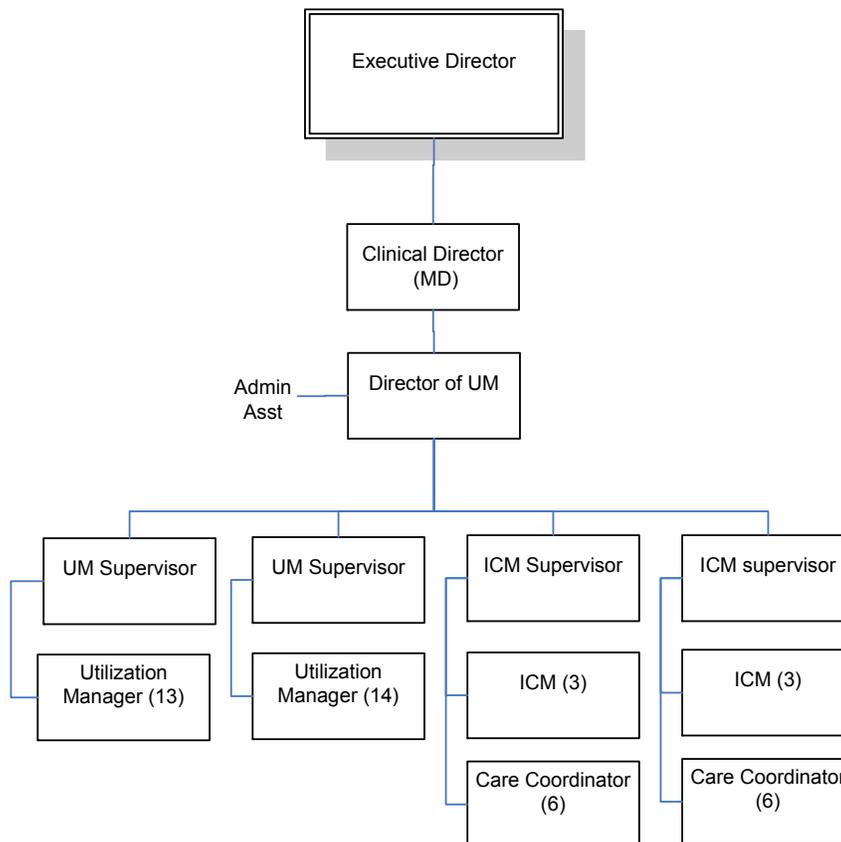
<b>Position Title (total number)</b>	<b>Credentials/Required Qualifications</b>	<b>Experience &amp; Expertise</b>	<b># Positions / Office Location</b>
<b>Clinical Director (1)</b>	<ul style="list-style-type: none"> <li>Iowa-licensed ASAM-certified psychiatrist</li> </ul>	<ul style="list-style-type: none"> <li>At least 5 years of behavioral health clinical experience</li> <li>Understanding of Recovery and Resiliency principles</li> <li>Previous experience as a managed care Medical Director</li> <li>Knowledge of Iowa Plan preferred</li> </ul>	<ul style="list-style-type: none"> <li>Des Moines</li> </ul>
<b>Director of Utilization Management (1)</b>	<ul style="list-style-type: none"> <li>Master's degree in Behavioral Health or RN</li> <li>Independent clinical licensure such as: LCSW, LMFT, LPC, PhD, PsyD or RN</li> <li>CADC or ACADC certification</li> </ul>	<ul style="list-style-type: none"> <li>At least 3 years of managerial experience in the health care industry</li> <li>At least 4 years experience in utilization and/or case management</li> <li>Familiarity with mental health and substance abuse community resources in the geographical area</li> <li>Knowledge of Iowa Plan preferred</li> </ul>	<ul style="list-style-type: none"> <li>Des Moines</li> </ul>
<b>Supervisor, Clinical (2 UM &amp; 2 ICM)</b>	<ul style="list-style-type: none"> <li>Master's degree in Behavioral Health or RN</li> <li>Independent Iowa licensure: LCSW, LMFT, LPC, PhD, PsyD or RN</li> <li>CADC or ACADC certification</li> </ul>	<ul style="list-style-type: none"> <li>Previous supervisory experience</li> <li>At least 3 years case and/or utilization management experience</li> <li>Previous experience in psychiatric or substance abuse health care settings</li> <li>Knowledge of psychosocial criteria for treatment</li> <li>familiarity with mental health and substance abuse community resources in the geographical area</li> </ul>	<ul style="list-style-type: none"> <li>2 Des Moines</li> <li>1 Davenport</li> <li>1 Sioux City</li> </ul>
<b>Utilization Manager - UM (27)</b>	<ul style="list-style-type: none"> <li>Master's degree in Behavioral Health or RN</li> <li>Independent Iowa licensure: LCSW, LMFT, LPC, PhD, PsyD or RN</li> <li>CADC or ACADC preferred (minimum one UM per office will be CADAC or ACADC)</li> </ul>	<ul style="list-style-type: none"> <li>At least 3 years experience in psychiatric and/or substance abuse health care settings</li> <li>Familiarity with mental health and substance abuse community resources and network providers in the geographical area</li> <li>Expertise in authorizing mental health and substance abuse services using psychosocial necessity to address needs for those with multiple, serious or chronic needs and special needs of children and their families</li> </ul>	<ul style="list-style-type: none"> <li>11 Des Moines</li> <li>4 Davenport</li> <li>4 Sioux City</li> <li>3 Waterloo</li> <li>3 Council Bluffs</li> <li>2 Mason City</li> </ul>
<b>Intensive Clinical Manager - ICM (6)</b>	<ul style="list-style-type: none"> <li>Master's degree in Behavioral Health or RN</li> <li>Independent Iowa licensure: LCSW, LMFT, LPC, PhD, PsyD or RN</li> <li>CADC or ACADC preferred</li> </ul>	<ul style="list-style-type: none"> <li>At least 3 years experience providing case management services</li> <li>Previous experience in psychiatric or substance abuse health care settings</li> <li>familiarity with resources in the geographical area</li> </ul>	<ul style="list-style-type: none"> <li>1 Des Moines</li> <li>1 Davenport</li> <li>1 Sioux City</li> <li>1 Waterloo</li> <li>1 Council Bluffs</li> <li>1 Mason City</li> </ul>
<b>Care Coordinators - CC (12)</b>	<ul style="list-style-type: none"> <li>Bachelor's degree in Social Work or equivalent experience</li> </ul>	<ul style="list-style-type: none"> <li>At least 2 years of experience in managed care or behavioral healthcare setting</li> <li>case management experience preferred</li> <li>Familiarity with mental health and substance abuse community resources in the geographical area</li> <li>Familiarity with service planning process</li> <li>Experience in discharge planning from facility based care</li> </ul>	<ul style="list-style-type: none"> <li>2 Des Moines</li> <li>2 Davenport</li> <li>2 Sioux City</li> <li>2 Waterloo</li> <li>2 Council Bluffs</li> <li>2 Mason City</li> </ul>

The clinical utilization management team will have primary responsibility for utilization management functions, but will coordinate with Clinical Quality Assurance Coordinators and Clinical Provider Liaisons regarding their respective roles in supporting best practices and contractual compliance consistent with appropriate utilization and recovery-oriented practices. The role of our clinical utilization management program is to support and guide direct service providers work with Eligible Persons and their families, ensuring utilization of best practices and delivery of quality services that support consumer-driven recovery. The rationale for our program is grounded in the following key recovery concepts 1) providing maximum opportunities for consumer and family voice and choice, 2) inspiring hope, 3) effective treatment, and 4)

appropriate engagement efforts. This approach teaches providers to utilize Motivational Interviewing techniques to effectively engage Eligibles. Our recovery-oriented providers then educate consumers about the possible outcomes that may result from various decisions and assist them in developing effective, individualized treatment and service plans, based on strengths and designed to empower consumers to have increased control and initiative in their personal recovery.

The organization of the department is designed to allow for maximum flexibility, clarity of roles and support for consumer choice and engagement in treatment planning. Utilization Managers (UM) typically interact with network providers and are primarily engaged in reviewing appropriateness of care utilizing psychosocial necessity-based utilization management guidelines. While Intensive Clinical Managers (ICM) and Care Coordinators (CC) primarily interact with consumers, they also communicate with providers, allied service agencies, school systems, court systems, families and natural supports as well as any organization that may be able to assist Eligible Persons in their recovery efforts. We reviewed utilization data and our staffing models for similar size markets, as well as the current vendor's staffing model, in determining to propose twenty-seven (27) UM, six (6) ICM and twelve (12) CC. These front line staff receive direction through (4) Clinical Supervisors, the Utilization Management Director and the Clinical Director. This model will provide sufficient independently licensed UM staff to conduct 24/7 utilization review activities for mental health and substance abuse services.

## Cenpatico Iowa Utilization Management Structure



All clinical Supervisors will be required to possess certifications as CADC or ACADC to ensure substance abuse issues are identified, appropriately assessed and addressed in treatment planning. At least 1/3 of all licensed staff will also hold substance abuse certification. Additionally, we will encourage all staff to undergo additional substance abuse training and will provide opportunities for staff to receive continuing education in this area. Research<sup>20</sup> indicates that co-occurring psychiatric and substance abuse disorders can be difficult to differentiate; therefore this will be a key focus for provider and community education as well as for ongoing in-service training of utilization management staff.

**Role Descriptions:** Cenpatico will hire clinical staff with a broad array of experience and expertise appropriate to the functions performed. The Iowa Plan **Clinical Director** will provide leadership, direction and guidance for all aspects of the Utilization Management Program, to include setting UM policy and procedure, review and implementation of psychosocial necessity criteria and utilization management guidelines, and leadership of the UM Committee, and is responsible for ensuring all clinical services are administered in a manner consistent with accepted standards of care. The Clinical Director has oversight of peer reviewers and clinical consultants utilized in the decision making process, and may conduct consultation with practitioners in the field as needed.

The **Utilization Management Director** will be responsible for the clinical operations and outcomes of the UM Program, will supervise the clinical staff and coordinate clinical utilization management functions with clinical consultants and with Quality and Network Management departments. The Utilization Management Director will ensure the appropriate policies and procedures are applied by staff in the course of day-to-day operational responsibilities when reviewing care requests for substance abuse or mental health services and in coordinating services across the care continuum.

**Clinical Supervisors** will be available at all times including after business hours and weekends to address questions from front line staff and to ensure consistency in the application of criteria, policies and processes. The supervisors will regularly conduct silent call monitoring and documentation audits to ensure the staff are appropriately using guidelines, address any opportunities for improvement and will regularly provide feedback to the staff.

**Utilization Managers (UM)** will apply criteria and perform clinical reviews for pre-certification, concurrent, and retrospective authorization requests for mental health and substance abuse services. All reviews related to substance abuse services will be completed by CADC or ACADC staff. UM are specifically prohibited from making adverse determinations. If initial clinical review indicates a potential issue regarding compliance with Utilization Management Guidelines, the care request is referred to an appropriate peer reviewer as designated by the Clinical Director. UM have immediate telephone access to consultation with licensed physicians and behavioral health professionals with various professional specialties and license types. UM are compensated through hourly fees or salaried positions. We do not permit or provide compensation or incentives to employees or agents based on the amount or volume of adverse determinations, reductions or limitations on lengths of stay, benefits, services, or frequency of contacts with health care providers or members.

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<sup>20</sup> Stewart, Christopher and Rif S El-Mallakh. (2007). "Is Bipolar Disorder Over diagnosed Among Patients with Substance Abuse?" *Bipolar Disorders*, 6, p. 646-648. Blackwell Munksgaard: 2009.

University of Utah. (2009). "Mental Illness: The Challenge of Dual Diagnosis." Retrieved: <http://learn.genetics.utah.edu/content/addiction/issues/mentalillness.html>.

National Drug Intelligence Center; US Department of Justice. (April 2004). "Drug Abuse and Mental Illness: Face the Facts." Retrieved: <http://www.usdoj.gov/ndic/pubs7/7343/index.htm#What>.

National Institute on Drug Abuse. (October 2007). "Co-morbid Drug Abuse and Mental Illness." Retrieved: <http://www.nida.nih.gov/pdf/tib/comorbid.pdf>.

**Intensive Clinical Managers (ICM)** serve as advocates and liaisons, making contacts with Eligibles and their treatment/service teams throughout the development and the implementation of individualized service plans for the coordination of behavioral health services, which includes interface with medical services, the CW/JJ service system, or any allied provider or system of care. Eligible Persons may be identified and referred for participation in the Intensive Clinical Management Program during the course of regular utilization review activities, through claims data review indicating a high level of services received, or by request from IME, direct service providers, community resource agencies, advocates, or family members. ICM assist with engaging Eligibles in the treatment planning process and the promotion of their ability to self-manage their disorders. Eligible Persons demonstrating high levels of risk or high need will be offered services by this program to include additional support, education, coordination of services and assistance as needed. Included among these six staff will be at least one identified specialist for each of the following populations: (1) adults with severe and persistent mental illness, (2) children with high risk factors (i.e. severe emotional disorders, involvement in child welfare or juvenile justice systems, or placement in PMIC), (3) persons 65 years of age and older, and (4) persons with substance use disorders. ICM specializing in serving these populations will have specific relevant experience and training and will serve as resources to all Cenpatico Iowa Plan clinical staff for issues related to these populations.

**Care Coordinators (CC)** conduct care coordination activities for Eligible Persons. A key function for CC will be engaging with facility providers for all higher levels of care to assist with discharge planning that engages Eligibles and their families in a viable plan to ensure they are appropriately served during transitions between levels of care in the behavioral health system. Care Coordinators provide outreach and support services, and help track individuals' progress over time. They are knowledgeable regarding local resources and take responsibility for educating Eligible Persons regarding available services and treatment options. Resources will include supportive services that fall outside the scope of health benefits and may include supported housing, employment, applications for food stamps, transportation or any other supportive service necessary to allow the individual to function independently in the community. For those Eligibles who are experiencing co-morbid physical health and mental health or substance abuse conditions, CC will be responsible for facilitating exchange of information between the primary care physician or specialist and the behavioral health provider for integration of efforts. Care Coordinators are not involved in any level of utilization management decision-making. As with the ICM, specific CC with the appropriate background experience will be designated as in-house specialists for the 4 categories of high needs populations noted above. Such CC specialists will be tasked with gathering and maintaining current information regarding resource availability, both formal and informal, by geographic regions for these high needs population. They will also function as resources to all Cenpatico Iowa Plan clinical staff for issues related to these populations.

**Strategies for Maximizing Coordination between UM Staff and Local Service Delivery System:** The regional distribution of utilization management staff is designed to facilitate collaboration with local service providers and community resources. This design allows for onsite utilization review when appropriate, as well as participation in joint treatment planning and discharge planning based on knowledge of the local delivery system. In addition to utilization management staff, Clinical Provider Liaisons will be located in each regional office and will directly interact with providers to enhance their skills in delivering recovery-oriented services, evidence-based practices, compliance with clinical practice guidelines and will be auditing provider fidelity to expectations regarding peer supports. This regional approach will ensure the capability of maximizing coordination efforts and in-person participation in treatment team meetings, discharge planning efforts and other local/regional activities.

Cenpatico uses a comprehensive case management and authorization system, CCMS, a McKesson product that supports maintenance of Care Plans, documentation of all interactions with providers and Eligible persons, treatment records, concurrent review, denial and appeal information or any other clinical information obtained regarding individuals. Utilization management staff is able to document all interventions and available information in CCMS, and with appropriate permission for release of information from Eligible Persons, serve to facilitate seamless information exchange between all involved parties. Our

internal centralized record keeping, as well as the *Health Passport* product we are proposing for the Iowa Plan, also facilitate continuity of care and communication *across regions* for Eligible Persons who may move from one area to another. All efforts include a focus on strengthening the ability of the Eligible Person to direct their own care and recovery efforts and to offer opportunities for the individual to take ownership.

As appropriate, ICM and CC will work with local Targeted Case Managers (TCM) to ensure coordination of care by facilitating and tracking communication among all participants in each joint treatment plan and/or individualized service plan, and offer support by providing information regarding extended resources in the community. ICM and CC will make referrals to TCM for Eligible Persons who appear in need of this service and who have not yet accessed it. One way we have increased coordination in other markets is through our *Caring Voices* program. Care Coordinators have delivered telephones to consumers to ensure their ability to access services and communicate with family members, service providers, community case managers, and ICM and CC staff. The telephones are pre-programmed with phone numbers of these involved participants in the consumers' recovery plans – including physical health and behavioral health providers, local resources and family members/natural supports who can assist in supporting their recovery.

**Continuity of Utilization Management for High-Utilizing Eligible Persons:** A primary responsibility of Intensive Clinical Managers is to assist Eligible Persons who frequently access the delivery system and have more complex needs. ICM are responsible for coordinating all of the various involved entities to avoid duplication of services and to engage Eligibles in decision-making. For Eligible Persons who frequently need to access the care system, a referral into our ICM program ensures a thorough assessment will be made by ICM staff to identify areas of need in all life domains. In partnership with the Eligible Person, the ICM will generate a Plan of Care and will provide linkage for the Eligible Person to a Comprehensive Service Provider in the local service delivery area. Cenpatico will establish at least 2 Comprehensive Service Providers in each region to promote choice for the Eligible Persons and these service providers will be required to offer a comprehensive continuum of services including community-based, wraparound services, Targeted Case Management and all required safety-net services the individual requires to allow them to successfully and safely remain in the community. Any individual who requires admission to a 24-hour congregate care facility will be screened for participation in the ICM program. ICM/CC participate in discharge planning to facilitate all appropriate referrals and to identify and engage all allied systems that are already involved or whose participation could offer benefit to the individual.

The utilization management department works seamlessly with our Network Management and Member Services departments in promoting recovery and resiliency across the local service delivery systems, with emphasis on coordination of care for the highest need, and therefore often highest utilizing, Eligible Persons. Clinical Provider Liaisons in the Network department are located in each region and focus on training, auditing, and serving to assist provider organizations in utilizing best practices, employing peer functions, following clinical practice guidelines, conducting motivational interviewing practices and providing maximum opportunities for consumer voice. Our recovery-oriented providers then educate eligible individuals about the possible outcomes that may result from various decisions and assist them in developing effective treatment/service plans. Member Services staff, including the Recovery & Resiliency Advisory and Family Advisor offer outreach and education opportunities directly to Eligible Persons and their families. The Director of Member Services and the Interagency Liaisons (IAL), in partnership with the Recovery Advisory Committee, will develop and implement an allied systems coordination plan that will operationalize processes for communication and collaborative service provision across systems. This plan will include interagency agreements with first responders such as local law enforcement, ambulance services, school systems, courts, jail systems and other agencies to support the development and operationalization of crisis intervention plans for high utilizing Eligible Persons. These interagency agreements will also help avoid duplication of services and promote broader community awareness regarding mental health and substance abuse needs, and assist in identifying gaps in the system of care and developing collaborative solutions to address those gaps.

**b) Provide the names, telephone numbers, and email addresses of three of the Bidder’s clients for which it has organized its Utilization Management staff to maximize coordination with local service delivery systems and who can be contacted to confirm the effectiveness of the Bidder’s performance.**

In **Ohio**, Cenpatico serves an Aged, Blind and Disabled (ABD) population, as well as a traditional Medicaid population of children and families. Our staff is co-located with Buckeye Community Health Plan staff and has worked to integrate physical and behavioral health care utilization management and care coordination efforts that have effectively reduced readmission rates and inpatient penetration rates since the inception of the program. A particular challenge in this market is that the outpatient mental health and substance abuse services are carved out of the contract. These services seek funding for payment through the State and not through the managed care contract. Cenpatico has developed positive working relationships with these non-contracted entities and is now able to regularly conduct joint treatment planning for the benefit of our Enrollees. Our ICM activities have received praise from the state for innovation and success.

In **Texas** our ICM teams are located in seven (7) offices to support regionalized coordination of care efforts. The licensed and non-licensed staff is effective in establishing communication with all stakeholders across a very complex system of care in our Foster Care product. We have demonstrated partnership not only with medical health plan partners but we regularly interact with the Department of Protective and Family Services to assist in permanency planning, resolve placement issues for children with difficult behaviors and support judges who are seeking input regarding appropriateness of medications and psychological evaluations.

In **Indiana** we have co-located Cenpatico ICM/CC staff in two regional offices with Managed Health Services (MHS) and we have worked together with health plan staff to integrate physical and behavioral health care utilization management and care coordination efforts. We facilitate and participate in regular clinical staffing meetings with community mental health centers. Through provider profiling we are working to reduce utilization management administrative processes for providers, such as Bowen Center (a CMHC), who demonstrate consistent appropriate service mix and utilization.

**References:**

State	Program	Name	Title	Phone	E-Mail
Ohio	Buckeye Community Health Plan	Jeff Davis	Director of Integrated Health Services	(866) 246-4356	<a href="mailto:jdavis@centene.com">mailto:jdavis@centene.com</a>
Texas	Superior Health Plan: Star Health (Foster Care)	Holly Munin	VP, Operations	(800) 218-7453	<a href="mailto:hmunin@centene.com">hmunin@centene.com</a>
Indiana	Bowen Center	Richard Ruhrold	VP for Clinical Services	(574) 267-7878	<a href="mailto:Richard.ruhrold@bowencenter.org">Richard.ruhrold@bowencenter.org</a>

**7A.2.8 Utilization Management**

**a) Attach to the proposal a complete copy of any Utilization Management Guidelines that the bidder would use in authorizing mental health services. Also, attach any guidelines the Bidder would use in applying ASAM criteria for the authorization or retrospective monitoring of substance abuse services. The attachment(s) must be clearly numbered and labeled. The pages in the attachments will not be counted in the page limit established for this section of the proposal.**

For mental health services, see *Attachment - Utilization Management Guidelines*. In addition the nationally recognized American Society of Addiction Medicine’s 2<sup>nd</sup> Edition-Revised Patient Placement Criteria (ASAM PPC-2R) will be applied in assessing appropriate utilization of substance abuse services.

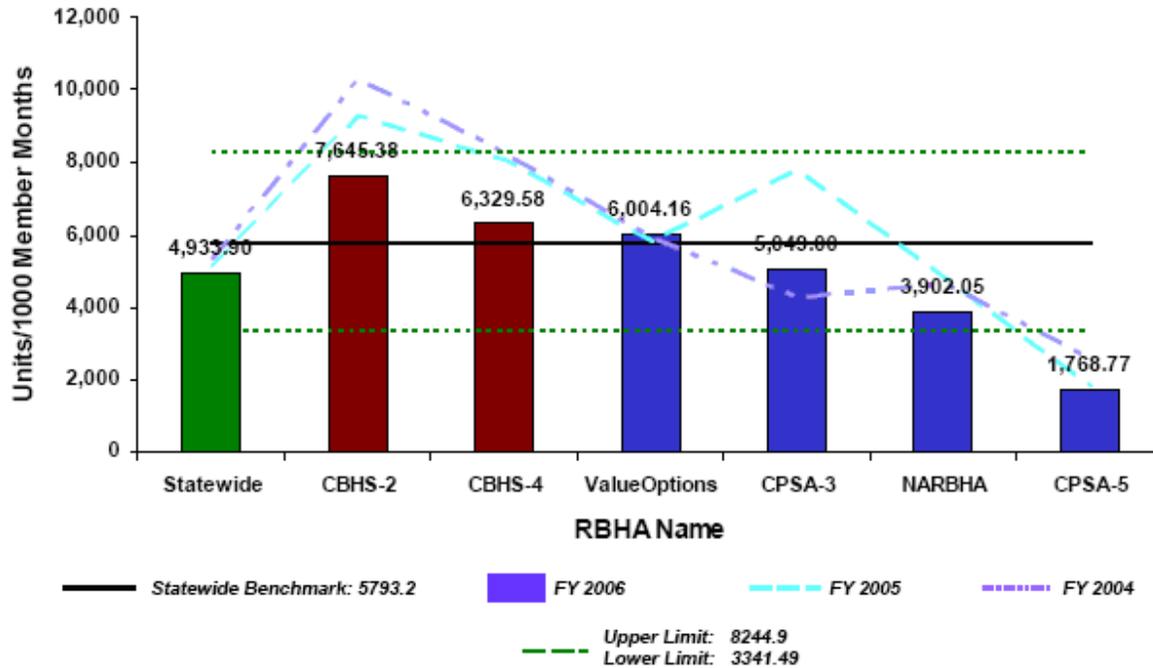
**b) Describe how the Utilization Management Guidelines would generally be applied to authorize or retrospectively review services. Specifically address how the bidder would both manage the appropriateness of the treatment duration and the potentially high volumes of service requests.**

The Utilization Management Guidelines and ASAM PPC-2R will be applied by Utilization Managers to assess requests for prior authorization (when applicable) and continued stay during concurrent review for facility-based levels of care (all 24 hour services and partial hospitalization services). The guidelines and criteria are used as tools to identify intensity of need across bio-psycho-social domains in order to determine the appropriate intensity and duration of service. As intensity of need decreases as progress is made in recovery, these tools assist UM and providers in identifying when a service is no longer necessary or when discharge to a lower level of care is appropriate. The utilization review process will be telephonic and available 24/7. Utilization Managers (UM) will respond to all requests for authorization of any facility-based level of care within 24 hours, including peer review when the UM is unable to immediately authorize due to some question as to whether the appropriate Utilization Management Guidelines are met. When a peer review discussion results in an adverse response to an authorization request, our peer reviewer will always offer alternative services appropriate to the presenting mental health and/or substance abuse needs of the Iowa Plan Enrollee. Utilization decisions are made in a fair, impartial and consistent manner using clinical criteria based on treatment efficacy and outcome research with annual input and review by practicing clinicians. Utilization review decisions follow currently accepted behavioral health care standards and take into account special circumstances that may warrant deviation from the norm stated in a guideline.

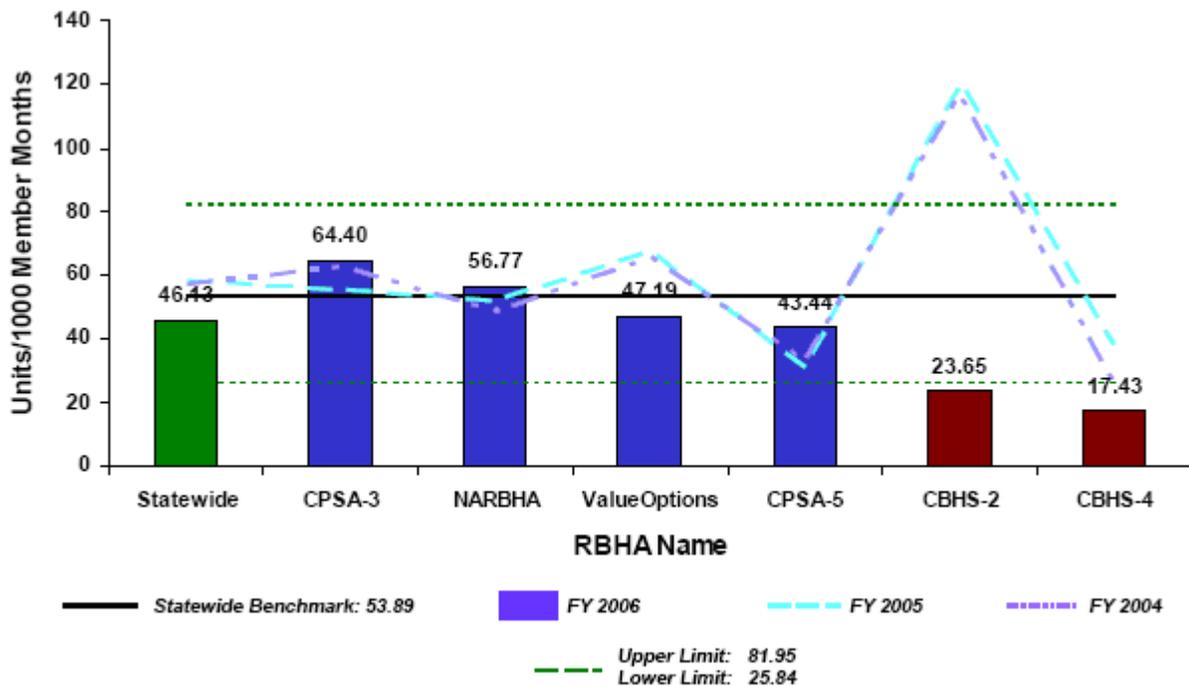
Non-facility-based services do not require prior or concurrent authorization and will be retrospectively reviewed. The Utilization Management Guidelines and ASAM PPC-2R will be applied retrospectively by utilization management staff, as well as by Clinical Provider Liaisons (Network Management department) and Clinical Quality Assurance Coordinators (Quality Assessment and Performance Improvement department). Application of these guidelines and criteria will occur through a variety of strategies, including chart audits, fidelity audits, and provider profiling, designed to ensure optimal quality of care and appropriate utilization of services across the behavioral health service delivery system. Clinical review for outpatient and community based services will be conducted through post service profiling activities where data can be compiled, analyzed and acted upon in collaboration with the provider. We will not be using a prior authorization process to shape provider behavior but will instead be partnering with our provider organizations to measure outcomes, consumer satisfaction and to promote evidence-based, family-centered and recovery oriented best practices. We expect to work with providers after profiling analysis to offer incentives to providers that demonstrate positive outcomes and strong efforts to incorporate best practices and recovery principles. Cenpatico will provide incentives for provider organizations to develop peer- run services and to initiative innovative solutions to address gaps in service provision in their regions.

Our Utilization Management processes, including application of our Utilization Management Guidelines, allow us to offer providers safe alternatives for recovery-oriented, community-based service options for Eligible Persons when more restrictive levels of care are being considered. The tables below are from the Arizona Department of State Health Services, Division of Behavioral Health Services (ADSH/DBHS) Provider Network Development and Management Plan issued in August 2007. Cenpatico is identified as CBHS-2 and CBHS-4. Graph A, illustrates increased utilization of supportive services while Graph B, reflects a decrease in inpatient utilization.

**Graph A - Statewide RBHA SMI Population – Support Services Utilization**



**Graph B - Statewide RBHA SMI Population - Inpatient Services Utilization**



In determining the appropriate number of Utilization Management staff for the Iowa Plan, we reviewed the utilization data provided and our staffing models for similar size markets. Our staffing model will support timely response to authorization requests. In addition our strong emphasis through the Network Management plan on provider education and training will ensure familiarity with the Utilization Guidelines. The Utilization Guidelines will be made available through our website as well as in provider manuals and will be

reviewed on-site as part of orientation for all newly contracted providers. Our experience has demonstrated that utilization reviews are expedited when the requesting providers are thoroughly familiar with the applicable guidelines and criteria.

Cenpatico actively promotes the engagement of Eligible Persons in their recovery planning process and within the scope of the Utilization Guidelines, will give preference/priority to Eligible Persons' decisions regarding successful interventions. To facilitate this process, we will utilize historical data to quickly identify individuals with high need/high risk situations for proactive intervention and assistance. These individuals will be referred to Comprehensive Service Providers to ensure the full spectrum and array of service options are available to support them in maintaining community tenure and in recovery efforts. Data to be included will be derived from claims, pharmacy information and any prior service authorization information available. ICM/CC staff will facilitate meetings involving Eligibles, family, and any current treating providers as well as allied service providers to determine desirable treatment interventions, and will monitor for success. All treatment options will consider the least restrictive environment possible while providing safety for the individual and the community, efficacy and focus on recovery. In determining the appropriate duration of treatment, we review the clinical information concerning progress in an established treatment plan with expectations for the symptoms to lessen over time with the stabilization of psychosocial functions. Our Utilization Management Guidelines not only address symptom distress reduction and intensity of service expectations but review additional life domains to ascertain the individual's cultural, environmental and psychosocial situation and available support system. This thorough analysis offers a more comprehensive picture of the complex context in which a service request is initiated. Utilization management review activities will be focused on improved outcomes for the Eligible Persons and measured via quality metrics. The duration and intensity of treatment must be directly responsive to the level of symptom distress and psychosocial stressors experienced by the individual receiving care. Charts reviewed retrospectively need to demonstrate the Eligible Person's involvement in the treatment planning (and family member involvement as appropriate), the use of evidence-based practices with established efficacy in treating the diagnosis and symptoms reported, progress and regular review of the established goals and treatment plan for updates and adjustments.

- c) **Discuss any special issues in applying the Guidelines for:**
- i. **substance abuse services for pregnant and parenting women;**
  - ii. **substance abuse services provided to enrollees in PMIC**
  - iii. **mental health inpatient services provided to enrollee children in state mental health institutes;**
  - iv. **Eligible Persons with concurrent need for both mental health and substance abuse treatment, and**
  - v. **Assertive Community Treatment (ACT).**

Cenpatico Utilization Management Guidelines and the ASAM PPC-2R allow adequate flexibility through consideration of psycho-social dimensions for application to special populations and the full spectrum of services, including ACT. Our clinical staff is trained to consider all bio-psycho-social factors when assessing appropriateness of level of care and service modality, and such consideration is supported by the guidelines we apply for both mental health and substance abuse treatment. Our guidelines are specific enough to ensure reliability of application and are based solidly enough in psycho-social necessity criteria and recovery principles to support applicability to demonstrated individualized need.

**Pregnancy** impacts both psychosocial and physical needs and can escalate the Severity of Need for anyone seeking intervention or treatment for mental health or substance use and may require more intensive interventions. All pregnant and parenting substance users will be candidates for ICM to facilitate coordination of care.

Cenpatico will utilize the ASAM PPC-2R when reviewing the necessity of congregate care in a **PMIC** and evaluating the need for admission or continued stay. We expect the PMIC provider to demonstrate inclusion of the family in the decision making and recovery process. Resolution of circumstances that led to admission to a PMIC will be considered on concurrent review and reviews will include available psychosocial supports

for discharge planning. A referral will be automatically triggered to ICM upon admission to a PMIC or other facility-based care setting.

We apply the specific age-appropriate guidelines when reviewing treatment requests at all levels of care. For **children who are receiving services in state mental health institutes**, Cenpatico will expect to see evidence of intensive family involvement several times per week unless clearly contraindicated. Discharge planning will begin upon admission with a strong focus on family or caregiver participation in the generation of a crisis plan and implementation of safety measures to allow the child to resume care in a less restrictive setting. All families whose children enter a mental health institute will be referred into the ICM program for additional assistance in coordination of care and services to support family reunification and returning the child to the home and community. Care coordination efforts will establish linkage and facilitate communication between all involved agencies to assure a safety net for the family. A primary underpinning of our utilization review process is the expectation that discharge efforts should begin at the time of admission and that the appropriate least restrictive environment is always sought.

We will require that all providers assess for **co-occurring substance abuse and mental health disorders** when conducting initial evaluations and maintain appropriate documentation of these assessments. Service plans will be required to address any identified co-occurring issues. In this way we will have information available during the utilization review process to ensure that we are applying the appropriate combination of criteria from the guidelines for both mental health and substance abuse services. We will audit charts to monitor the rate at which provider organizations complete substance abuse screenings and appropriately refer for further assessment and treatment. A primary focus of our provider education efforts will be to promote identification of substance abuse issues, and increase provider awareness of how substance abuse symptoms can appear to indicate mental health diagnoses. We support use of Motivational Interviewing to assess readiness for change and will be partnering with our provider organizations to promote consumer awareness of their treatment options and the benefits of addressing both mental health and substance abuse conditions simultaneously. Individuals who are dually diagnosed will be referred to the ICM program for assistance in coordination of services and to facilitate exchange of information among service providers.

Our application of utilization guidelines supports use of **ACT teams** for persons with mental illness, who require that level of outreach and support in order to achieve recovery in their communities. We recognize the demonstrated efficacy of ACT teams in increasing service accessibility to many persons diagnosed with serious mental illness. Cenpatico will also support expansion of ACT team capacity for Iowa through community reinvestment funds and will promote access and incorporation of these services into Joint Treatment Team planning.

**d) List each Medicaid mental health or substance abuse service or level of care for which the Bidder would not require prior authorization.**

- i. Describe a quality improvement related circumstance that would lead the Bidder to request Departments approval to require prior authorization for a service that does not usually require prior authorization.**

Cenpatico will not require prior authorization for any services within the following levels of care:

- rehabilitation and community support services
- outpatient services

We also will not require prior authorization for the following levels of care *except when provided by hospitals or other facility providers*. This is intended to support Comprehensive Service Providers and Community Mental Health Centers in implementing these services to achieve greater service coordination and continuity of care:

- partial hospitalization
- day treatment
- intensive outpatient programs

We will require prior authorization for 24 hour care that removes Eligible Persons from their home environment (including acute and sub acute inpatient, residential, and substance abuse services in PMIC). We will require notification for Observation and Crisis Stabilization services.

In the interest of quality improvement, we may **request the approval to require prior authorization for a service that does not usually require it**. If we recognize through claims review or profiling data that a certain type of service appears to be inappropriately utilized in a way that may be fraudulent or counter therapeutic, we may request approval to either conduct a targeted review of a provider whose practice patterns are an obvious outlier, or we may recommend a change in prior authorization practices to include a certain service.

For example, in Georgia we identified that some providers were consistently inappropriately utilizing an Intensive Family Intervention (IFI) service that was intended to stabilize families who were undergoing a crisis situation. Previously these services did not require prior authorization under the Georgia FFS system. We identified that multiple providers were maintaining families at the IFI level of care for many months – long past the resolution of the crisis situation. Providers were continuing to bill for IFI services inappropriately rather than facilitating service planning that supported families in moving towards independence and sustained recovery. In fact, during our fact finding activities we made outreach calls to families, and found several instances where providers reported outreach or in-person visits but consumers subsequently reported that the providers had not actually performed the services. In collaboration with the Georgia Department of Human Services we implemented prior authorization and concurrent review requirements for IFI services and were able to intervene with providers during the utilization review process on behalf of families to advocate for appropriate services.

**e) Discuss how the Bidder would self-evaluate both the clinical effectiveness and administrative efficiency of these authorization processes. Describe in what circumstances, if any, the Bidder would consider waiving prospective utilization review for certain providers based on a provider's past performance.**

We continually evaluate the **clinical effectiveness and administrative efficiency of our utilization management processes** to ensure that these activities produce improvements in utilization that result in better quality of care and whether improvements exceed any administrative burden for providers or Cenpatico. Utilization review processes are only applied where they can clearly and positively impact the quality of care delivered and outcomes offered for consumers. Because of our existing internal quality review process and our consumer-driven approach to care delivery, we will not be conducting prior authorization review for any level of care that does not involve facility based services for the Iowa Plan. For our Iowa-specific prior authorization processes, we will evaluate the effectiveness of our interactions with facility providers seeking authorization and our efforts to facilitate improved discharge planning. Our internal evaluation process will include examination of: denial rates, average length of stay, discharge planning efforts, readmission rates, and rates of referral to peer review, adverse occurrences, complaints and timeliness. Additionally, we conducts inter-rater reliability audits to ascertain the level of agreement between our Utilization Management staff in making authorization decisions and conducts chart audits as well as silent call monitoring to review the quality of documentation, professionalism and clinical accuracy of interactions. All of these indicators are currently monitored in our existing lines of business and through review of these data points we have often identified action steps for revising and improving our utilization management processes. We have identified providers in many of our current markets whose profiling data indicate positive adherence to best practices and have warranted **waiver of prior authorization requirements**. For these identified acute care providers we have altered the review process to allow the provider to simply provide demographic information upon admission and subsequent review with clinical information only if the length of stay reaches a certain threshold. The notification facilitates ICM activities to aid the family in discharge planning and accessing needed coordination services. Quarterly claims data is reviewed to identify any changes in practice patterns and these are addressed in meetings with the facility. We also share comparative data with our acute care providers to enhance care delivery by identifying

regional patterns, age and diagnostic category patterns and service gaps that need to be addressed such as failure to obtain a timely follow up appointment after an acute care stay.

**f) Describe how the Bidder would operationalize the state’s concept of “psychosocial necessity” in the authorization process for substance abuse services. Contrast this to the Bidder’s use of a stricter “medical necessity” approach with clients under other contracts, or if not applicable, describe how, in the Bidder’s understanding, the authorization process approaches differ.**

**Operationalizing psychosocial necessity for substance abuse services** is achieved through the use of ASAM PPC-2R guidelines and understanding of the circumstances and social support system surrounding the individual seeking treatment. Immediate access to treatment has been demonstrated to be of vital importance for substance abuse disorders as often the “window of willingness” can be very brief and immediate access increases the likelihood of recovery progress. Therefore, we support consumer-directed access to care. For acute and inpatient levels of care, we review the medical necessity of treating withdrawal symptoms and the impact of detoxification on physical health, as well as the multiple life domains or dimensions that impact the need for treatment.

Cenpatico currently manages mental health and/or substance abuse benefits for Medicaid, SSI and ABD populations as well as SCHIP and Medicare products in nine states for over 1.2 million lives. Some of our contracts **require application of a strict “medical necessity” approach** to authorizing substance abuse services. A strict medical necessity approach looks only at whether a person’s condition will deteriorate immediately if the service is not offered and thus will result in a clear inference of harm if no action is taken. **In contrast**, through our experience in our contracts that permit a broader approach, we find that appropriate use of psychosocial necessity criteria doesn’t exclude medical necessity but expands upon it. Simply put, a psychosocial necessity approach reviews potential benefits of services although they may not yet be “necessary” from an immediate medical perspective, and takes into consideration the individual’s support system, culture, environment and motivation when determining appropriate utilization. Use of psychosocial necessity criteria when reviewing substance abuse services increases recovery options and improves outcomes for consumers with substance abuse issues.

**g) Describe the process the Bidder would implement for the administrative authorization of services. Include the way in which the Bidder would allow for authorization of services provided during all the months of enrollment even if Medicaid eligibility is determined after the initiation of services.**

Requests by providers for utilization review outside of the generally required prior authorization process (i.e. administrative authorization requests), will typically only occur for inpatient and facility based services because we will not require authorization for other levels of care/services. When these requests are based on extenuating circumstances (Enrollee was unable to or did not provide accurate information regarding eligibility, for example) and are not due entirely to contractual non-compliance, the **process for administrative authorization** will include a retrospective chart review when the episode of care has already been completed. For requests for administrative review when the Eligible Person is engaged in ongoing services, telephonic retrospective review will occur regarding the services provided to that point, and then ongoing concurrent review will follow the normal procedure.

Claims that are initially denied due to eligibility status will be reviewed and reprocessed **when eligibility is retroactively granted to Enrollees**. Since only facility based services require authorization, most claims will be reprocessed internally without further action from the provider. For claims which involve services that would have required prior authorization, we will retrospectively review the clinical information and authorize based on application of Utilization Management Guidelines or ASAMPPC-2R. We will not administratively deny based on failure to comply with contractual requirements for prior authorization when the Enrollee’s eligibility is established retroactively.

**h) Describe how the Bidder would provide Intensive Clinical Management to certain Iowa Plan Enrollees, and the relationship of those activities to Targeted Case Management.**

Eligible Persons with multiple or catastrophic disease processes that require frequent and/or costly services or have unmet psychosocial needs, will be eligible for our Intensive Clinical Management (ICM) program. Our underlying assumption in offering this program is that while we are not a direct healthcare service provider, it is our role and responsibility to work collaboratively with direct service providers to ensure integrated and coordinated services that promote recovery. Toward that end, our vision for the Iowa Plan Provider Network includes a regionally-focused statewide system of Comprehensive Service Providers (CSP) as we have found this to be an effective network design for greater systemic coordination of recovery services. Our collaboration with direct service providers will include Targeted Case Management (TCM).

During the network development phase we will work with County Boards of Supervisors to request and encourage them to contract with our network CSP for Targeted Case Management services, to facilitate integrated service delivery and streamline service coordination. Targeted Case Management involves direct face-to-face interaction when necessary and usually tangible assistance to the Eligible Person, such as transportation. Cenpatico maintains overarching administrative responsibility for facilitating information exchange, maintaining clinical documentation including crisis intervention plans and consulting with the Eligible Persons to determine their level of satisfaction and identify any unmet needs. We fulfill that responsibility for highest needs Eligibles through our ICM program. We will also encourage all Eligibles engaged in TCM and/or ICM to opt in to our *Health Passport*, which provides a vehicle for information exchange among providers and functions as a foundational tool for integration and coordination of services.

The goals of our ICM program are to ensure that services are generated in a timely and cost effective manner through early identification and appropriate consumer-driven service planning and to assist individuals in achieving an optimal level of wellness and function by facilitating timely and appropriate healthcare and support services. Our ICM program includes an initial screening assessment tool; a comprehensive assessment once admitted to the program; the development of a care plan in conjunction with the Eligible Person, their family and social support system and primary direct service provider; and referrals to appropriate providers as necessary. ICM will regularly monitor Eligible Persons progress in relation to their individual recovery goals as documented in the service/treatment plans. Coordination with other agencies and resources that enhance Eligible Persons' ability to access appropriate recovery support is an integral part of our program. Intensive Clinical Management services are performed and staffing levels configured within the framework of Cenpatico's Integrated Care Model. Once an Eligible Person is identified as a potential candidate for ICM, the Care Coordinator or ICM will screen for admission into the program. Determination to offer ICM is made according to a set scoring mechanism based on an assessment of key areas of functioning. Initial screening considers the following criteria:

- Two or more acute admissions within 60 days
- Existence of complex medical/psychiatric co-morbidity which may include substance abuse, significant/complex medical condition or major trauma to include pregnant members with a diagnosis of substance abuse.
- Identification of negative patterns in care (non-adherence with medication and/or treatment recommendations, inability to safely adhere to treatment regimen, suicidal/homicidal factors)
- Existence of psychosocial and environmental factors in the home to include abuse, multi-agency involvement, legal concerns, school or work disruption, housing, poverty, etc
- Cultural needs and level of understanding regarding treatment options
- Inclusion in top 2% of behavioral health utilization

ICM components include:

- Assessment of needs and strengths
- Short and long term treatment/service goals
- Action steps/interventions to be taken to achieve goals

- Timeframes for action steps and follow up/evaluation
- Collaborative approaches to be used
- Regular progress updates
- Identified participants for team treatment planning including natural supports
- Criteria for discharge from the ICM program

**i) Describe how the Bidder would provide 24 hour crisis management, and provide examples of how that service has been provided in other states.**

We have found that direct crisis intervention services, such as Mobile Crisis Teams and urgent care providers, are most effective when locally focused and adapted to meet the geographic areas needs. However, the overall administrative and access functions of crisis management services are more efficient and effective when centralized and utilize specialized staff. Therefore, we will operate a specified toll-free phone line for 24 hour crisis management. As we do in Arizona, we will leverage resources and skills of Centene-owned NurseWise, to operate this crisis response line. NurseWise will add Iowa licensed staff to ensure adequate coverage and rapid response within the state’s expectations of abandonment rate, speed of answer and service levels. NurseWise staff responding to calls to this Iowa Plan crisis management line will be Iowa licensed Master’s level behavioral health clinicians or Registered Nurses with behavioral health training, with specific training in crisis management, de-escalation, assessment of lethality. These staff will be familiar with the Iowa Plan provider networks and other local resources so that they can effectively provide referral as needed for urgent services. Staff will use a screening tool developed and vetted through McKesson as part of their InterQual criteria set that is available in the CCMS system currently used by all of Cenpatico for maintaining all clinical documentation. When a call is received, staff can readily identify whether the Eligible Person caller has accessed care previously, determine if the individual has a crisis intervention plan, and, if so, identify any strategies from the plan that can be implemented to facilitate rapid de-escalation. Access to historical information is essential in offering individualized and appropriate triage and referral. NurseWise, as a Centene company, is already using our *Health Passport* in Texas, and crisis line staff will have such access to *Health Passport* data for any Iowa Plan Eligibles who opt in.

As part of our overall crisis management approach, our network management plan includes establishment of Comprehensive Service Providers (CSP) in each region and will utilize community reinvestment funds to enhance and expand Mobile Crisis Team and other 24 hour crisis management services at a CSP in every region. Our network management efforts include provider training to ensure all Eligible individuals accessing care develop a crisis intervention plan which is forwarded to Cenpatico so that crisis management staff can access it. Additionally, in every market served, Cenpatico maintains local “on-call” staff clinicians. These clinicians are available by mobile telephone for immediate response to crisis management staff to help facilitate access to services when needed. They are able to access after-hours provider staff to generate urgent appointments, providing service linkage for individuals in crisis.

**7A.2.9 Required Elements of Individual Service Coordination and Treatment Planning**

- a) **Describe the 24-hour crisis and referral service that the Bidder would make available to Iowa Plan Eligible Persons. The description should include a discussion of:**
- **How the Bidder would ensure the availability of clinicians with expertise in providing mental health and substance abuse services to children, and**
  - **How the 24-hour crisis and referral service would interface with the emergency crisis service system.**

Cenpatico’s vision for crisis services in Iowa includes partnering with counties, regional Comprehensive Service Providers (CSP), local Community Mental Health Centers, and other community support network providers to develop mobile crisis teams that can be quickly deployed for in-person crisis de-escalation and care throughout the state. The use of crisis services should be considered in the context of a comprehensive system of care that addresses all levels of need and responds with the required urgency demanded by the Eligible Person’s situation and needs. Cenpatico will participate and support Iowa’s State-wide initiatives already underway through the Division of Mental Health and Disability Services (MHDS) aimed at reducing

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risk of persons in crisis engaging in self-harm, reducing distress, and supporting individuals in their efforts to remain successfully in the community.

Cenpatico will contract with Iowa providers to develop regional Comprehensive Service Providers (CSP). These regional providers will have the capacity for a broad array of community based services, and will be required to establish 24/7 availability for Eligible Persons they serve. CSP will engage Eligible Persons in crisis planning and advanced directives to proactively generate care solutions BEFORE the Eligible Person enters a crisis. CSP will be able to offer appointments within 15 minutes of presentation in an emergency crisis situation or within 24 hours of telephone contact for urgent non-emergent needs. **CSP will be contractually required to have clinicians available for emergent care services with expertise in providing mental health and substance abuse services to children.** Cenpatico will leverage our own resources to provide Crisis Line services which will allow for early intervention and alternative resource use as appropriate, and close the communication gap between outpatient, acute care, and hospital staff. Availability and compliance with the above standards will be monitored through Cenpatico's Quality Assurance department during quarterly chart audits.

### **24-Hour Crisis and Referral Service**

Immediately upon contract go-live, Cenpatico will establish and operate a dedicated toll-free line where Eligible Persons can access crisis counseling, referrals and triage. These Iowa licensed clinicians will have a minimum of 3 years experience in mental health and substance abuse services. At least one clinician with specialized training in providing mental health and substance abuse services to children will be available at all times. All clinicians will receive initial and ongoing in-service training related to crisis intervention and verbal de-escalation techniques, assessing lethality and will receive regular updates regarding available services by county.

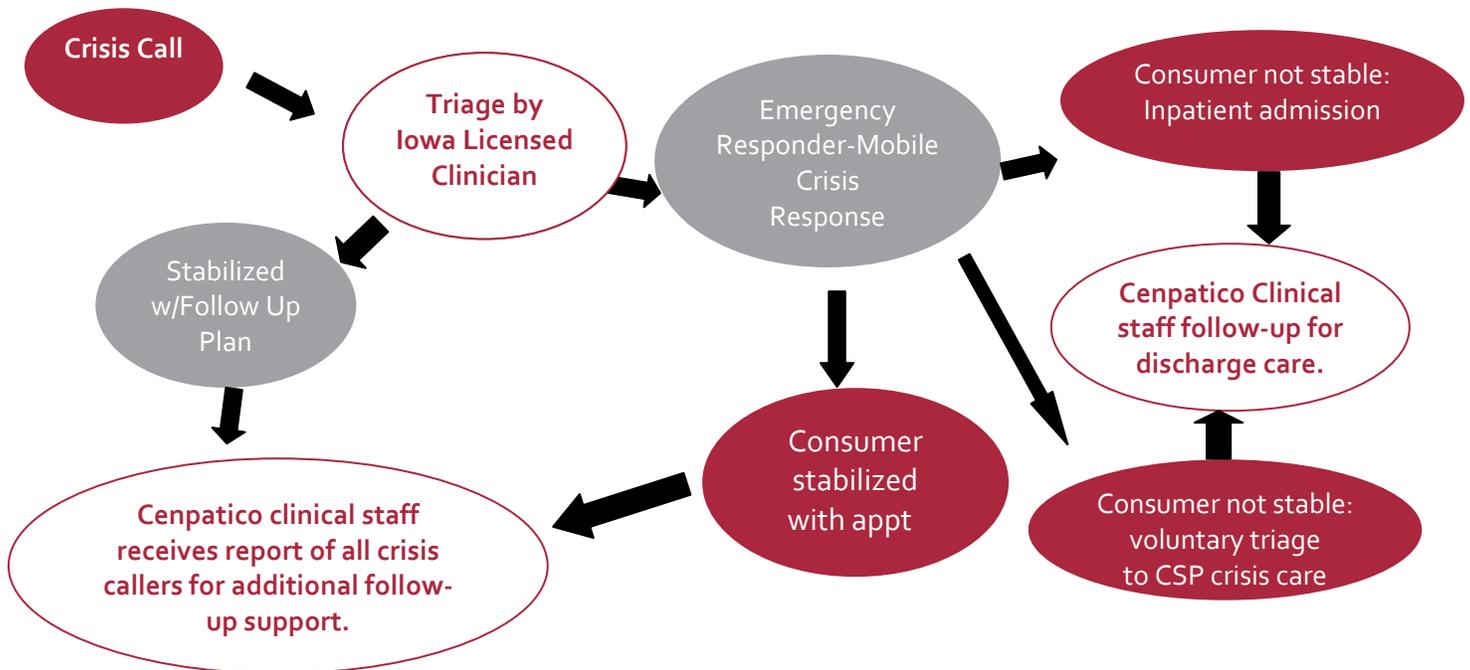
Cenpatico's toll-free number will be accessible 24 hours a day, seven days a week, and 365 days a year. Cenpatico will leverage the resources of our sister company, NurseWise, that currently operates a crisis response line in Arizona for behavioral health needs. In addition to the qualifications listed above, Cenpatico provides crisis line clinicians detailed information for each county regarding available acute and sub-acute care, out-patient providers, community-based care, and Mobile Crisis Teams. Crisis line clinicians utilize the same CCMS care management package that Utilization Management staff work in, and have access to any clinical documentation already obtained concerning the individual such as a crisis intervention plan, prior treating providers, natural supports who have previously been helpful and previous crises. The clinicians responding to crisis line calls will be able to initiate Mobile Crisis Response when necessary to de-escalate a crisis or when the urgency of the call warrants immediate in-person intervention. Additionally, Cenpatico will develop collaborative relationships with first responders such as law enforcement and emergency medical teams to ensure that safety measures can be taken if a situation requires such intervention.

Crisis services are an important aspect of the larger system transformation model that we propose through our regional CSP model. To this end, Cenpatico will develop and submit for approval to the Departments a proposal to utilize community reinvestment funds to develop full spectrum crisis services programs, including Mobile Crisis Teams, at every CSP.

When Cenpatico receives a crisis call, the Cenpatico clinician will conduct a triage screening generated through the CareEnhance Care Management System (CCMS) McKesson system that addresses current level of severity, lethality and intent as well as resources available to be accessed immediately. This triage and screening will be conducted with the caller to determine the level of need for services. If the Eligible Person's level of need does not require immediate care, then Cenpatico will work with the Eligible Person and his/her supports to obtain an appointment within 24 hours. If the Eligible Person's level of need requires immediate care, Cenpatico will assist the Eligible Person in accessing care through a 24/7 mobile crisis team, or urgent or emergent crisis facility in his/her area, including providing transportation for the Eligible Person as necessary. Often, individuals accessing the crisis line are not entering the behavioral health service

delivery system for the first time. Individuals who have already begun receiving services will have a provider of record as well as a crisis intervention plan in the Cenpatico CCMS system and/or in their *Health Passport* (for consumers who have opted in to use *Health Passport*), which the crisis line respondents will be able to access and follow. Where a Crisis Plan exists, Cenpatico crisis line workers will support the Eligible Person in following their Plan and identifying the most effective interventions for their individual needs. Daily reports on crisis line activity is provided to the Clinical team to ensure follow up from the Intensive Clinical Manager or Care Coordinator as appropriate.

The graphic below illustrates the Crisis Line Service Delivery Process.



All providers will be trained on the importance of developing a crisis intervention plan with Eligible Persons from the point of first contact. Such plans allow Eligible Persons to identify supports they find helpful during times of crisis, as well as list key triggers and behaviors that have led to a crisis for them in the past. Crisis intervention plans and provider training on the importance of planning for crisis intervention have been successful in other Cenpatico markets as this supports a recovery and strength-based approach to care, offers the individual the ability to direct their own services, and engages Eligible Persons in the responsibility for positive outcomes.

Development of a crisis intervention plan accomplishes the following:

- Assists Eligible Persons to consider and choose those resources and supports that they believe will be most beneficial in times of crisis;
- Helps Eligible Persons locate and connect with those resources;
- Facilitates communication among Eligible Persons, their support network and treatment providers
- Provides immediate access to support during crisis situations and coordinate appropriate follow-up care through a community provider or support service

## Interfacing with Emergency Service

In many situations, the first responders to a crisis are not behavioral health clinicians and many individuals contact 911 rather than seeking help through a crisis line. Because the first responders are often EMS, Fire Department or Police officers, these allied services workers benefit from training regarding mental health conditions, crisis intervention and ways to successfully de-escalate a situation. Police Officers without adequate training in the management of mentally ill individuals are often the first responders when a mentally ill person is in crisis. In these situations, tragic consequences can result. With appropriate training, first responders can take steps to de-escalate a crisis situation with consumers, in order to prevent loss of life or other serious consequences. Cenpatico will establish relationships with these entities to serve as a resource for law enforcement and emergency workers who arrive at a crisis scene and will help them recognize when behavioral health intervention is needed. Cenpatico will encourage these first responders to access the crisis line for telephonic triage, referral and intervention by our licensed clinicians as well as ensure law enforcement officers are aware of and have access to Mobile Crisis and ACT teams.

Cenpatico has developed law enforcement and first-responder trainings in Arizona based on the Crisis Intervention Team (CIT) program first developed by the Memphis (TN) Police Department and now endorsed by NAMI.<sup>21</sup> This program is currently offered in several service areas throughout Iowa. We will partner with existing programs and work to make this program available state-wide. CIT works because it educates local police forces and first responders about how to respond to someone experiencing a mental health crisis. Through this voluntary program, CIT officials will undergo training that exposes them to the different ways one can handle a crisis situation. This training program will be offered through Cenpatico with the guidance of local community members, Peer Support Staff, Enrollees, and families of those who are affected by mental illness. The goal of this is to de-escalate situations where an Eligible Person is experiencing a mental health crisis preventing unnecessary criminal incarceration, which could further exacerbate a mental health condition or prolong time to appropriate care. This program has been proven to be a valuable asset to producing results for communities in Arizona and many other states and will be a priority in Cenpatico's implementation of mental health awareness for the State of Iowa.

- b) **Describe the Bidder's process for identifying those Eligible Persons who have demonstrated the need for a high level of services or who are at risk of high utilization of services. Describe how the Bidder would initiate ongoing treatment planning and coordination with the Iowa Plan Eligible Persons and all others appropriate for planning the Eligible Person's treatment.**

**Identifying Risk:** Eligible persons benefit from coordination activities that facilitate linkage, access, and individualized services, as they are often unaware of the full spectrum of services available or they experience barriers when attempting to access care. Coordination activities also avoid duplication of services and ensure various agencies or providers that are working with individuals are collaborating to ensure maximum effectiveness. Cenpatico has in place multiple screening processes to identify Eligible Persons in greatest need of services or at risk of high service utilization, including those with coexisting mental health and substance abuse disorders, and with co-morbid behavioral health and medical conditions.

1. Eligible Persons needing higher levels of services, or who are at risk of high service utilization are screened for our Intensive Clinical Management (ICM) program based on risk and resiliency factors. Eligible Persons may be identified as potential candidates for ICM **by Utilization Management staff who are conducting a utilization review, the Care Coordinator assisting with service coordination, provider referral, primary care physician, self or family member referral, or by referral from other community support.** Determination to offer ICM is made according to a set scoring mechanism based on an assessment of risk and resiliency in key areas of functioning.

Initial ICM screening considers the following criteria:

- Multiple Admissions: two readmissions within 30 days
- Any request from a physician, hospital case manager, IME, or family or Enrollee.

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<sup>21</sup> NAMI CIT Toolkit, CIT Facts. Retrieved at: <http://www.nami.org>

- Catastrophic Cases:
  - Complex medical/psychiatric co-morbidity which may include chemical dependency, significant/complex medical condition or major traumas
  - Children involved with multiple state agencies
  - Children in PMIC care
- Patterns of Care:
  - Non-participation such as with medication, outpatient follow up, or treatment recommendations
  - Safety – for the individual or the community
  - Suicidal/Homicidal Factors
- Social and Economic:
  - Lack of financial support
  - Lack of social, family or significant support
  - Illiteracy or significant communication barriers
  - Access to care issues/transportation
  - Abuse

2. Eligible Persons demonstrating a risk of high service utilization are identified through Cenpatico's quarterly **claims review**. Eligible Persons with a history of high service utilization are identified and referred to Intensive Clinical Management (ICM) for additional assistance in coordinating services and to survey satisfaction as well as effectiveness with the Eligible Persons. Claims review allows Cenpatico to identify diagnoses and to identify what types of services each individual has accessed.

3. For Iowa, Cenpatico would request **historical data** regarding services provided and information concerning any Eligible Persons who have already been identified for additional services or identified as High Risk/High Need. Those Eligible Persons who have been diagnosed with Serious Mental Illness, or for children, Serious Emotional Disturbance, would be offered Intensive Clinical Management services. Additionally, Cenpatico offers assistance routinely to special populations such as pregnant consumers with substance abuse indicators, dually diagnosed with mental health and substance abuse conditions, individuals with co-morbid physical illness and adults age 65 and older.

4. We will use our **Psychotropic Medication Utilization Review (PMUR)** program to assist in identifying Eligible Persons who are receiving antipsychotic medications, SSRI medications or other indicators of serious mental illness for potential assistance and intervention. The primary function of the program is to ensure quality of care for Eligible Persons and monitor for potential inappropriate or high risk prescribing patterns associated with psychotropic medications and medications with high likelihood of abuse.

**Ongoing Treatment Planning and Coordination:** Cenpatico supports involving Eligible Persons and families fully in orienting the mental health system toward recovery, through avenues such as consumer- and family-run services, the use of family support partners as caregivers, and the development of peer support services that provide Eligible Persons and families the chance to share their experiences of recovery.

A strong focus of Cenpatico care coordination activities involves including Eligible Persons, family members, and identified community supports in the development of individualized service plans that incorporate existing strengths and individualized goals for each child and adult.

To achieve this goal, we will take the following actions:

- Monitor treatment team composition to ensure that appropriate social supports are included in the assessment process and treatment planning. This monitoring would be performed by Clinical Provider Liaisons who are working closely with provider agencies as well as through quality audits of provider records

- Provide training and technical assistance to ensure that providers have the knowledge and skill needed to engage family members and other significant social supports in the child and family process. We will offer extensive education services to providers regarding the recovery process, engaging consumers, motivational interviewing and ways to empower individuals to participate in their own recovery processes.
- Inform and empower Eligible Persons, their families, and supports to understand the expansion of covered services, community resources available, and their direct control over treatment plan goals. Our Intensive Clinical Managers and Care Coordinators will always include in their contacts with Eligible Persons efforts to support and train family members to develop family support partners, consumer or family-run services, faith-based services, business-supported services such as supported employment opportunities and other means to ensure family members direct care and provide services. Intensive Clinical Managers assist the Eligible Person through collaborative processes including:
  - Full continuum of care coordination services,
  - Ensuring the Eligible Person is offered opportunities to direct care and is engaged fully in the decision making process
  - Offer culturally and linguistically appropriate services
  - Quality reviews of service or treatment plans against clinical practice guidelines,
  - Participate in multi-disciplinary clinical staffing to address the care and needs of High Risk Eligible Persons,
  - Take an active role in coordinating follow-up care and supportive community services,
  - Encourage appropriate use of evidence-based outpatient and community-based services to reduce inpatient and residential services through individual provider, consumer, or family education and outreach.
  - Engage peer supports and natural support systems in the treatment planning process

Cenpatico has a successful model for Intensive Clinical Management that involves partnering licensed and non-licensed staff to achieve more intensive and comprehensive case management services when needed. In multiple markets, we utilize this team approach which enables the clinician to focus on the care plan of the Eligible Person, while a non-licensed Care Coordinator focuses on locating needed resources to support that care. Our role will be to facilitate service delivery that addresses all aspects of an individual's needs – not only the specific behavioral health condition, but to the social and environmental issues that often have a significant impact on the ability of an individual to recover and contribute to the community. This approach will improve outcomes for Iowa Eligible Persons by expanding the availability of care coordination activities and referrals and by further facilitating cross-agency involvement.

Non-licensed Care Coordinators with behavioral health experience will assist licensed clinicians by developing detailed knowledge of specific service and community resource availability such as local transportation options, housing options, supported employment programs, inpatient and residential bed availability, and so forth. Care Coordinators will identify services for special populations as well as gaps in the service system that may need to be addressed with additional resources. This frees up the clinicians to focus on ongoing monitoring of the treatment plan and to participate in the Treatment Team with the Eligible Person and their support system to further enhance recovery.

A key component of the Intensive Clinical Management program will be a focus on discharge planning. For any individual who is placed in a 24 hour care setting – including Acute Inpatient, Residential (PMIC), and sub-acute levels of care, discharge planning will be initiated on the first day of admission and will involve natural supports/ family members as well as the full spectrum of community-based services to ensure the individual can achieve community tenure. Our clinical staff will be available in each region to attend discharge planning meetings in-person when necessary and to facilitate wrap-around planning that addresses the psychosocial needs of individuals who have required these more intense and restrictive care settings to stabilize. In current markets served, ICM staff meet with the individual in-person, as appropriate, prior to discharge to ensure the discharge plan meets with approval of the consumer.

For some consumers, not having regular means of communication to schedule appointments or make contact with case workers is a barrier to recovery. When this barrier is identified for Eligible Persons discharging from an acute care setting our *Caring Voices* program can help. Through *Caring Voices*, we provide cell phones pre-programmed with the phone numbers of the Eligible Persons support team including ICM staff, behavioral health and physical health providers, case workers, pharmacist, and key family or natural supports. We cover the cost of the phone usage. This tool supports independence for the individual and allows them to access services as needed. **We have successfully implemented this program in Ohio and have experienced a 75% reduction in behavioral health inpatient readmissions for our *Caring Voices* participants.** Additionally, we have created **Discharge Toolkits** that are provided to individuals who are leaving an acute care setting. These toolkits are age appropriate – and offer guidelines for staying healthy, information concerning resources, medication records/diaries for the consumer to utilize, suggestions for discussing a mental health or substance abuse diagnosis with significant others as well as education to reduce stigma including references to famous individuals with mental health or substance abuse diagnoses.

**c) Describe the program the Bidder would implement in conjunction with officers of the courts to assure that court-ordered treatment complies with substance abuse criteria and therefore is reimbursable through the Iowa Plan.**

Cenpatico will implement in Iowa an education and outreach plan for officers of the court similar to our successful program developed for the Texas Foster Care market. For Foster Care, our clinicians were required to interact with multiple agencies to coordinate care and service planning, over which Cenpatico did not have any managing authority or leverage. Specifically, judges working to navigate challenging foster placements and care often mandate inappropriate clinical interventions with the best of intentions. As our utilization review staff worked with hospitals to arrange the best discharge and follow-up care for children, they would be constrained to court rulings. In response, our clinical trainers and ICM staff offered to provide training on behavioral health services and best practices to officers of the court during their regularly scheduled trainings. The local judges were happy to participate and trainings were well attended. This outreach and education effort has built a rapport between Cenpatico clinical staff and officers of the court. The result of which is that now, local judges will not hesitate to contact our staff to discuss available treatment options and best practices prior to making their rulings involving court ordered treatment.

**We will provide specific training to local judiciary, probation officers, and any other officers of the court in Iowa who have a role in recommending court-ordered treatment to ensure that such treatment is based on appropriate use of criteria for services.** The training will cover substance abuse treatment options and appropriate level of care based on ASAM criteria to ensure court-ordered treatment is mandated in the most effective and least restrictive way. Without this ownership and engagement, court ordered services may lack desired efficacy and will not serve the purpose of improving recovery and wellness.

Guiding principles of our trainings will include:

- Improve the quality and accountability of substance abuse services for Eligible persons
- Promote evidence-based clinical practices
- Improve clinical outcomes
- Improve access to services
- Improve treatment involvement
- Improve the coordination of care and promote partnerships for all participants in the system
- Provide information and resources to support the judicial system

Training will be offered in a variety of settings but will be located in each region of the state. To provide the greatest access to training, we will locate Clinical Provider Liaisons working with the provider agencies to infuse the system with recovery principles. Additionally, in each region we will hire Interagency Liaisons who will coordinate trainings as appropriate and ensure local stakeholders and court officers have multiple

opportunities for training and can easily utilize Cenpatico as a resource. These staff will meet with local organizations and can be available to individual providers or groups. They will be instrumental in organizing community advisory councils or forums in the community to facilitate additional feedback into the system of care, initiate changes and involve consumers/peers. We also offer on-line training for evidence-based treatment of substance abuse through Essential Learning.

- d) **Describe how the Bidder would actively promote and ensure coordination by Iowa Plan network providers with Enrollee’s primary care physicians**
- **Describe how the Bidder will assess network provider compliance with such care coordination requirements, and**
  - **Provide results of monitoring efforts conducted for other clients of the Bidder to verify that coordination had been occurring effectively. Information provided should include the names of the programs and the names and telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.**

Integration of care between behavioral health professionals and medical professionals is a primary initiative for Cenpatico across all markets. We will collaborate with the Iowa Medicaid Enterprise (IME) to develop quality initiatives for co-morbid physical and behavioral health conditions. Promoting and ensuring coordination of care between behavioral health providers and primary care physicians creates special challenges and opportunities for our Utilization Management program. We will work with the IME to establish joint clinical rounds, as we have done in many markets, to ensure integrated care for Iowans. Our staff is trained to focus on improving communication between behavioral and medical service providers, families, Enrollees and other involved parties. This seamless exchange of information is a key to success for individuals, eliminates duplication of services and offers an integrated approach to the individual’s needs.

**Health Passport:** In Texas, we have partnered with Superior Health Plan and the Texas Health and Human Services Commission to bring an integrated health, electronic solution to market called *Health Passport*. 6,120 physical health providers and 3,800 behavioral health providers currently use *Health Passport*.

*Health Passport* is a secure electronic, web-based repository for behavioral health assessments, crisis, treatment, and service plans so that current behavioral and physical health care providers can continue the plan of care. Providers can upload psychological evaluations, pharmacists can enter prescription activity, and physical health doctors can add exam results or lab activity all to the Enrollee’s *Health Passport* so that services are not duplicated or undermined. Immunizations, medications, and drug allergies are part of *Health Passport*. For example, a primary care physician prescribing medication for ADHD can view the latest pharmacy activity and see the child’s service plans scanned in to *Health Passport* by their case manager to make care integrated and seamless as possible.

*Health Passport* is an “opt-in” web-based application that allows for role-based access designated by the individual consumer. Enrollees may choose their level of participation with this comprehensive database that allows for recording all Enrollee contact and demographic information, as well as referral request and follow-up information. Once the Enrollee “opts-in”, they continue to maintain control over which providers and care givers have access to their care information. The Enrollee’s information is “layered”, allowing for example, the psychiatrist and cardiologist to see only prescription and diagnosis information, while the Enrollee elects for their Targeted Case Manager to have access to their complete database. *Health Passport* functions as a repository that allows multiple agencies to record and track Enrollee information while allowing the individual to maintain control over access. Providers who currently use the *Health Passport* have identified the ability to view a snapshot of the consumer’s history and the issues covered with past clinicians as the most helpful feature. Second to that, providers also highlight reviewing the medication history as a useful tool in identifying previous treatment successes and failures.

**Team-Based Service Planning:** One mechanism for reducing communication barriers between behavioral care providers and primary care physicians is by having the all the stakeholders at the table. In Iowa, we will utilize the framework of the current Joint Treatment Planning Conferences to ensure network providers are

coordinating with primary care physicians. Based on our success in Arizona with the similar concept, Child and Family Teams (CFT), we will further develop *team-based service planning* through our Comprehensive Service Providers in each region. These specialized treatment planning teams will focus on improving outcomes for Eligible Persons by bringing all those involved in the Eligible Person's care together as a team focused on the specific needs of the consumer. Our Clinical Provider Liaisons will monitor the treatment team process by conducting team observations utilizing the Treatment Team Observation tool, which will provide information to guide technical assistance and support to the Treatment Team facilitators. The tool will measure multiple indicators including primary care physician involvement in the service planning process. In our Arizona market we have increased the number of children engaged in team-based service planning (CFT) from 40% to 95%, thus improving our ability to monitor primary care physician involvement in service planning.

***Communication of Discharge Plan:*** Currently in all markets, when an Eligible Person discharges from an acute inpatient level of care, our Care Coordinators fax the discharge summary to both the primary care physician (PCP) and outpatient behavioral health provider to ensure both providers are aware of the hospitalization and any treatment or medication changes that may have occurred. Each are informed of the other's name and phone and fax number for ongoing collaboration with appropriate release of information permission from the individual. All our network providers are contractually obligated to facilitate communication (unless prohibited by the Eligible Person) with the PCP. We provide a "PCP Communication Form" on our website for guidance to network providers on what information should be shared with the PCP.

Our Integrated Care Model places much of the responsibility for facilitating communication on the Care Coordinator. Their role includes identifying all involved agencies, providers, natural supports or other stakeholders and obtaining permission from the individual to engage each in working toward a unified Treatment Team. Particularly for individuals who are identified as high risk or who have known co-morbid conditions, these efforts take priority. For instance, in our Georgia market, the local MCO identified an adolescent diabetic who was jeopardizing his health status due to behaviors that he refused to address. Cenpatico was able to engage the parent, the adolescent, the physical health provider and facilitate a treatment meeting. The individual's fears regarding the diabetes, resistance and need to direct his own care were addressed successfully and he agreed to follow up with recommendations including regular blood sugar monitoring. The ICM staff also engaged the adolescent's former coach who offered a natural support for him to seek out when struggling to adjust to the new diagnosis and required cautions.

***Assessing Provider Compliance:*** Cenpatico will ensure providers' adherence to communication and coordination requirements, through the following mechanisms:

- Contract requirements, which include the requirement to coordinate treatment with medical professionals who are involved in the behavioral health recipient's care
- Initial and ongoing training for provider agencies. Training will be tied to quarterly audits and ongoing collaboration with provider agency leadership to identify training needs. It is expected that training will include training on the importance of collaboration with the PCP.
- Quarterly chart audits conducted by Clinical Liaisons of high volume providers

***Results of Monitoring Efforts:*** In Arizona, we conduct both initial and quarterly chart audits of providers to ensure PCP communication is occurring. Provider report cards are generated to provide feedback to the providers on their communication efforts. Our Arizona market is a "carve out" program to manage the behavioral health needs of Enrollees. The coordination of care between the Arizona Health Care Cost Containment System (AHCCCS) health plans and the Regional Behavioral Health Authorities has specific monitoring protocols. One performance measure monitored relates to Coordination of Care with Health Plan PCPs at the point of referral. Data is collected through a sample chart audit. In the first Quarter of FY2008 (July-Sept 2007), Cenpatico demonstrated a compliance rate for adults and children of 0.00% in both of our

service areas. **With considerable training and monitoring efforts introduced, the compliance rate reported in Quarter 2 FY2009 (Oct-Dec 2008) was 100% for both adults and children in both service areas.** Below is a description of the how we effected such a dramatic transformation on this measure.

Coordination of care for consumers starts with quarterly meetings with the AHCCCS health plans. Each health plan has a point of contact for behavioral health coordination. Cenpatico of Arizona has a Health Plan Liaison that is the point of contact for the medical health care plans. Protocols are managed between the entities to track referrals from Primary Care Physician's and health plans for behavioral health services. Quarterly meetings cover educating each other on the needs of the mutual communities, how behavioral health manages specific illness and or additions, crisis services and protocols. This joint planning protocol facilitates communication between health plans and Cenpatico as it enables health plans to alert behavioral health staff to community trends and issues to be addressed.

When Cenpatico became one of the Regional Behavioral Health Authorities (RBHA's) in Arizona, we discovered there was a significant lapse in the coordination of care by the previous RBHA's. Cenpatico developed improvement plans for the coordination of care with positive results. Our quality improvement department performed a root cause analysis as to why coordination was not occurring as required. Several areas of system and compliance problems were discovered and addressed. Provider agencies were involved in the process and were given technical assistance to improve their coordination. We performed outreach activities to PCP offices on a regular basis to inform local clinics of our services and available programming. An information packet was developed specially for PCP offices and clinics that contains emergency and behavioral health referral information for the clinic staff. We have maintained the practice improvement plan and monitors compliance monthly.

We perform medical records audits on all intake providers at least 2 times a year for each provider agency. The coordination of care is audited through record reviews upon introduction to the network and on an annual basis. All providers are monitored on their systems to ensure coordination occurs and if they need corrective action that is requested by Cenpatico. Corrective action plans are monitored by the Clinical Operations provider mentor each month. Providers are financially sanctioned if they fail to have documented coordination efforts and if they do not meet minimum standards after 3 reviews. Results of auditing are fed back to the provider agencies on a regular basis and the outcomes of the improvement progress are reported to our Quality Improvement Committee.

#### **References for Integrated Coordination:**

<b>Program</b>	<b>Name</b>	<b>Title</b>	<b>Phone</b>	<b>E-Mail</b>
Phoenix Health Plan/ Community Connection	Bonnie Urweiler	Behavioral Health Coordinator	602-824-3967	<a href="mailto:Burweiler@abrazohealth.com">Burweiler@abrazohealth.com</a>
Health Choice	Heidi Eccleston	Behavioral Health Coordinator	480-303-4423	<a href="mailto:heccleston@aisishhealthcare.com">heccleston@aisishhealthcare.com</a>
Community Intervention Associates	Leigh Anderton	Chief Compliance Officer	(928) 376-0026 Ext 1154	<a href="mailto:landerton@ciayuma.com">mailto:landerton@ciayuma.com</a>

#### **7A.2.10 Children in Transition**

**Describe the Bidder's experience in transitioning children from inpatient settings (including inpatient hospital and PMIC-like entities) and provide successful strategies for putting in place appropriate discharge placement from such settings.**

**Our Approach to Care for Children:** Our Iowa proposal supports an integrated approach to care starting at the entry of the child and family into the behavioral health delivery system through ongoing service planning, service delivery, discharge and evaluation of outcomes. We will support the rehabilitation philosophy of involving the community to encourage the use of natural supports to assist recovery and better integrate children and families into the community. We will have concentrated training efforts to promote and inform Iowa providers about the Recovery Model, Family-Centered Practice, and Evidence-Based Practices including Trauma-Informed Care. Adoption and support of these practices will be included in our provider

agreements. Providers will also be required to employ consumers in recovery and to ensure that all staff are trained in the evidence based and best practices.

In all of our contracts, we monitor each child's care throughout treatment, regardless of service level and anticipate transition to a less restrictive level as soon as safely appropriate. We assist facilities in transferring of children's care to the next level by identifying community resources, providers and alternative resources. We will use a similar process for children Enrollees, even though mental health services provided in a PMIC setting are "carved out" of the Iowa Plan. While Cenpatico will not be the funding source for the child's care and will not be performing utilization management, we will maintain close contact with the treatment team throughout the child's stay to ensure that services are in place well before the child is discharged. We strongly believe that with appropriate services that are outcome oriented, effective and coordinated, children can recover. All children and families need to know that treatment progress and recovery are possible and that recovery will result in resuming life in a normalized environment. We know, based on our experience serving child populations, that by initiating discharge planning at admission and maintaining this activity with a recovery focus, we optimize the opportunity for children to succeed.

From a systemic perspective, we recognize that effective transitions from higher levels of care can only occur if the service continuum is complete with appropriate step down levels of care. Our network management plan for the Iowa Plan offers strategies for addressing gaps in services, including the lack of adequate step down levels of care for children discharging from inpatient or residential settings.

**Our Experience:** Specific interventions for transitioning children from inpatient and residential settings are an integral part of our utilization management and care coordination services for all our managed care products. Inpatient and residential treatment are serious events for children and families requiring intensive monitoring and coordination to ensure positive outcomes. From our experience, we know services for children and families require collaboration with providers, agencies, and other community stakeholders to arrange services that are not necessarily part of the benefit package we manage. The innovative strategies developed for the foster care program continue to be developed and refined for special populations across our entire organization, and will be specifically valuable for coordinating services for children discharging from PMIC care in Iowa. The Behavioral Health and Child and Family Service delivery system in Iowa involves many contributors. Treatment, rehabilitation and community services occur within a larger system and require the support of many stakeholders involved with the individual and family. This support is most critical in the process of successful transitioning from inpatient or residential care.

Cenpatico provides **Intensive Clinical Management** for children in all of our contracts. Our staff facilitates discharge planning from the date of inpatient or residential facility admission. We thoroughly review the child's behavioral health treatment history and precipitating events leading the current admission from a bio-psycho-social perspective. This perspective takes into account all information available that could impact recovery. In addition, we monitor the treatment children receive, the creation of an integrated care plan, and assist hospitals and residential facilities with step-down alternatives for children when their treatment goals have been achieved. For example, in Indiana, our Intensive Clinical Managers and Care Coordinators work closely with hospitals, families, community caregivers and other stakeholders to ensure that appropriate treatment and discharge plans are in place. In Kansas and Texas where we manage SCHIP services, we work closely with all hospitals and residential services, as well as community outpatient and rehabilitation providers, to ensure smooth transitions and continuity of care. However, it is our experience with foster care that provides the most comprehensive overview of our success and how we will apply successful strategies in Iowa.

***Locally-Focused Comprehensive Service Coordination Supports Discharge Transitions:*** On April 1, 2008, Cenpatico began managing the behavioral health services for approximately 30,000 children in foster care in the state of Texas. In Texas, as in many other states, we learned that the behavioral health care delivery system was often fragmented due to multiple funding sources and programmatic requirements. This

fragmentation was the major impetus for using a managed care model for Texas children. Prior to the implementation of this program, Cenpatico participated in numerous meetings with the Texas Department of Health and Human Services, the Texas Division of Family and Protection Services, Child Placing Agencies, foster parents, behavioral health providers, the judiciary, CASA and others across the state to ensure that we had a thorough knowledge of the system of care as well as the particular entities involved. From these meetings, Cenpatico quickly identified that this fragmentation resulted in varying access to or provision of quality behavioral health care in many regions of the State, and too often children were relocated from their local communities to receive care.

**Successful Strategy:** To address these issues, Cenpatico has implemented a **regional model** for managing foster care behavioral health services, with offices in seven areas in Texas similar to the Comprehensive Service Provider (CSP) model we propose for Iowa. Within these regions we have staff providing utilization management, intensive clinical management services, discharge planning and care coordination across systems, as well as training and consultation to address the diverse needs of each area. In Texas, our foster care staff are also housed with staff from our sister company, Superior Health Plan, who manages the medical needs of our members. This integration allows staff to address the complex medical and behavioral health needs of our members in a seamless manner. Integrated coordination of services is the key in the model for our Texas foster care program. We understand that treatment decisions cannot be made without direct communication between all of the entities involved in the child’s life.

**Application in Iowa:** To allow for greater coordination of services in Iowa, we are proposing Comprehensive Service Providers (CSP) to provide a regionally-focused, statewide system of providers as this network design results in greater systemic coordination of recovery services. We use this model to support a true community based system of service delivery that is able to provide and coordinate waiver and wrap around services not typically provided by independent providers or more limited outpatient agencies. In addition, CSP allows children and families to receive a broader service mix through a central agency, which acts as a stabilizing factor for coordination and integration of care post-discharge.

**Successful Strategy:** Utilization data tells us that generally, a child who has one inpatient admission is more likely to have a multiple admissions. Through our **Intensive Clinical Management** program, we address this risk by planning and implementing appropriate follow-up care and services from day one. In our foster care program the intensive clinical management service model includes contacting the state caseworker to determine placement and working with the foster parent/conservator or case manager to review the events precipitating the hospitalization. Our staff encourage appropriate family therapy, needs assessments, facilitate treatment team meetings, and create or modify service plans to address the individual needs of each child. We contact hospital discharge planning staff to identify community resources and wrap around services, follow-up on each child within seven days of discharge and then again within thirty days to identify any unmet needs and provide resources. The chart below demonstrates the positive impact of our Texas ICM program based on the variance between measures at 30, 60, and 90 days prior to ICM program involvement versus 30, 60, and 90 days after ICM program involvement during 2008.

**Measured Variance Following ICM Program Involvement  
For 2008 Q1, Q2, Q3 Texas ICM Enrollment Combined**

Measure	30 Days Prior to ICM vs. 30 Days in ICM Program	60 Days Prior to ICM vs. 60 Days in ICM Program	90 Days Prior to ICM vs. 90 Days in ICM Program
IP Days	58% reduction	38% reduction	24% reduction
Total Admissions	63% reduction	39% reduction	20% reduction
ALOS <sup>22</sup>	14% increase	2% increase	5% reduction

<sup>22</sup> ALOS, or average length of stay, increased during the initial phase of ICM involvement. As individuals referred for ICM are by definition, in need of the most intensive services, inpatient admissions with longer lengths of stay during early ICM involvement reflect that in these situations, this level of care was an appropriate and required intervention.

Measure	30 Days Prior to ICM vs. 30 Days in ICM Program	60 Days Prior to ICM vs. 60 Days in ICM Program	90 Days Prior to ICM vs. 90 Days in ICM Program
<b>Community Tenure</b>	5% increase	2% increase	1% increase
<b>Medical expenses per day</b>	41% reduction	21% reduction	7% reduction
<b>Medical expenses per member</b>	41% reduction	21% reduction	7% reduction

**Application in Iowa:** Our ICM program assists families with identifying strengths and needed supports to successfully sustain the child within the family and community. Our Utilization Managers will automatically refer children admitted to a PMIC or other facility-based care setting for an ICM screening. Discharge planning will begin upon admission with a strong focus on family or caregiver participation in the creation of a crisis plan and implementation of safety measures to allow the child to resume care in a less restrictive setting. An underlying assumption in this program is that while we are not a direct provider of health care services, we are responsible to work collaboratively with health services partners to coordinate care including Targeted Case Management (TCM) or other appropriate agencies. We maintain overarching administrative responsibility for facilitating information exchange, maintaining clinical documentation including crisis intervention plans and consulting with families to determine satisfaction with services and identify any unmet needs.

**Successful Strategy:** Early in the implementation of the Texas Foster Care program, we instituted a **weekly placement meeting** with the Division of Health and Human Services (DHHS) and the Department of Family and Protection Services (DFPS) to review the situation of any child whose placement barriers were resulting in extended inpatient admissions. Placement meetings are a variation of our **Child and Family Treatment team** meetings used in Arizona. Both variations bring a coalition of caring individuals together to strategize the best plan for recovery for the child. Placement meetings are collaborations among our clinical staff, caseworkers, DFPS supervisors, regional placement staff, Child Placing Agencies, providers, foster parents and other stakeholders to strategize placement and treatment alternatives. These meetings have proven to be extremely beneficial in coordinating care, but most important is the opportunity for those serving the child to come together as a team to build rapport and eliminate barriers. We are an active participant in a Public/Private Partnership to address placement strategies for children who are repeatedly admitted to inpatient facilities due to the inability to remain stable in community settings. Our strategies and activities bring together key stakeholders in the child’s system of care have been critical to providing a seamless transition from inpatient to community care for children in Texas, and give us a wealth of experience that we will apply in Iowa.

**Application in Iowa:** In Iowa, we will facilitate the joint treatment planning conferences for children in PMIC and other inpatient settings. We will provide recommendations for enhancing these efforts based on our experience with foster care placement meetings and Child and Family Teams (CFT). These specialized treatment planning teams will focus on improving outcomes for children and their families and will include Peer and Family Support staff to assist with care and the crisis intervention planning process.

**Successful Strategy:** In Texas, Cenpatico is not responsible for placing children in residential facilities or payment for the room and board, but we are responsible for managing the treatment services that occur within the facilities. This was a change for providers, but the transition has been very smooth due to **regionally based training initiatives** prior to and during the initial months of implementation of the program.

**Application for Iowa:** Our Clinical Provider Liaisons will provide support to Iowa providers – for both those in our network and those providing required services to children that are not covered by the Iowa Plan. Based in each of the six regions, they will provide education and technical support on topics ranging from benefits packages to evidence-based practices for high needs populations. It is our role to ensure that each

facility provides individualized care treatment planning utilizing best practices appropriate for the needs of each child. Our regionally based training, supported through the Clinical Provider Liaison staff, will offer collaborative solutions for providers to ensure smooth transitions and continuity of care for children.

#### **7A.2.11 Appeal Process**

**a) Describe the process the Bidder would put in place for the review of Enrollee appeals, including which staff would be involved. Provide a flowchart that depicts the process and time frames the Bidder would employ, from the receipt of a request through each phase of the review to notification of the disposition.**

Cenpatico is committed to maintaining an appeal system that meets the needs of Iowa Plan Enrollees and the expectations of the State of Iowa including a clearly defined appeals process and right to a state fair hearing. We currently process first level appeals for nine states with membership over 1.2 million covered lives. We maintain staff that provides initial response letters, forward medical necessity documentation for physician review as appropriate, and document resolution. For the past two years, all appeals timeframe standards and benchmarks have been met in all markets.

Cenpatico's appeals process for Iowa will be a function of the Quality Assurance and Performance Improvement department. We will hire four Grievance and Appeals Coordinators for Iowa who will report to the Manager of Grievance and Appeals. The Grievance and Appeals Coordinators will work closely with the Utilization Management team to meet timeliness, notification, and documentation standards. Additional support and **advocacy for Enrollees will be available at all levels of the appeal process through our proposed Ombudsman program.** Our staff will communicate consumer rights and responsibilities, seek to assist Enrollees with the completion of forms, coordinate oral or written interpretation services including access to Iowa Relay/TTY/TDD services with interpreter capability, facilitate understanding at all steps in the process, and provide information about and access to Ombudsman if additional support is needed or requested.

We believe that access to Ombudsman services is key to a fair appeals and complaint system that emphasizes consumer empowerment. Pending approval by the Departments, we will implement an Ombudsman program to provide another layer of safeguards for consumer rights to protect the most vulnerable populations. For Ombudsman services that are free of conflict of interest we will sub-contract with a local consumer or family advocacy group to provide Ombudsman services. Ombudsmen will be Certified Peer or Family Support Specialists who will assist Enrollees with their appeal and, if requested by the Enrollee or family members, serve as their advocate during any or all steps of the appeal process.

**Right of Appeal:** Enrollees, their representatives, or providers acting on their behalf have the right to appeal any adverse determination verbally or in writing within 30 days from the date of the notice of action. If the initial request for an appeal is made orally, a written signed request for the appeal must be submitted. If the Enrollee or representative believes the standard timeframe for resolution would jeopardize the consumer's ability to maintain or regain maximum function, they may file a request for an Expedited Appeal. **Expedited appeals are processed within 24 hours of the request.**

If the consumer verbalizes a request for Ombudsman services, the Cenpatico employee receiving the appeal will provide the name and the contact information of the Ombudsman to the consumer and will assist the consumer in reaching the Ombudsman as needed. As with all services, should the consumer need assistance in any language other than English, our staff will ensure that the Ombudsman have access to our contracted interpreter services and Iowa Relay/TTY/TDD.

**Step 1 Acknowledgement of Appeal Request:** Each appeal request is acknowledged in writing within one working day. Explanation is provided in the acknowledgement that, as part of the appeals process, the Enrollee or his/her representative has the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Enrollee, or the Enrollee's representative, has the opportunity before and during the appeal process to examine the Enrollee's case file, including medical records, and any other

documents and records. If an Expedited Appeal is requested, the Enrollee is advised that a decision must be rendered within 24 hours and thus the limited timeframe to submit additional information. Provisions are also made available to access assistance as needed with interpreter services and toll-free numbers with Iowa Relay capability.

**Step 2 Documentation and Tracking:** The Appeals Coordinator is responsible for documenting all appeals activities using our CareEnhance Care Management System (CCMS) progressive utilization management software; allowing for access to records and retrieval of data for quick and easy monitoring. CCMS is a McKesson product and provides an electronic record which serves as a data repository that leverages member data, pinpoints where care is needed, and implements customized intervention strategies. CCMS promotes better coordination of care through workflow automation, effective communication, and integrated data at key points within the workflow. All information provided in the initial and concurrent review process is housed in the CCMS database along with any additional information offered by the provider or Enrollee to support the care request. Any peer-peer conversations which occur in the process of issuing a denial are logged into the system so that the entire record of the request and Cenpatico actions is easily accessible in one place. It also supports an efficient documentation process that improves clinical outcomes as all activities including Intensive Clinical Management, treatment team activities, all care requests and crisis plans can be maintained together. We keep an electronic record of all appeals activity, including information about the Enrollee, the provider, the service in question and the dates of appeal reviews, documentation of actions taken and final resolution.

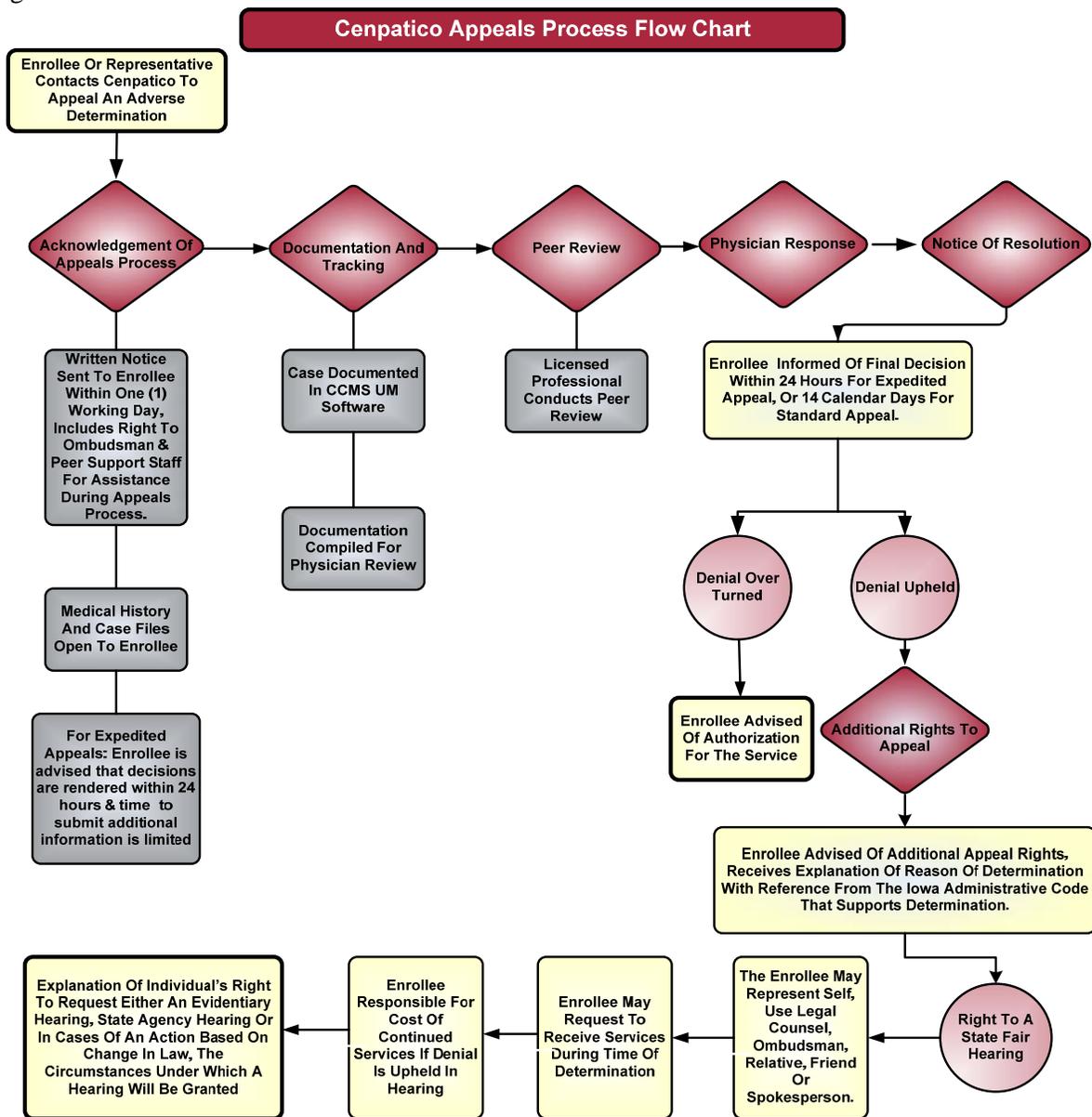
**Step 3 Peer Review:** The Cenpatico Iowa Plan Clinical Director or his/her designee reviews the appeal request and sends the appeal to a Peer Reviewer who was not involved in the original decision and who is not a subordinate of the person who made the initial adverse determination. This Peer Reviewer must hold a current Iowa license and be qualified to review the requested care. We conduct a specialty match to ensure a child psychiatrist will review care requests for children, an ASAM certified Peer Reviewer is selected for substance abuse requests, etc. The Peer Reviewer conducts a thorough review of the case facts and requests additional information if needed. If additional information is needed, the Peer Reviewer requests it through the Appeals Coordinator. The appeal consideration will take into account all information regarding the case, whether or not the information was available at the time of the original determination.

**Step 4 Notice of Resolution:** Once the Peer Reviewer reaches an appeal decision, they forward it to the Clinical Director, who will ask the Appeals Coordinator to send out the appeal decision to the Enrollee and his/her associated provider. Written notification of appeal determinations includes:

- The results of the resolution process and the date it was completed;
- An explanation of the reason for the determination;
- If not wholly in the Enrollee's favor, the option for a State Fair Hearing and instructions for initiating this request;
- The right to request to receive services while the hearing is pending and how to request the continuation of benefits;
- Notice that if the denial is upheld in a hearing, the Enrollee may be liable for the cost of any continued services;
- The relevant citation from the Iowa Administrative code, which supports the decision;
- That in the state fair hearing:
  - The Enrollee may represent him(her)self or use legal counsel, a relative, a friend or a spokesperson;
  - The specific regulations that support, or the change in federal or state law that requires, the action, and

- An explanation of the individual’s right to request an evidentiary hearing if one is available or a state agency hearing or in cases of an action based on change in law, the circumstances under which a hearing will be granted.

**Cenpatico provides resolution and written notification of a Standard Appeal within 14 days from receipt, and verbal and written resolution notification within 24 hours of receipt of an Expedited Appeal.** We monitor the effectiveness of the Utilization Management and Appeals staff in meeting standard goals for appeals turnaround time including compliance with state guidelines and those of URAC and NCQA. Our internal staff monitoring ensures that we will meet the tracking timeliness requirements for the State of Iowa including: 95% of all appeals are resolved and notified within 14 calendar days of written receipt. 100% of appeals are resolved within 45 calendar days of receipt of the appeal. Additionally, we will monitor Ombudsman activities through congregate data and confidential monthly reporting to our Quality Assurance and Performance Improvement (QAPI) Committee who will review for potential conflict of interest, trends in appeals, and ensure that consumer voice is communicated back to the Cenpatico executive management team.



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### **7A.2.12 Grievance and Complaint Processes**

#### **a) Describe the processes the Bidder would put in place for the review of Enrollees grievances and Eligible Persons complaints.**

Cenpatico will develop and maintain a Grievance System that meets the needs of Iowa Enrollees and Eligible Persons including a grievance and appeals process and access to the State Fair Hearing process. We will include an Ombudsman program that ensures consumer-friendly access for Enrollees to our Grievance System and for Eligible Persons submitting complaints. Cenpatico is currently responsible for processing grievances, complaints, and first level appeals for nine states and maintains staff who provide initial response letters, forward medical necessity documentation for physician review as appropriate, and document resolution.

To ensure that the Grievance System is applied consistently throughout Iowa, we will manage all components of the process through the Manager of Grievances, Appeals and Complaints. This individual will be located in our central Des Moines office and will oversee our four Grievance and Appeals Coordinators, and will be responsible for developing and implementing the Ombudsman Program for Eligible Person complaints.

***Grievance Process:*** Grievance and Appeals coordinators are the primary actors at all points of the grievance process. Should the Enrollee or their representative request assistance filing the grievance, such as the use of interpreter services or Iowa Relay/TTY/TDD services, the Grievance and Appeals Coordinator will provide written information in the Enrollee's preferred language or if appropriate arrange a conference call with our contracted interpreter service. For other assistance needs the Grievance and Appeals Coordinator will enlist the assistance of the Ombudsman to assist in filing the grievance or complaint.

**Step 1 Receipt of Grievance:** The Grievance and Appeals Coordinator receives and documents all grievances in CareEnhance Care Management System (CCMS), a software package developed by McKesson. If the Grievance and Appeals Coordinator does not receive the grievance directly, the grievance is documented by the recipient, and sent via the electronic reminder system in CCMS to the Grievance and Appeals Coordinator.

**Step 2 Acknowledgement of Grievance:** The Grievance Coordinator acknowledges receipt of the grievance verbally if received orally and documents this acknowledgment in CCMS. The Grievance and Appeals Coordinator follows-up with a written acknowledgement letter within five days and requests a written and signed grievance statement within seven days of the original filing if not already received. If the grievance was received in writing, the Grievance and Appeals Coordinator also acknowledges receipt within one day and acknowledges the written request within five days of receipt of the grievance. Acknowledgment of the grievance is documented in CCMS by the coordinator.

**Step 3 Investigation of the Grievance:** Investigation of the grievance is conducted by staff appropriate to the content of the grievance. A primary goal of the investigation is to ensure that there is no retaliation in the process, either toward the consumer or to the party filing the grievance on behalf of the consumer. The investigation can take up to thirty days from receipt of the grievance. It may be resolved more expeditiously if the consumer's mental health condition requires. The investigation may be extended for up to fourteen additional days if the consumer requests it or if there is a need for additional information. If an extension is requested, the State must agree that the delay is in the best interest of the consumer or that the consumer has requested the extension. Enrollees are notified in writing of any reason for extension or delay.

**Step 4 Grievance Decision and Notification:** The Grievance and Appeals Coordinator is responsible for obtaining resolution of the grievance and notifying the Enrollee of the decision or resolution in writing. Included in the resolution letter, the Grievance and Appeals Coordinator forwards information about how to access and request a Fair Hearing. If the consumer requests a State Fair Hearing, the request must be filed

within twenty days of receipt of the resolution letter. Cenpatico representatives, the consumer, and his or her representative are present at the Fair Hearing.

***Complaints for Eligible Persons:*** All Eligible Persons, which includes IDPH Participants, are encouraged to contact Cenpatico with any concerns or complaints. We have a well defined complaint system for Eligible Persons in place to allow consumers or their representatives to express dissatisfaction with any aspect of our organization. Complaints from Eligible Persons are tracked using a complaint log, categorized, and addressed within specified timeframes. Complaints are addressed on an individual basis as well as systematically to determine issues with processes such as timeliness of claims payment, the authorization process, etc. Data from the Eligible Persons complaint process coupled with data from the annual member satisfaction surveys assist Cenpatico in meeting the needs of Eligible Persons. This complaint process is also open to providers wishing to express dissatisfaction.

**In addition to our internal complaint process, we propose an external, consumer-run Ombudsman program** as an integral component of a fair Grievance and Complaints System, and an effective way to process complaints for Eligible Persons. Pending state approval of such system, we will develop rigorous safeguards for consumer rights within our Ombudsman program to protect vulnerable populations. Ombudsman will be Certified Peer or Family Support Specialists who will assist the Eligible Persons with their complaint and to serve as their advocate within the complaint process. The process itself would mirror the complaint process for Enrollees. To provide Ombudsman services that are supportive of the consumers' rights, fair, and free of conflict of interest we will sub-contract with a local consumer or family advocacy group to provide Ombudsman services. The sub-contracted group will have autonomy to direct the hiring of Ombudsman personnel and to supervise their performance (any necessary certification will be provided through Cenpatico as needed). It will be incumbent on the Ombudsman and the supervising group to encourage consumers to forward Quality of Care Concerns to Cenpatico directly, though this is at the discretion of the consumer. The Ombudsman will provide congregate data and confidential monthly reporting to Cenpatico's Quality Assurance and Performance Improvement (QAPI) Committee who will review for potential conflict of interest, trends in grievances, and ensure that consumer voice is communicated back to the Cenpatico executive management team.

Cenpatico will provide the name and contact information for the Ombudsman in all correspondence to allow easy access to Ombudsman services. If the consumer verbalizes a request for Ombudsman services, the Cenpatico employee receiving the grievance or appeal will provide the name and the contact information of the Ombudsman to the consumer and will assist the consumer in reaching the Ombudsman as needed. As with all services should the consumer need assistance in any language other than English, our staff will ensure that the Ombudsman have access to interpreter services. This will include oral or written interpretation services including access to Iowa Relay/TTY/TDD services with interpreter capability.

***Documentation and Reporting:*** The Grievance and Appeals Coordinator maintains documentation of the grievance process. The tracking log includes all data elements related to the process including a summary of the grievance itself and the data are reported to the Mental Health Division quarterly. In addition to the monitoring noted, Cenpatico will institute automated reminder "triggers" within CCMS that alert the Grievance and Appeals Coordinator of all upcoming key dates within the process. CCMS has been configured to track the number of days an issue is open in five day increments so action is taken without delays. The receipt of the grievance, acknowledgment of the grievance, and the data of the resolution letter are all part of this automated grievance system, allowing systematic monitoring geared to a timely resolution.

Enrollees are guaranteed the right to have a grievance filed on their behalf and allows for any representative of the consumer to file a complaint or grievance. Guardians and providers are also able to request an appeal or State Fair Hearing on behalf of the consumer. For pursuit of action, and to receive grievance resolution information, consumer representatives must obtain appropriate written consent from the consumer to receive

Protected Health Information. This documentation is available through our Ombudsman services and provided upon received request by Cenpatico.

Enrollees are afforded every opportunity to ensure their appeal and/or grievance is acted upon in a fair and timely manner that is sensitive to the culture, circumstances, and recovery needs of the individual. In Iowa, we will provide assistance and accommodations as needed for interpreter services and a toll free number with Iowa Relay or TTY/TDD capability. Cenpatico staff can assist in, or provide access to Ombudsman services for, the completion of forms and other steps in the process in which the consumer may need assistance and will communicate consumer rights and responsibilities, including access to Ombudsman services.

We will utilize the grievance process data as a source for performance improvement. In addition to the performance measure tracking timeliness to complete the grievance process, 95% of all grievances are resolved within 14 days of receipt of all required documentation and 100% of grievances are resolved within 90 days of receipt of all required documentation, we use the categorization of grievances to assess areas for further study and performance improvement. We use both the raw number of grievances as well as a grievance rate per thousand to standardize the quantity of grievances accounting for fluctuations in membership. We traditionally utilize a grievance rate of 0.75 grievances per thousand Enrollees as its threshold.

The Grievance System provides first hand information about provider performance, benefits issues, access to care, and consumer concerns. This glimpse into the mental health system through the eyes of the consumer is an important source of data for our Quality Program. As such, it is required that Grievance System data be shared across Cenpatico departments, the QAPI Committee, with the Recovery Advisory Committee, and with all contracted agencies and their sub-contractors. Data sharing allows for systems transformation and performance improvement through collaborative efforts between Cenpatico, providers, and the community.

#### **7A.2.13 Requirements for the Provider Network**

**a) Describe how the bidder would ensure that the provider network is adequate and that access is maintained or increased to meet the needs of the Iowa Plan Eligible Persons. Where there are potential issues of lack of capacity within the Bidder's network, please describe the steps the Bidder would take to increase capacity. Provide examples from current contracts of how the Bidder has ensured network adequacy in states with a shortage of psychiatrists or other specific behavioral health professionals.**

**Cenpatico will have fully contracted panels for both IDPH substance abuse providers and Medicaid providers in place by the contract implementation date that will provide access in meeting the needs of Iowa Plan Eligible Persons in excess of the current level.**

**Immediately upon contract award, we will initiate a robust recruitment outreach effort to all providers contracted with the current vendor** in order to maintain network capacity at the level prior to our implementation. Our first goal is to ensure Eligible Persons receiving services upon the implementation date continue with their providers with no interruption in service. As is our practice in all markets, we will maintain an open panel for the Iowa Plan; any eligible, appropriately licensed provider that executes a participating provider agreement and successfully completes credentialing will be able to participate in the network. We have standard policies and procedures which will be adapted for the Iowa Plan that address the issues of providing single case agreements to out-of-network providers, should a current provider decline to contract with us, to further ensure continuity of care for Eligibles receiving ongoing services at go-live.

**Simultaneously, we will use multiple tools to identify service or provider specialty gaps in the existing network.** We use a number of tools to identify access and/or capacity deficits, including Geo Access time and distance analysis, density analysis, asset mapping and direct input from consumers and their families, providers, advocates, and other stakeholders.

**Geo Access time/distance analysis** alone does not provide a complete and accurate picture of capacity to serve the needs of Iowa Plan Eligible Persons. It does not demonstrate whether there is a sufficient number of each provider type available to meet the needs of Iowa Plan Eligible Persons. This analysis demonstrates that a provider of each type is located within the mandated travel time/distance. The current vendor's network analysis netted 100% provider accessibility in their *Quality Improvement Report- April 1, 2008-June 30, 2008* and these results were mirrored by our own initial Geo Access analysis.

To overcome the limitations of Geo Access time/distance analysis and ensure an accurate gap analysis, we will implement the use of **provider density analysis** and **asset mapping**, as another method of monitoring network adequacy. Geo Access time/distance analysis tells us whether there are *any* provider offices of certain types within a certain geographic distance in a specified area. Density analysis allows us to dig deeper and gauge if there is a sufficient *number* of each provider specialty type in the network to support the potential need in a specific area, based on the number of Eligible Persons in that area. Our initial assessment of the data available indicates that there are not enough providers of all types in all areas to meet the needs of these Enrollees within the required appointment time standards. This is undoubtedly true for prescribers in many of Iowa's rural regions, given that Iowa's approximately 227 psychiatrists are concentrated primarily in Polk and Johnson counties.<sup>23</sup> Asset mapping is another tool we will implement to fully and accurately assess the capacity of the provider network panels. We will use the Recovery Advisory and Clinical Advisory Committees in this community participatory approach to service capacity assessment and development. We use this structured approach to:

- achieve comprehensive data gathering, including information on all existing formal and informal services and resources available in each regional service area,
- build relationships to broaden local involvement,
- develop and implement a shared vision and plan for strengthening community based behavioral health services delivery systems, and
- leverage outside resources to support local activities.

We will gather additional information to identify specific underserved communities as defined by density analysis and asset mapping, and we will implement multiple strategies to work toward improved capacity, as described below.

**Next we will implement strategies to resolve identified gaps.** Cenpatico is accustomed to addressing network deficiencies in new markets. In our Texas operations, we implemented a telehealth program for the Texas STAR Health (Foster Care) program in response to access and capacity gaps for psychiatric services. Although telehealth psychiatry services were not previously billable under this program, we sought and received approval from the State to expand the program to support these services. We will recruit Iowa-licensed psychiatrists to offer **telehealth psychiatry services**, using a telehealth-specific provider agreement designed for the Iowa Plan. Our plan includes recruiting Iowa-licensed psychiatrists located outside of Iowa to provide these telehealth services. We propose to cover evaluation/assessment services and psychotherapy with medication management services via the provision of interactive telehealth services and will also cover the facility originating fee (Q3014 billing code). We will pursue partnerships with the University of Iowa School of Medicine's Department of Psychiatry to create solutions to gaps in psychiatry services for Iowa Plan Enrollees.

Our vision for the Iowa Plan provider network includes a **regionally-focused statewide system of Comprehensive Service Providers (CSP)** as we have found this to be an effective network design for greater systemic coordination of recovery services resulting in increased access. In our Arizona service delivery areas, we use this model to support a true community based system of service delivery that is able to

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<sup>23</sup> Iowa Civic Analysis Network: The University of Iowa. An Analysis of Iowa's Mental Health Care System. 2006.

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provide and coordinate waiver and wrap around services not typically provided by independent providers or more limited outpatient agencies.

We will restructure the existing Iowa Plan network to include two Comprehensive Service Providers (CSP) per region. A CSP is a locally focused multi-service agency that, in addition to offering access to a full continuum of outpatient and waiver services, will function as a service coordination hub for high needs individuals. We will negotiate with existing Community Mental Health Centers (CMHC) and other multi-service agencies in the six IDPH regions of Iowa to develop at least two CSP per region. Our regionally focused network model will provide the structure to build statewide availability for required services; it starts by developing the strengths of existing local assets and focuses targeted resources to address specific local service gaps.

In our initial assessment of the Iowa Plan's current delivery system, we found that many CMHC offered less than full continuum services with significantly limited services at many rural CMHC. Our plan is to develop CSP that offer, develop capacity to offer, or have structured referral systems in place to facilitate access to a continuum of care that includes the following services: wraparound, Peer Support, in-home service delivery focused on rural access and capacity issues, telehealth remote site, 24 hour mental health stabilization, crisis intervention and management, prevention, Mobile Crisis Teams, Assertive Community Treatment teams, higher level and/or intensity outpatient services to address the existing gap between 24 hour level of care and traditional outpatient/community based services. Access for Enrollees to specialty services, such as substance abuse treatment, will be provided directly by appropriately licensed CSP or coordinated with independent providers in the region. CSP and other providers as appropriate will receive training for treatment team facilitators to support and enhance team based service planning, including joint treatment planning conferences. In addition, we will work with County Boards of Supervisors to request and encourage them to contract with CSP for Targeted Case Management services, in order to further streamline access and coordination of services. Comprehensive Service Providers will offer extended hours to include evening and weekend routine and urgent appointments, in order to expand access and to provide crisis services support.

Our open panel provider networks will also include independent providers and other agencies in order to ensure the greatest geographic access and to allow for consumer choice of providers. Through our credentialing process, we are able to capture referral demographics and specialty information which is loaded into our referral system. This information includes service location address, phone, hours of operation, languages spoken other than English, handicapped accessibility, and treatment types and modality. While Eligible Persons are able to self refer for any service, our care coordinators are available to assist in finding specialized referrals to meet individuals' unique recovery needs. The CSP offers a choice that simplifies access for consumers who require multiple services to meet their recovery needs.

While CSP may serve any Eligible Person, they will provide comprehensive integrated programming and service integration specifically intended to better serve Eligibles who are identified as having the highest needs for support in their recovery. Acute care and specialty services will be available through local hospitals, Mental Health Institutes, Community Mental Health Centers, substance abuse treatment programs or other contracted independent providers/groups available locally. If a CSP lacks certain services or provider types, we will partner with that CSP to develop the service, recruit the provider type, or collaborate with other providers to address the service gap. We will work with the CSP to develop and implement referral systems and business agreements among CSP and other local providers/resources to ensure integration, coordination, and adequate access of all services. In addition, we will work with County Boards of Supervisors to request and encourage them to contract with CSP for Targeted Case Management services, in order to further streamline access and coordination of services. Comprehensive Service Providers will offer extended hours to include evenings and weekend routine and urgent appointments, in order to expand access and to provide crisis services support.

Crisis services are an important feature in our CSP network model. We will start by contracting with the existing **Mobile Crisis Team** providers (including Heartland Family Services in Council Bluffs and Behavioral Health Resources Golden Circle in Des Moines). We will develop and submit for approval to the Departments a proposal to utilize community reinvestment funds to develop full spectrum crisis services programs at each CSP, including at least one Mobile Crisis Team per region – increasing the number of Mobile Crisis Teams statewide from two to six. Our network management plan includes training for providers to ensure all Eligible Persons with high needs are supported in developing crisis intervention plans upon initiation of services, and that these plans are then provided to Cenpatico and/or entered into the *Health Passport* system. These plans can then be accessed by our crisis management staff and the information utilized to provide telephonic crisis intervention and de-escalation, and shared as appropriate with Mobile Crisis Teams, emergency treatment staff, and other crisis services staff. Use of crisis intervention plans assists consumers in accessing the right services at the right time and helps reduce unnecessary emergency department utilization and acute care admissions for stabilization.<sup>24</sup>

Through the use of community reinvestment funds, we will support expansion of **Assertive Community Treatment services**. We will work with the existing five ACT teams now in Iowa to expand services and will pursue development of additional teams where need is identified.

In order to expand peer support services, we are creating a **certification program for peer support specialists**. This training curriculum will be a forty (40) hour training consistent with National models such as the Georgia Peer Support Specialist Training and the DBSA Peer Support Training. We are also developing a twenty-four (24) hour Train-the-Trainer curriculum. Both will be readily included in our network development strategies for the Iowa Plan and will be implemented with support from community reinvestment funds.

Our experience in resolving very specific service gaps is evidenced in our work as the behavioral health vendor for Bridgeway Health Solutions, a long term care managed care organization in Arizona. We identified a significant gap in behavioral health support for consumers in nursing homes. When consumers' behavioral health issues escalated, most nursing homes would send them to the ER and frequently would decline to readmit them back to the nursing home once they were stabilized. As a result consumers were often then placed out of their community, far from their families and support systems. We designed and implemented a training program with nursing home staff to teach them to appropriately and effectively de-escalate behavioral health issues. This included teaching nursing home staff the skills for early identification of warning signs and methods to overcome and address these issues before they became disruptive. At present, we are training staff at three nursing homes in the Yuma area. In addition to this specific behavioral health related training program, we are working with the local nursing homes, behavioral health agencies and the local medical center to develop integrated strategies to better meet the overall healthcare needs of the elderly. Asset mapping in Iowa will allow us to identify similar specific types of gaps in services that may negatively impact the overall recovery of Eligible Persons. And as we did with the Arizona nursing homes, we will develop specialized strategies to address these areas.

**b) Describe proposed strategies to bring services to underserved communities, including but not limited to:**

- the use of telehealth and distance treatment options, and
- provision of child psychiatric consultation services to primary care clinicians

In addition to the strategies outlined in our response to the previous question, including expansion of **telehealth services** for psychiatry through the use of telehealth-specific provider agreements and active recruiting of Iowa-licensed psychiatrists both in and outside of Iowa, we will **recruit Iowa Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) to serve as telehealth remote site partners** to further expand access across the State. We will also implement community focus groups to

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<sup>24</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), Action Planning for Prevention and Recovery: A Self Help Guide.

assess the value and impact for communities of potential **expansion of covered telehealth services to include certain psychotherapy services.**

We will negotiate **contracts with FQHC and RHC which have behavioral health services in place and/or to expand their services to include behavioral health screenings and basic services.** We will recruit and incentivize providers willing to offer home-based services to cover gaps in rural service availability and will contract for an array of reimbursable home-based services to include assessment and evaluation, ongoing therapy services, family counseling, and medication management services with those behavioral health providers willing to provide services in home-based settings. We will contract with providers in bordering states that meet the licensing and accessibility requirements.

We will bring **specific psychiatric consultations** to Iowa. The limited number of child/adolescent psychiatrists available to provide treatment, more specifically medication management services for children and adolescents, is a prevalent issue across the state. We faced a similar issue in Texas and implemented a Psychotropic Medication Utilization Review (PMUR) program to address the need. ***In the past ten months there has been a 13% decline in the number of foster children over-prescribed psychotropic medications overall and specifically a 74% decline in polypharmacy.*** The revised prescribing patterns are the result of improved compliance with quality of care and prescribing guidelines. The primary function of the program is to ensure quality of care for consumers prescribed psychotropic medications. We will contract with Iowa-licensed child/adolescent psychiatrists to serve as consultants. We will recruit out-of-state child psychiatrists and offer incentives for obtaining Iowa licensure.

We propose to implement the following PMUR process for the Iowa Plan:

- 1) The PCP or other requesting physician submits a request to Cenpatico for a Psychotropic Medication Utilization Review (PMUR) consultation with a child/adolescent psychiatrist.
- 2) The Cenpatico Utilization Manager or Care Coordinator obtains medical notes from the requesting physician, as well as psychological reports and treatment summaries from any behavioral health providers treating the consumer.
- 3) Cenpatico staff forwards the information gathered to the Cenpatico Medical Director for review and triage to the consultant child/adolescent psychiatrist.
- 4) The consultant child/adolescent psychiatrist reviews the record and contacts the requesting physician within seven business days.
- 5) The child/adolescent psychiatrist discusses concerns and medication questions with the requesting physician via a doctor-to-doctor teleconference.
- 6) A formal report is completed by the consultant child/adolescent psychiatrist after the phone contact, and submitted to Cenpatico's Medical Director for review. Cenpatico staff forward the completed report to the requesting physician.
- 7) If any quality-of-care concerns arise during this process they are submitted for action in accordance with our Quality Assurance Performance Improvement Program.

In order to **promote development of new behavioral health professionals**, we propose using community reinvestment funding to collaborate with Iowa community colleges to develop programs to enhance workforce development to support Iowa's recovery model. To do so, we will adapt a successful strategy we implemented for our Arizona service delivery system, which is outlined fully in the next section.

**c) Describe the Bidder's experience under other contracts to ensure delivery of services to these populations when provider network capacity was initially found to be inadequate. Include the names of the programs and provide the names, telephone numbers and e-mail addresses of three references who can be contacted to verify the description submitted by the Bidder.**

Cenpatico is accustomed to addressing network deficiencies in new markets. For example, operating in **Texas** as Integrated Mental Health Services, we implemented a telehealth program for the Texas STAR Health (Foster Care) program. **Psychiatric services in rural counties** were limited and consumers,

particularly those under the age of eighteen, did not have adequate access to local psychiatrists. The physicians were either booked for months, only accepted referrals for consumers age eighteen and older, or were not in the immediate service area. To overcome these issues, we partnered with Mental Health and Mental Retardation centers (organizations similar to Iowa's Community Mental Health Centers) in areas with deficient access. Many of the centers had technology in place to provide telehealth services, however the provision of psychiatry services through this method was not billable under the program. We sought and received approval from the Texas Health and Human Services Commission to develop and implement the program. To date, Cenpatico has 11 centers contracted for the provision of these services.

In **Kansas**, for our HealthWave XXI product, a statewide SCHIP program, Cenpatico faced a network adequacy issue in the Northwest corridor of the state when the local mental health center decided it no longer wanted to participate in managed care. The Northwest corridor of the state offered no other alternatives to support consumers in the region. In order to bring services to this part of the state, we partnered with an in-home treatment agency already participating in our network in the Eastern part of the state. Through this partnership, this agency expanded its service area to include the Northwest corridor for Cenpatico members and offered a full array of outpatient services (including medication management) provided through an **in-home service delivery model**. In addition, this partnership also established telehealth services for Cenpatico members in this part of the state. A remote location was established by the agency in the Northwest corridor for consumers to obtain telehealth services from physicians located in their Eastern offices.

We also recognize the need for **continued development of new and existing behavioral healthcare professionals** and propose using community reinvestment funding to collaborate with Iowa community colleges to develop programs to enhance workforce development to support Iowa's recovery model. Our efforts will be based on our work with various community colleges in **Arizona** to add a Behavioral Health Basic Certificate program and an Advanced Certificate program. These certificate programs prepare students for careers as behavioral health technicians, case managers, parent aides, peer support, family support, family advocates, respite care workers and paraprofessional staff. The programs include courses designed to provide students with the skills necessary to deliver basic, specialized, and comprehensive behavioral health services. The program offers a 19 credit hour Basic Behavioral Health Certificate and a 47 credit hour Advance Behavioral Health Certificate. The majority of these credits will transfer to an Advanced Behavioral Health Sciences Associate in Applied Science degree and to a Bachelor's degree program. All of the instructors have a minimum of a Masters degree in Counseling or Psychology. The Basic Program includes the following courses: Intro to Ethical Counseling Issues; Intro to Human Relations; Communication Skills in Counseling I; Counseling in a Multicultural Setting; Therapeutic Intervention Models; Case Report Writing; Child and Family Advocacy; and Career Work Experience. The Advance Program includes the Basic Program courses, and the following: Group Dynamics; Chemical Dependency; Supervised Practice; Group Process; Applied Case Report Writing; Introduction to Psychology; and Developmental Psychology. Students also choose 10 credits of electives in Violence and Abuse Prevention, Substance Use Recovery, Recovery and Resiliency and Grief & Bereavement Recovery.

Our experience in resolving very specific service gaps is evidenced in our work as the behavioral health vendor for Bridgeway Health Solutions, a long term care managed care organization in Arizona. We identified a significant gap in behavioral health support for consumers in nursing homes. When consumers' behavioral health issues escalated, most nursing homes would send them to the ER and frequently would decline to readmit them back to the nursing home once they were stabilized. As a result consumers were often placed out of their community, far from their families and support systems. We designed and implemented a training program with nursing home staff to teach them to appropriately and effectively de-escalate behavioral health issues. This included teaching nursing home staff the skills for early identification of warning signs and methods to overcome and address these issues before they became disruptive. At present, we are training staff at three nursing homes in the Yuma area. In addition to this specific behavioral health related training program, we are working with the local nursing homes, behavioral health agencies and the local medical center to develop integrated strategies to better meet the overall healthcare needs of the

elderly. Asset mapping in Iowa will allow us to identify similar specific types of gaps in services that may negatively impact the overall recovery of Eligible Persons. And as we did with the Arizona nursing homes, we will develop specialized strategies to address these areas.

### References:

State	Program	Name	Title	Phone	E-Mail
Texas	STAR Health (Foster Care) Program-Medicaid	Holly Munin	VP Operations, Superior Healthplan Network	(800) 218-7453	<a href="mailto:hmunin@centene.com">hmunin@centene.com</a>
Kansas	HealthWave XXI-SCHIP	Chris English, KHPA	HealthWave Program Manager, State of Kansas	(785) 296-3981	<a href="mailto:Chris.english@khp.ks.gov">Chris.english@khp.ks.gov</a>
Arizona	Glendale Community College	Bruce Thomas	Professor	(623) 845-3061	<a href="mailto:Bruce.thomas@gmail.maricopa.edu">Bruce.thomas@gmail.maricopa.edu</a>

**d) Describe the Bidder’s experience in implementing Medicaid managed behavioral health programs in which the bidder successfully promoted the development of:**

- psychiatric rehabilitation services
- mental health self-help and peer support groups, and
- peer education services

**Provide the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.**

Cenpatico focuses solely on Medicaid and public funded behavioral health managed care contracts. We have been successful in developing psychiatric rehabilitation services, mental health self-help and peer support groups, and peer education services for Medicaid and other populations. We will work in collaboration with recognized self-help and peer support leaders and other stakeholders throughout Iowa to assess need and then create, develop and implement “Best Practice” Medicaid managed behavioral health programs which are grounded in recovery principles and suitable to meet the local community needs.

A recovery-oriented system must include services that focus on psychiatric rehabilitation, self-help and peer education. Recovery oriented services increase an individual’s ability to live, learn and work in the community and are important to help support the person on their recovery journey. Recovery-oriented principles must be incorporated into all aspects of service delivery. These principles include:

- Recovery is possible.
- Mental health consumers must be welcomed as partners in their recovery.
- A “Just Start Anywhere” mode of consumer action must be fostered.
- A broad range of consumer run services is promoted.
- Meaningful work/educational activities are valued and worked toward.
- Service providers must encourage and facilitate an increase in consumers’ abilities to self manage disorders.
- Use of community resources should be encouraged.
- Staff must be empowered.<sup>25</sup>

Iowa’s **Psychiatric Rehabilitation Services** are designed to restore, improve, or maximize the level of functioning, self-care, responsibility, independence, and quality of life and to minimize impairments, disabilities and disadvantages of persons with a disabling mental illness. These services are focused on improving personal capabilities while reducing the harmful effects of psychiatric disability and resulting in Enrollees recovering the ability to perform a valued role in society. To ensure the appropriate implementation of these services it is necessary to appropriately train the providers who offer those services. We worked with consultants from Boston University’s Center for Psychiatric Rehabilitation to implement

<sup>25</sup> [http://www.procovery.com/files/blueribbon\\_article.htm](http://www.procovery.com/files/blueribbon_article.htm), retrieved February 3, 2009.

**Rehabilitation Readiness Training** for our Arizona network provider staff in agencies offering psychiatric rehabilitation services. These training modules are considered a best practice in the psychiatric rehabilitation field.<sup>26</sup>

We have promoted the implementation **mental health self-help and peer support groups** in many communities throughout Arizona. We worked with staff at the **Transitional Living Center (TLC)**, a provider in the Yuma, AZ area to become a peer-run Community Service Agency. We then worked with TLC to develop a Community Service Agency in another city. TLC has expanded to offer services to the Casa Grande, AZ community in January 2009. As part of its peer-based psychiatric rehabilitation recovery support services for people recovering from substance abuse TLC emphasizes "dealing with life on life's terms," identifying skills to address the personal, vocational, familial, legal and social consequences of addiction. TLC offers a regular program of peer-based recovery services, including peer-led support groups, individual peer support and mentoring, a peer-led resource connector program, life skills classes and workshops, alcohol and drug-free social and recreational activities and a drop-in center. This program includes workshops developed in response to needs identified by peers.

**Peer Education:** We have facilitated the training of over 200 peer support specialists in the four counties of our Arizona service delivery area through our collaboration with **Recovery Innovations of Arizona**. Recovery Innovations has focused on developing peer support for young adults aged 18-25 and is adding additional focus on peer support for older adults in 2009. Also, we are currently developing our own training curriculum which we expect to make available in 2009. This training curriculum will be a forty (40) hour training consistent with national models such as the Georgia Peer Support Specialist Training and the DBSA Peer Support Training, and will be readily adaptable to meet Iowa's needs. In addition, we are creating a twenty-four (24) hour Train-the-Trainer curriculum which will also be adapted for Iowa communities.

#### References:

Program	Name	Title	Phone	E-Mail
Rehabilitation Readiness Training	Letitia M. Labrecque, MSW	Statewide BH Services Coordinator, Rehabilitation Services Administration	602-803-8688	<a href="mailto:Llabrecque@azdes.gov">Llabrecque@azdes.gov</a>
Transitional Living Center	Rick Polski	Executive Director	928-261-8668	<a href="mailto:Transitional_home@yahoo.com">Transitional_home@yahoo.com</a>
Recovery Innovations	Christy Dye	CEO	602-636-4478	<a href="mailto:Christyd@recoveryinnovations.org">Christyd@recoveryinnovations.org</a>

e) Describe the Bidders' experience with contracts that include SAPT Block Grant funding. Provide the names, telephone numbers and email addresses of two references that can be contacted to verify the description submitted by the Bidder.

Cenpatico manages SAPT Block Grant funding in Arizona. **Substance Abuse Prevention and Treatment Federal Block Grant Funds are dispersed by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)** annually, to ensure specialized substance use prevention and treatment services are available for high risk recipients in Arizona. These high risk recipients are prioritized:

- Prevention services for at risk children and adults
- Treatment services for pregnant substance using women
- Treatment services for intravenous drug users (men and women)
- Treatment services for women with dependent children, or parents in the process of regaining custody of their children from Child Protective Services
- All other recipients that need substance use treatment

ADHS/DBHS allocates these federal SAPT funds to Cenpatico to distribute to providers as appropriate to meet the goals of the SAPT Grant. We allocate these SAPT funds to select treatment providers who employ

<sup>26</sup> <http://www.bu.edu/cpr/products/curricula/index.html>, retrieved February 26, 2009.

case managers, clinical liaisons, nurse practitioners, psychiatrists, and support and prevention staff, and offer specialized programs to meet the needs of the identified populations. A majority of our network providers are located in rural areas, with others located in urban areas that offer additional placement and treatment options.

We allocate SAPT funds to each provider on a yearly basis and use of these funds is focused on uninsured, high risk priority recipients in need of substance use treatment, to include participation by their family members. Services are developed by the providers which are specifically created for the priority populations and based on best practice treatment models. Gender specific treatment, outreach activities, peer support, vocational rehabilitation, coordination for housing, residential programs and services involving family participation, are included in the continuum of care. Providers screen SAPT recipients by using several clinical assessments, to include a risk needs assessment to determine the appropriate level of care. Providers develop and maintain appropriate treatment services that include: outpatient, intensive outpatient, gender specific groups, parenting classes, methadone treatment, detoxification treatment, pre-natal education, HIV intervention, Abused Women's Group, referrals to 12 Step and faith-based programs. We provide training and technical assistance to the providers to achieve desired outcomes.

To ensure access to treatment and long term recovery support services for pregnant women and teenagers who use substances, persons who use drugs by injection and woman/teenagers with dependent children and their families, programs are required to include:

- Risk Assessment
- Pre-Post Test counseling
- Testing
- Case Management
- Supportive and rehabilitation services

Providers identify SAPT recipients during the intake process and determine whether they meet financial criteria for participation. Providers also assess for Medicaid eligibility and refer consumers as appropriate to apply for Medicaid, to ensure that SAPT Block Grant is utilized as funding of last resort.

We developed an SAPT report which improved data collection relating to the identified populations, per state and federal guidelines. We compile these reports each month and provide information relating to access to care data, referral to treatment timelines, interim services information and financial estimates on expenditures on the five priority SAPT categories. In addition, the report indicates the capacity for existing programs, services barriers and gaps that currently exist.

We implement in-depth trainings with all of the contracted providers and present new information concerning SAPT guidelines. We facilitate monthly provider SAPT meetings to discuss priority access for specified SAPT populations, required timelines for treatment, funding limitations and service gaps and barriers. These monthly meetings concentrate on various areas relating to SAPT, such as:

- How to improve existing programs by utilizing available resources, staff and facilities.
- How to market SAPT services to the community.
- How to increase recipient engagement and participation in SAPT services.
- How to improve overall data submission on monthly SAPT reports.
- How to increase provider staff awareness and knowledge concerning appropriate SAPT spending.
- How to improve programming based on recognized best practice modalities.

We provide SAPT prevention funds to Pinal Gila Council for Senior Citizens (PGCSC) for primary prevention services targeting senior citizens, including the program "Ambassadors." PGCSC is the Area

Agency on Aging organization for Pinal and Gila Counties and they have been contracted with us since July 2005. Ambassadors, a program that trains and promotes elder-to-elder peer support services, was awarded the Center for Substance Abuse Prevention (CSAP) *Service to Science Award* which provided the agency the additional technical assistance to work toward meeting the criteria for SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

We also provide SAPT funds to the **Pinal Hispanic Council** to develop a community based substance abuse coalition, Superior Substance Abuse Coalition and the One Village program to build community cohesiveness to reduce the prevalence of drug use in Eloy and Casa Grande. The programs have brought stakeholders together to build upon the communities' strengths and develop approaches unique to the respective communities.

We allocate SAPT prevention dollars to SouthWest Center for HIV/AIDS to deliver educational HIV lectures and to complete HIV testing for enrolled participants attending substance use treatment. The provider also includes pre-post counseling to educate the recipient on the impact of testing positive for the HIV virus.

In Fiscal Year 2008, we conducted meetings with six Native American communities to discuss how to provide SAPT funded services to their members. We developed work plans with the tribes to organize the steps on how the delivery of these services can be offered.

**References:**

Program	Name	Title	Phone	E-Mail
Arizona Department of Behavioral Health Services (SAPT funds)	Victoria Navarra	Division Chief of Compliance	(602) 364-4558	<a href="mailto:navarrv@azdhs.gov">navarrv@azdhs.gov</a>
Pinal Hispanic Council	Ralph Varela	CEO	(520) 466-7765	<a href="mailto:rvarela@pinalhispaniccouncil.org">rvarela@pinalhispaniccouncil.org</a>

**f) Describe the Bidder's experience contracting with networks of comparable or greater size than those of the Iowa Plan within the timeframe afforded by this procurement. Provide the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.**

Cenpatico is accustomed to building networks under tight timeframes. With a dedicated network implementations staff in Austin, and a local network development team for each market, we have the staff and experience needed to quickly expedite a full-continuum network build. As most implementations average a six month pre-go-live implementation period, we anticipate no general issues in building an Iowa Plan network within the allocated eight months.

In comparing the seven network builds that we have completed in the past four years, and considering variations such as statewide versus regional delivery areas, significant rural demographics, continuum of services and provider type requirements, membership size and populations served, we find that the following three contracts were comparable to the Iowa Plan network requirements.

**References:**

State	Health plan or State client	Name	Title	Phone	E-Mail
Texas	STAR Health (Foster Care) Program- Medicaid	Holly Munin	VP Operations, Superior Healthplan Network	(800) 218-7453	<a href="mailto:hmunin@centene.com">hmunin@centene.com</a>
Georgia	Peach State Health Plan	Patrick Healy	President & CEO	(866) 874-0633	<a href="mailto:phealy@centene.com">phealy@centene.com</a>
Arizona	Arizona Department of Behavioral Health Services	Dr. Laura Nelson, MD	Deputy Director	(602) 364-4558	<a href="mailto:Laura.nelson@azdhs.gov">Laura.nelson@azdhs.gov</a>

### **7A.2.14 Network Management**

a) Describe how the bidder would actively manage quality of care provided by network providers of all covered services. The description should include:

- Bidders proposed methodology for conducting provider profiling, including as examples, the content of the report for providers of inpatient mental health services to children; providers of outpatient mental health services to adults, and providers of substance abuse services. The Bidder shall specify the frequency of report distribution, and a timeline for developing and implementing provider profiles for all providers and service types
- The explicit steps the Bidder would take with each profiled provider following the production of each profile report, including a description of how the Bidder would generate and facilitate improvement in the performance of each profiled provider
- The process and timeline the Bidder proposes for periodically assessing provider progress on its implementation of strategies to attain goals for improvements
- Examples of how the Bidder has used provider profiling to improve services delivered by a provider, or provider type in a managed care program
- A description of how the Bidder would reward providers who demonstrate continued excellence and /or significant performance improvement over time, and how the Bidder would share "best practice" methods or programs with providers of similar programs in its network
- A description of how the Bidder would penalize providers who demonstrate continued unacceptable performance or performance that does not improve over time

Our Network Management plan is designed to ensure quality of care. Our network development structure combined with network management plan are the foundation for achieving the Departments' ultimate goal of a statewide recovery-oriented care system that matches each person's strengths, needs and choices with appropriate and coordinated services and supports. We are not a direct service provider, but our administrative role is the means by which we are able to ensure the quality of direct services to Eligible Persons. In addition to provider profiling, audits and other monitoring activities, Network Management provides ongoing training and support to participating providers. Trainings include administrative information such as: claims submission information; grievance and appeal processes; covered benefits; contractual obligations; and State-specific legislation and requirements. Clinical training topics include: evidence based and best practices, utilization guidelines, crisis intervention planning, treatment team facilitation; consumer engagement; and use of peer and natural supports.

In addition to on-site and web-based training, we share best-practice approaches to treatment or treatment program information with providers using several feedback methods. A Clinical Record Feedback Form may be faxed by a Utilization Manager (UM) or Clinical Quality Assurance Coordinator to an outpatient provider following retrospective review of an Eligible Person's behavioral health clinical record. The Feedback Form lists several of the documentation categories that are necessary to an individualized service plan (ISP) that is focused on resiliency, recovery, and consumer self-determination and empowerment. The Utilization Manager offers specific feedback on the clinical record being evaluated, as well as suggestions regarding adequate documentation in subsequent clinical records. The Clinical Record Feedback Form identifies the Cenpatico clinician who performed the evaluation, along with their direct telephone contact information. Providers are encouraged to contact our staff for clarification of the feedback or any other aspects of outpatient treatment planning and service documentation.

When our review of a clinical record suggests a possible best-practice 'disconnect' among an Eligible's presenting issues, diagnosis and treatment goals, the provider may also receive a Cenpatico clinical Fact Sheet. Each Fact Sheet, compiled by Cenpatico staff from various research sources (e.g., the Journal of the American Academy of Child and Adolescent Psychiatry and SAMHSA's National Registry of Evidence-based Programs and Practices), describes best-practice, diagnosis-specific treatment information. A list of research sources for each Fact Sheet is available to any provider upon request.

We also provide additional technical assistance in the form of market-specific billing codes lists, designed to serve as an at-a-glance reference guide for providers' data entry staff charged with the responsibility of submitting claims for services rendered. The billing codes list help to ensure that providers receive prompt payment on appropriate claims submissions and that the specific treatment modality utilized by providers in

each session is accurately identified in the enrollees' clinical records. Providers' use of accurate billing codes is critical because much of the provider profiling utilization data are derived from claims submissions. The Clinical Record Feedback Form, the market-specific billing codes lists, and each 'Fact Sheet' may also be accessed by providers from the Cenpatico website.

Utilizing multiple methods, including those described above and the profiling activities detailed below, we evaluate network providers at all levels of care on at least a quarterly basis, to ensure they are providing services that are consistent with accepted standards of care and that all Eligible Persons have adequate access to covered and required services that can reasonably be expected to achieve their intended purpose and improve the functional outcomes of service recipients. Additionally, we monitor for patterns of over-utilization or under-utilization. Utilization Managers and ICM staff work in unison with the Department of Quality Improvement (QI) to monitor providers in the areas of: Complaints and Grievances; Cultural competence; and Availability, Timeliness, and Convenience of desired and necessary services.

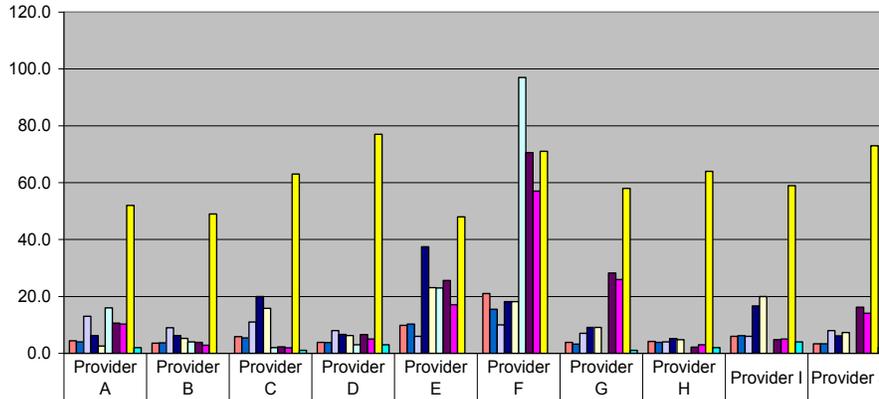
Our provider profiling methodology consists of the collection, generation, analysis, and dissemination to providers on a quarterly basis of claims/encounter-based data for: inpatient providers who collectively represent 50% or more of the annual aggregate mental health inpatient admissions; outpatient providers who collectively represent 50% or more of the annual total number of outpatient mental health service units provided; and all Comprehensive Service Providers. Key performance indicators and subsequent data elements will be determined and reviewed on a quarterly basis by the Director of Network Management, Director of Utilization Management, Clinical Director and the Director of Quality Assurance. Benchmarks for each performance indicator will be derived from Iowa Plan network provider averages.

Key indicators, as appropriate to provider type, will include at a minimum:

- Admission Rates
- Readmission Rates within 30 Days (<10% for children and <14% for adults)
- Denial Rates
- Average Length of Stay
- Average Length of Treatment (Outpatient Visits)
- Timely Outpatient Appointments following discharge from Inpatient Events (within 7 Days)
- Utilization of Evidence-Based Practices (Library reviewed and updated at least annually)
- Quality Assurance Reports (Quality of Care and Performance Improvement reports)
- Service Coordination with primary care physicians, integrated services and supports, relevant state agencies and programs, and collateral providers
- Utilization Management processes that stress resiliency, rehabilitation, and recovery
- Monitoring of Pharmaceutical Management services

### Sample Report (hypothetical data) of IP Utilization Trends for children’s mental health service provider:

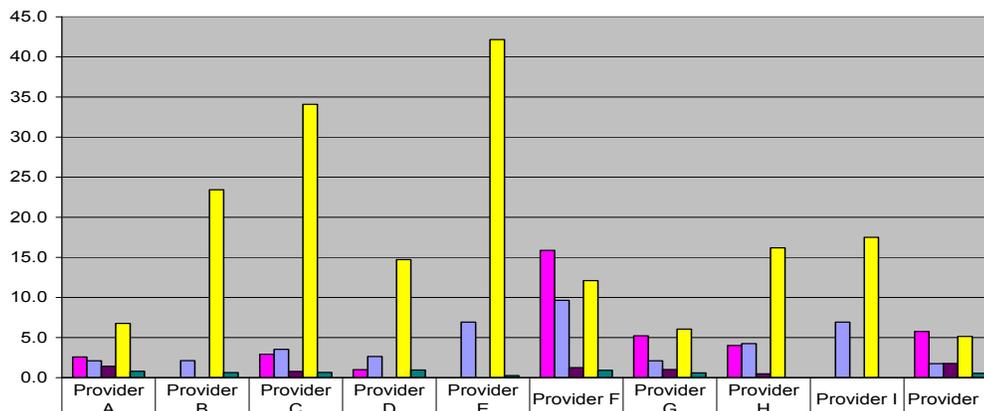
Iowa Inpatient Utilization Trends  
Enrollees Age 0-17  
Quarterly Reports, Rolling Year



	Provider A	Provider B	Provider C	Provider D	Provider E	Provider F	Provider G	Provider H	Provider I	Provider J
Previous ALOS	4.4	3.6	5.9	3.9	9.8	21.0	3.9	4.2	6.0	3.3
Current ALOS	4.0	3.7	5.4	3.8	10.3	15.5	3.2	3.9	6.2	3.3
Re-admissions	13	9	11	8	6	10	7	4	6	8
Previous Readmission %	6.3	6.3	20.0	6.7	37.5	18.2	9.1	5.2	16.7	6.1
Current Readmission %	2.6	5.3	15.8	6.3	23.1	18.2	9.1	4.8	20.0	7.3
Days Denied	16	4	2	3	23	97	0	0	0	0
Previous Denial %	10.6	3.9	2.3	6.6	25.6	70.6	28.2	2.2	4.8	16.2
Current Denial %	10.3	2.8	2.0	5.0	17.2	57.1	26.0	3.0	5.0	14.1
7-Day Follow-up %	52.0	49.0	63.0	77.0	48.0	71.0	58.0	64.0	59.0	73.0
QOC Reports	2	0	1	3	0	0	1	2	4	2

### Sample Report (hypothetical data) of Outpatient Utilization Trends for children’s mental health service providers:

Iowa Outpatient Utilization Trends  
Enrollees Age 0-17  
Quarterly Reports, Rolling Year



	Provider A	Provider B	Provider C	Provider D	Provider E	Provider F	Provider G	Provider H	Provider I	Provider J
FT Avg. Units	2.6	0.0	2.9	1.0	0.0	15.9	5.2	4.0	0.0	5.8
IT Avg. Units	2.1	2.1	3.5	2.6	6.9	9.6	2.1	4.3	6.9	1.7
FT/IT Ratio	1.4	0.0	0.8	0.0	0.0	1.2	1.0	0.5	0.0	1.8
CBS Avg. Units	6.8	23.4	34.1	14.7	42.2	12.1	6.0	16.2	17.5	5.1
Med. Mgmt. Avg. Units	0.8	0.6	0.7	1.0	0.3	0.9	0.6	0.0	0.0	0.5

**Sample of Iowa Plan Outpatient Network Provider Benchmarks (hypothetical data):**

**Iowa Services by Treatment Category**

**10/1/07 – 9/30/08**



<b>Service Category</b>	<b>Number of Patients 0-12</b>	<b>Total Units</b>	<b>Average Units per Patient</b>	<b>Number of Patients 13-17</b>	<b>Total Units</b>	<b>Average Units per Patient</b>
Community Support	1,073	62,183	58	1,040	53,456	51.4
Crisis Intervention	2	8	4	14	53	3.8
Day Treatment	79	919	11.6	100	1,134	11.3
Diagnostic Assessment	5,136	12,837	2.5	3,034	10,079	3.3
Evaluation & Management	44	44	1	44	45	1
Family Therapy	1,093	3,498	3.2	692	3,074	4.4
Inpatient Psychiatric Hospital	61	525	8.6	264	1,922	7.3
Intensive Family Intervention	111	13,494	121.6	220	24,265	110.3
Intensive Outpatient Treatment	223	3,006	13.5	149	1,866	12.5
Medication Administration	1	2	2	2	83	41.5
Medication Management	1,315	4,159	3.2	870	2,618	3
Nursing Services	314	1,070	3.4	221	782	3.5
Outpatient Group Treatment	66	278	4.2	127	657	5.2
Outpatient Therapy	3,389	17,796	5.3	2,138	13,999	6.5
Outpatient Treatment & Meds.	2,063	7,294	3.5	1,360	4,666	3.4
PRTF	1	7	7	13	681	52.4
Psychological Testing	695	2,947	4.2	222	1,066	4.8
Inpatient, Residential, Day Treatment	73	422	5.8	266	1,415	5.3

In addition to the quarterly analysis and dissemination of aggregate inpatient and outpatient claims-based utilization data, we will also conduct quarterly retrospective analysis of a random sampling of outpatient-enrollee clinical records to monitor quality of care.

Within the first quarter following the start date of the contract, CADC/ACADC Quality Assurance Coordinators will begin conducting quarterly retrospective reviews of all IDPH-funded substance abuse providers of substance abuse services and will develop standardized data analysis and provider reporting formats and processes. The minimum elements to be evaluated will be:

- Required utilization management guidelines were met for all services provided
- Services provided were consistent with the level of care authorized
- Clinical services provided for all levels of care were consistent with best-practice guidelines
- I-SMART data were accurately reported
- IDPH funds were used as payment of last resort for IDPH Participants
- Existence of standardized record-keeping systems that include adequate documentation of all service-delivery components
- Compliance with all other contractual requirements

Within six months following the start date of the contract, the Network Management staff, in partnership with our Quality department, will collect, generate, analyze, and disseminate, on a quarterly basis, data for:

inpatient providers who collectively represent 50% or more of the annual aggregate substance abuse inpatient admissions; and outpatient providers who collectively represent 50% or more of the annual total number of outpatient substance abuse service units provided. Key performance indicators and evaluative data elements will be selected in accordance with American Society of Addiction Medicine Patient Placement Criteria 2<sup>nd</sup> Edition Revised (ASAM PPC-2R) and SAMHSA requirements for the SAPT Block Grant.

After the quarterly data has been generated and analyzed by our staff, a “de-identified” performance chart is generated and disseminated to each of the Top 10 high-volume Inpatient and Outpatient providers. Clinical Provider Liaisons will then conduct follow-up telephone outreach and face-to-face meetings to discuss interpretation of the data, how each provider’s performance compares to the established network benchmarks (averages), and how service delivery and overall quality of care could be enhanced. We will contact any provider regarding under- or over-utilization and/or quality of services who demonstrates a continued trend of key performance indicators significantly outside of the established benchmarks (“outliers”), irrespective of their ranking in total volume of services relative to the state total, in order to facilitate improvements.

We will offer strategies for appropriately decreasing inpatient average length of stay, which include advocating for the development of outpatient safety plans with the members’ family members or legal guardians within the first two days of the admission event (unless specifically contraindicated by the attending physician). Opportunities for decreasing admission and readmission rates are discussed, which may include: crisis intervention planning on-site trainings provided by Cenpatico staff to help avoid admissions to an inpatient facility when a less restrictive level of care is medically indicated; and discharge planning assistance provided by our Intensive Clinical Management (ICM) staff beginning at time of intake to more restrictive levels of care.

Profiling data are generated on a quarterly basis and report on one full calendar year of claims/encounter submissions, presented in a “rolling year” format. Each report end-date is three months prior to the date the report is generated, which helps ensure that all claims have been received for the period being analyzed. All reports can be formatted to include data from previous reports, in order to show at-a-glance any recent trends in the key indicators being analyzed.

Quarterly performance data are disseminated to each of the providers included in the report, representing at a minimum, the top 10 high-volume inpatient and top 10 high-volume outpatient providers. Also included in each quarterly report is a list of the top 10 high-cost consumers seen by the inpatient providers represented in the report. Intensive Clinical Management (ICM) staff conduct follow-up telephone outreach to high-cost consumers, family members, and the outpatient providers to review and facilitate appropriate resource and referral linkage and increase support for consumers’ outpatient treatment adherence in order to: increase consumers’ community tenure; avoid overlap and/or duplication of outpatient services; avert hospitalization when appropriate; and decrease length of stay when a more restrictive level of care has been required to stabilize consumers deemed at imminent risk of harm to themselves and/or others. ICM staff also facilitate communication with and between behavioral health providers, primary care physicians and Iowa Plan medical providers for all Enrollees with identified co-occurring medical conditions.

Each outpatient report includes a breakdown of treatment modalities and diagnoses reported by the providers. Analysis of this data allows us to identify provider training or other support needs, which are addressed by our network staff. This data collection and analysis have led to discussions with providers regarding best-practice guidelines in the areas of assessment, service planning, and service delivery that result in improved quality of care for consumers (See examples below in response to Question b.)

**Rewards:** Providers that demonstrate service excellence, as determined by the quarterly profiling reports relative to established Iowa Plan Benchmarks, will be eligible to become *Preferred Providers*. Inpatient *Preferred Providers* are authorized an established number of covered days for each behavioral health admission without undergoing the Cenpatico Utilization Management (UM) Guidelines review process; the

review process is required of *Preferred Providers* only when the length of stay exceeds the established threshold.

*Preferred Providers* agree to: quarterly profiling data monitoring to ensure continued compliance with established criteria; cooperate with Cenpatico, Comprehensive Service Providers, and Community Mental Health Centers and other outpatient providers for the purpose of streamlining and improving their aftercare/discharge planning services; and, to provide written documentation of completion of Crisis Planning training by their clinical staff or an agreement to participate in Crisis Planning training provided by a Cenpatico or an alternative trainer. *Preferred Providers* experience a decrease in utilization management administrative requirements that affords more time for the preparation and delivery of high quality services.

Cenpatico will offer Service Incentives to Iowa Plan providers who meet specified requirements, when ever Contractor performance incentives with the State are achieved. For providers receiving block payments, incentives will be calculated as a percentage of the block payment and are paid to providers based on encounter data in reported from our claims processing system. The following criteria must be met:

1. Encounter value must be met at 100% to be eligible.
2. Provider shall meet all contractually required data submission requirements, including encounter submission requirements.

The time frame for measuring and meeting performance measures shall be based on the State fiscal year. Service incentives are paid to providers on an annual basis, four (4) months following year end.

Incentives may be available to providers who meet the following standards:

1. Score of at least 95% on at least 90% of all medical records audited.
2. At least 90% of Eligible Persons report on the MHSIP demonstrated improvement between 6 months and 18 months from start of behavioral health services.
3. At least 90% of Eligible Persons receiving substance abuse services report on the MHSIP demonstrated improvement between 6 months and 18 months from start of substance abuse services.
4. 7 Day follow-ups are in at least the 75<sup>th</sup> percentile of HEDIS measures for Medicaid members.
5. PCP communication is present in 90% of charts audited quarterly.

**Penalties:** Providers with performance measures that are out of contractual compliance face several possible consequences. Any Cenpatico staff that becomes aware of a potential quality of care issue or adverse occurrence with a provider will trigger an automated notice to QI staff. All QI triggers are investigated and assigned a Level of Severity, with Levels 3 and 4 resulting in notification to our Peer Review Committee. The Cenpatico Clinical Director and other staff as appropriate will make an on-site visit to the provider to discuss the report and review all relevant data and documentation. Depending on the merits of the report and supporting documentation, the provider may: be placed on a performance-specific and time-limited Corrective Action Plan; be suspended from expanding services to Enrollees within the service delivery area; be suspended from adding new Enrollees to its client roles; have its contract terminated for failure to meet contractual obligations and/or be reported to the appropriate state licensing or regulatory oversight authority for possible sanctions and additional penalties; or, be subject to financial disincentives for failure to meet contractual performance standards.

**b) Describe any comparable network management activities performed by the Bidder for other state clients.**

In our Georgia service area, profiling data helped to identify those providers which might benefit from **technical assistance and clinical trainings**. Cenpatico clinical staff conducted on-site trainings to Community Service Boards and Community-Based Services providers around the state. These trainings:

- Provided and discussed utilization management guidelines for authorization of outpatient services that require authorization in this market
- Provided examples and discussed completion of the Outpatient Treatment Request form to expedite the authorization process
- Provided and discussed literature regarding Best-Practice approaches to outpatient treatment, including:
  - Center for Mental Health Quality and Accountability ‘Reviews of Children’s Evidence-Based Practices’
  - Motivational Interviewing
  - Dialectical Behavior Therapy
  - National Wraparound Initiative ‘Wraparound Process for Families’
- Established direct lines of communication between Network Providers and our clinical staff

After these trainings, authorization requests from these providers were more consistent with UM guidelines and best practices which resulted in shortened turnaround time for processing those requests and improved care for consumers.

For our **Arizona contract, we designed and implemented a system of fidelity audits** for the two Service Delivery Areas for which it serves as a Regional Behavioral Health Authority (RBHA). This audit system is such a success that the State of Arizona now requires all RBHA statewide to utilize the fidelity audits as designed by Cenpatico Arizona. Fidelity audits are part of an overall network provider monitoring system aimed at ensuring consumers receive the right services to support their individual recovery goals. We will adapt and implement these fidelity audits for use with Iowa Plan providers. The audits will be conducted quarterly until minimum thresholds are achieved. Once minimum thresholds are achieved, the fidelity audits will be conducted semi-annually to ensure ongoing adherence to recovery and resiliency principles. Network liaisons will conduct spot checks on the service planning process and documentation during monthly visits to provider sites. The spot checks provide teaching opportunities to ensure ongoing quality improvement processes are in place to enhance consumer-led service planning. In Arizona, a profiling report measures access, variety of services performed and other key metrics which are required by the state. **A sample of these reports is included below:**

Report Period	10/1/2008 - 12/31/2008													
Provider Agency	Avg Monthly Pop	Complaints	Complaints Inc/1000 *	QOC CAPS	QOC CAPS Inc/1000 *	Chart Review	Data Valid	7-Day Access	23-Day Access	COC 1	COC 2	30-Day Readmit	WFI Score	DRM Score
GSA 2			≤ 3.0		< 2.0	≥ 85%	≤10%	≥90%	≥85%	≥80%	≥70%	≤10%	≥75%	≥75%
Agency 1	389.67	1	2.5663	0	0.0000	82.00%	36.00%	98.67%	100.00%	55.00%	33.00%	0.00%	76.00%	92.00%
Agency 2	960.33	3	3.1239	1	1.0413	89.00%	26.00%	100.00%	98.76%	94.00%	67.00%	25.90%	83.00%	67.00%
Agency 3	178.67	0	****	0	****	89.00%	41.00%	98.25%	100.00%	36.00%	96.00%	100.00%	85.00%	NA
Agency 4	186.33	0	****	0	****	95.00%	14.00%	100.00%	100.00%	70.00%	93.00%		NA	NA
Agency 5	3165.33	7	2.2115	6	1.8955	75.00%	20.00%	100.00%	95.49%	68.00%	91.00%	21.90%	73.00%	76.00%
Agency 6	183.67	1	****	0	****	69.00%	58.00%	66.67%	100.00%	13.00%	87.00%	0.00%	66.00%	77.00%

Cenpatico has developed and made available a broad array of training curricula, which have been utilized extensively across all markets. Training is available through live training, webinars, e-learning, provider coaching and mentoring, newsletters and clinical, training and quality improvement conference calls.

**Samples of training topics in Texas include:**

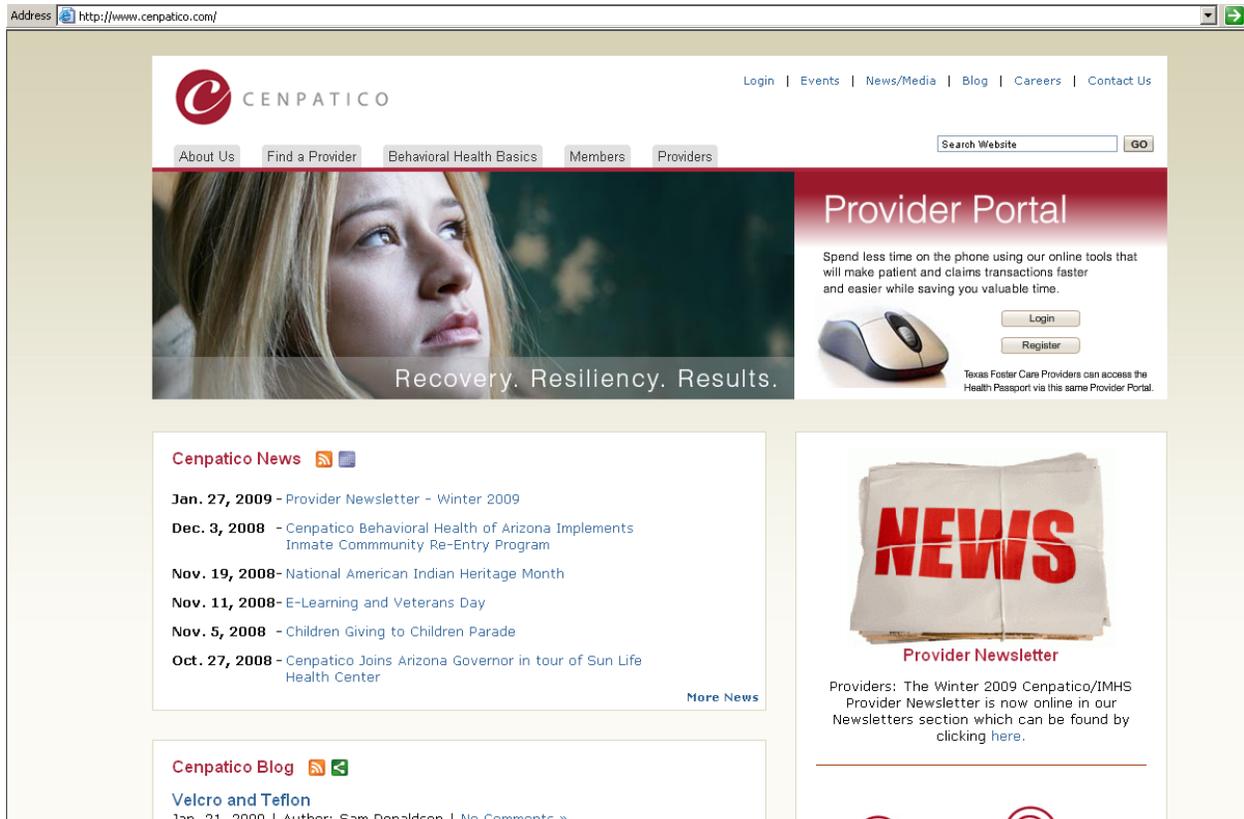
- **Why STAR Health? Children in conservatorship have greater healthcare needs.**
  - Many have been abused and neglected
  - May need more behavioral health services
  - May need more help in treatment with asthma, depression, etc.
  - Developmental delays may be present
  - Dental and Vision Services were limited
- **Helping children cope with separation grief and loss**
  - Grief is a reaction to a significant loss that may include psychological, emotional, cognitive, behavioral and physiological components
- **Telemedicine**
  - Using previously unavailable capabilities, psychiatric care can be provided via satellite/television services
  - Physician extenders assist the member on site during telehealth sessions
  - The Physician or APNP interacts with the member in real time to provide evaluation or medication management services from a remote location

Training curricula in Texas are developed by the Training Manager and distributed to the Regional Trainers to ensure consistency. A survey was implemented to identify training topics to meet the needs of our provider network. All training participants have the opportunity to evaluate the information provided and offer recommendations for additional training. This information is used to modify and adapt the current curriculum and to develop future training. Training evaluation results are compiled and reviewed by our Quality department monthly.

Cenpatico creates and distributes Provider Manuals in all markets we serve. The Provider Manual consists of Cenpatico's Utilization Management, Credentialing and Claims Submission guidelines. In addition, it contains Access Standards as prescribed by each State contract, Complaint/Grievance /Appeals process information, and eligibility verification information. In the **Texas market, the Provider Manual** is distributed to each participating provider within 30 days of contract execution, upon any material changes to Cenpatico processes, and on an annual basis. The manual is made available via our website as well as paper and CD-ROM versions.

Cenpatico makes available additional educational materials for participating providers through Quick Reference Guides (QRGs), Frequently Asked Questions (FAQs) and frequent notifications advising providers of current policies and procedures and any process changes. In addition, a **Provider Newsletter** is distributed quarterly to all participating providers in the Cenpatico network. This Newsletter contains the most recent information promoting Recovery, Resiliency, Results, as well as providing information concerning the latest trends in Behavioral Healthcare. This newsletter is posted to the Cenpatico website ([www.cenpatico.com](http://www.cenpatico.com)) quarterly.

Cenpatico maintains a **website** ([www.cenpatico.com](http://www.cenpatico.com)) for providers, members and stakeholders use. This site is available for all markets we currently serve. This website is available to provide information concerning Cenpatico as a whole, as well as market specific information. Participating Providers have the ability to verify eligibility, submit claims and review claims status through our web portal. In addition, searchable Participating Provider Directories are available for both Member and Provider use.



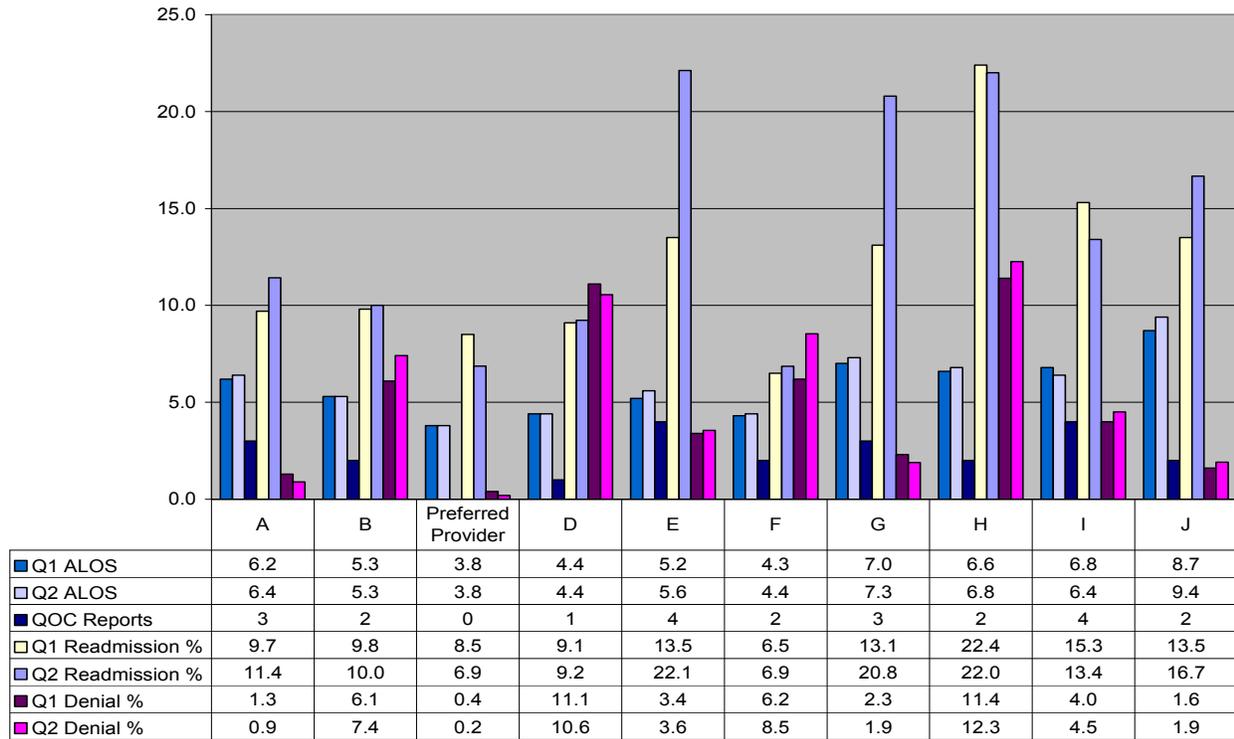
**c) Provide copies of provider profiles that the Bidder has employed for two clients, and describe measurable performance improvement achieved as a result of such efforts.**

The first example of a provider profiling intervention is for inpatient providers in the Ohio market. The claims-based trend analysis of first and second quarter data identified Akron Children's Hospital as a *Preferred Provider* candidate, based on data values below the established thresholds for Average Length of Stay (ALOS), Readmission Rates, Denial Rates, and Quality of Care Reports. (Beginning in the 3<sup>rd</sup> quarter of 2008, measuring the frequency of established Follow-Up Appointments within seven (7) days of discharge was added as an evaluative criterion for *Preferred Provider* eligibility.) On January 20, 2009, the UM Clinical Supervisor and Ohio Network Manager met on-site with representatives of the *Preferred Provider* candidate to review the data, answer questions regarding parameters of the Provider Profiling Initiative (PPI), and award *Preferred Provider* status.

Table 1 (below) shows the *Preferred Provider* claims-based data for the first two quarters of 2008 and Table 2 shows the *Preferred Provider* data for the first three quarters of 2008. As shown in Table 2, the *Preferred Provider* has maintained its ALOS and Readmission Rates, achieved a 0% Denial Rate, and again had no QOC Reports. As a result of maintaining its *Preferred Provider* status, Akron Children's Hospital will be saved approximately 60 hours of time annually that were previously spent conducting telephonic medical necessity reviews with Cenpatico UM staff.

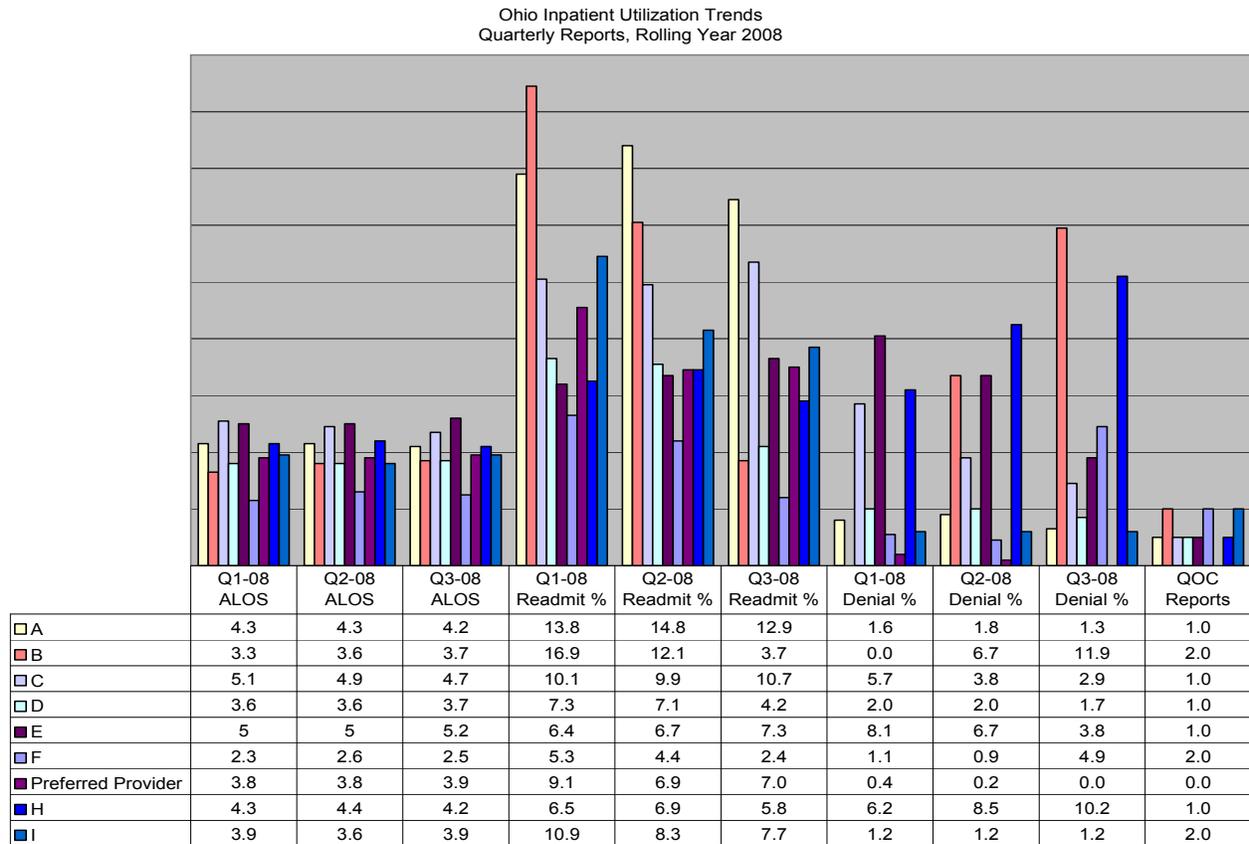
**Table 1 showing Ohio Inpatient Preferred Provider Candidate:**

Ohio Inpatient Utilization Trends  
Quarterly Reports, Rolling Year 2008



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**Table 2 showing Ohio Preferred Provider Maintenance of Performance:**



The second example of a provider profiling intervention utilized retrospective analysis of an outpatient provider in the Indiana market. The Center for Mental Health (“The Center”) is an active participant in **Cenpatico’s statewide Best Practice Project**. The Center identified family therapy as one of its ongoing best practices for treatment involving children and adolescents. Our Clinical Provider Trainer requested data regarding the ratio/volume of family therapy in children’s services and completed an on-site chart audit in September 2008. Sample size for the audit was determined by the following assumptions:

- Z= 1.96 (To be 95% positive)
- T= .05(+ or – 5% points)
- p = .50 (population base rate equal to 50%)
- q = .50 (q = 1- p)

At the time of the audit, The Center had 225 members 18 years of age or younger. Thus, the sample size computed to 137 ( $0.61 \times 225 = 152$ ). We assumed that if the first 100 charts were consistent, then a sample size of 100 charts would be sufficient to establish statistical significance. Our auditor determined the first 100 charts were consistent. For this audit, family was defined as any individual(s) actively involved in the support/care of the member. For all 100 charts, each clinical note posted by a mid-level clinician or PhD within the analysis timeframe was reviewed. Criteria included:

- Family therapy identified as a treatment modality in the member’s treatment plan;
- Family member(s) were identified as being present in session;
- Participation of family member(s) was indicated in the note;
- Identification of family patterns of interaction and/or family roles were identified;

- Description of therapist intervention was noted;
- Family progress towards goals was indicated; and,
- Immediate issue was addressed and adequately described in the note.

The audit tool was able to identify the:

- Ratio of family therapy to other clinical charges, per member;
- Ratio of family therapy to other clinical charges, per diagnostic category;
- Overall ratio of individual therapy to family therapy;
- Percentage of members receiving family therapy during the six month time period; and,
- Percentage of members receiving medication management and/or case management services only.

The audit results were consistent with the literature<sup>27</sup>, which recommends the inclusion of family members when providing mental health treatment to children and adolescents. According to Hoagwood et al (2001), “in child mental health research the family is central not only to the development of treatment or service but also to the understanding of the diagnosis itself (p. 1181).” As a result, The Center was awarded *Preferred Provider* status. According to analysis of (the most recent) claims-based data for the period 10/1/07 – 9/30/08, The Center: has a service population that is 70% ages 0-17; 57% of members receiving services were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or an Adjustment Disorder; and, each member age 0-17 received an average of 3.5 individual and 2.43 family therapy units of service. The Center provided services to 348 Cenpatico members during the reporting year and continues to demonstrate a strong commitment to family involvement in treatment for children. *Preferred Provider* status saves them a significant amount of staff time previously spent completing Outpatient Treatment Request (OTR) forms.

**d) Describe the Bidder’s plan to assure the accuracy of I-SMART data submitted by the providers of substance abuse services (Section 4B.5).**

Our Network Management team will be responsible for providing clinical training and education to participating substance abuse treatment providers to ensure adherence to Utilization Management guidelines as well as I-SMART submission requirements. I-SMART reporting will be a contract requirement for participating providers and Cenpatico will ensure the provider fully understand the requirements. Clinical Provider Liaisons will offer monthly scheduled trainings as well as ad hoc trainings.

On a monthly basis, the Quality team will pull claims data for analysis against and comparison with data pulled from the I-SMART system to ensure data accuracy. This analysis will be presented to participating providers on a monthly basis for review. If discrepancies arise, the Provider Liaison will review the data with the participating provider, offer remedial training and identify specific strategies or process changes needed. If discrepancies continue in the following months’ review, the participating provider, in collaboration with the Provider Liaison will develop and implement a Corrective Action Plan (CAP), detailing necessary steps for improvement, to be complete within 30 days. Participating providers who continue to demonstrate noncompliance with accurate I-SMART reporting will be subject to administrative penalties that include restricting referrals, de-credentialing, and ultimately, termination from the network.

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<sup>27</sup> Trowell ,J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J., Tsiantis, J. (2007). Childhood depression: a place for psychotherapy: An outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child & Adolescent Psychiatry*, 16(3), 157-67.

Hoagwood, K., Burns, B.J., Kiser, K., Ringeisen, H., Schoenwald, S.J. (2001) Evidence-Based Practice in Child and Adolescent Mental Health Services. *Psychiatric Services*, 52, 1179 - 1189.

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### **7A.2.15 Quality Assessment and Performance Improvement Program**

- a) Describe the Bidders experience in using data-driven evaluation of organization-wide initiatives to improve the health status of covered populations. Provider quantified, statistically significant evidence of:
- Improved mental health quality-process measures
  - Improved substance abuse quality-process measures
  - Improved mental health quality- functional or clinical outcome measures
  - Improved substance abuse quality - functional or clinical outcome measures
  - Improved mental health quality- consumer-reported outcome measures
  - Improved substance abuse quality - consumer-reported outcome measures

Include the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

At Cenpatico our quality assurance performance improvement plans and our quality-focused policies and procedures drive our overall recovery, resiliency, results oriented model of managed care. We have extensive experience in gathering data and have made analyzing such data central to our model of continuous quality improvement. Our organizational structures, including the model proposed for the Iowa Plan, are based on interdependent relationships among quality, network management, utilization management and member services staff, with the quality assurance team providing both leadership and support for interdepartmental clinical quality processes. The quality team functions include auditing and monitoring of network providers' services and Cenpatico's internal care management processes; data collection and analysis; and communicating data analysis results to appropriate staff for implementation in specific training and corrective action planning with providers. The quality team, in collaboration with other departmental staff, is also responsible for developing and implementing population-wide quality improvement activities in response to identified statistically significant deficits in both Cenpatico's internal care management processes and in network providers' quality of care. Our quality driven organizational structure and our experience, demonstrated more fully in the specific examples below, will result in continual quality improvement through data driven evaluation processes for the Iowa Plan.

**Improved mental health quality-process measures:** Cenpatico collects and analyzes data, and implements improvement processes as needed, to maintain appointment availability standards across all of our contracts. Our collection of appointment availability measures includes data pertaining to both routine and urgent care. To determine our network's adherence to standards in the contract, Quality Improvement Coordinators call a statistically significant sample of provider offices asking when their first available routine care and first available urgent care appointment is. The responses are documented in the appointment access excel database and collected data are analyzed and results communicated to network staff. In addition to real time feedback during the phone contacts, letters to re-educate the provider are mailed when they do not meet any of the appointment access standards. Data is also gathered from member complaints regarding access and availability to give a more complete picture. Network department staff utilizes the data provided by the Quality team in conjunction with geo-access time/distance and density analysis and participates in the improvement process from re-education to corrective action planning to assist the provider.

Once providers have received re-education, they are contacted again to ascertain compliance. If still non-compliant, they are asked to submit a corrective action plan to address this deficiency. The corrective action process is monitored through communication with the quality department to assure the provider understands the need for change and takes action to make those changes happen. The quality department and/or network management staff contact providers' offices after the activity noted in the corrective action plans has been performed and gives the providers feedback on the success of their actions.

If through our monitoring efforts, providers are found to be habitually out of compliance with required standards despite our outreach and supportive efforts to improve their performance, we will utilize our quality improvement committee structure to limit participation of or terminate a provider as necessary.

Results of the data analysis are reported to the client, in the quarterly report and the annual quality program evaluation. An example from the 2008 Annual Quality Program Evaluation is provided for Peach State Health Plan. Peach State Health Plan is divided into three regions for the purposes of reporting. In 2007, the first full year of data collection for the health plan, there were deficits in the network providers' appointment availability. As a result, we initiated a two pronged plan that including recruiting additional providers and implementing an education program for existing providers on the need to comply with existing standards. Results are noted in the Table below.

Peach State Health Plan	Urgent : within 24 hours	2007	2008	Statistically Significant Improvement
Atlanta	Urgent	52%	85%	Yes P=0.0011
Central	Urgent	53%	85%	Yes P=0.0241
South West	Urgent	51%	79%	No P=0.3551
	Routine: within 14 calendar days	2007	2008	Statistically Significant Improvement
Atlanta	Routine	73%	75%	No P=0.2145
Central	Routine	63%	82%	Yes P=0.0474
South West	Routine	74%	86%	No P=0.3479

**Improved substance abuse quality-process measures:** Research demonstrates overall increased risks for persons dually diagnosed with substance abuse disorders and Severe Mental Illness (SMI)<sup>28</sup>. Therefore, we developed an innovative quality process to collect data for consumers with substance abuse diagnoses related to methamphetamine use that also have SMI across our Cenpatico of Arizona organization. For such dually diagnosed consumers we also collect data regarding their engagement in services in general, and in peer services and in employment services specifically. The report sample listed below shows this data collection.

Cenpatico of Arizona: SMI/METH Report for FY 08				
Total SMI Consumers	SMI w/SA diagnosis	SMI-SA engaged in services	SMI-SA engaged in peer services	SMI-SA engaged in employment services
2405	620	606	216	50
Percentage of total	38%	36%	10%	4%

To effectively treat participants with co-occurring diagnoses, providers will initially need to identify them through screening processes, and then engage them in evidence based treatment modalities targeted for this population. Through the screening process, providers can refer identified participants to services which will give them the highest rate of success in reaching and maintaining recovery. Longitudinal data will indicate increases or decreases and will signal Cenpatico to adjust the procedural activities each provider follows in order to ensure that screenings and referrals to appropriate services is occurring. Our network management activities, directed by analysis of this data, include training mental health providers regarding best practices

<sup>28</sup> Dickey, B., Normand, S.T., Weiss, R.D., Drake, R.E., & Azeni, H. (2002). Medical morbidity, mental illness, and substance abuse disorders. *Psychiatric Services*, 53, 861-867

for substance use screening, and conversely, training substance abuse treatment providers regarding best practices for mental health screening. Given the reported high incidence of methamphetamine use in Iowa, we anticipate that this particular measure and process will have significant impact for Iowa Plan Eligibles.

**Improved mental health quality – functional or clinical outcome measures:** We collect and report clinical data consistent with the National Committee for Quality Assurance (NCQA) Health plan Employer Data Information Set (HEDIS) to all of our contracts. *Note that our measurement is consistent with HEDIS technical specifications and differs from the performance measure currently utilized by the Iowa Plan (as reported in its quarterly quality reports) in that we compile actual claims data only and do not count Contractor contact with the Enrollee in the seven day follow-up data.*

For example, Cenpatico measures the 7-day Follow-up Rate after Discharge for a Mental Health Admission, using NCQA HEDIS technical specifications, for Superior Health Plan for whom we provide behavioral health management. Results of this measurement indicate a statistically significant improvement from 2007 to 2008.

Results of the HEDIS 7 Day Follow-up Measure	2007	2008
Superior Health Plan/ Texas	28.32%	40.56%

The HEDIS data listed in 2007 were the foundation for performance improvement activities whose goal was to increase the number of consumers who access services timely following discharge. To affect this change, we implemented several initiatives:

- Our Utilization Managers support initiation of discharge planning from the time of admission by providing the treatment facility staff, at first contact, with the name and phone number of outpatient providers with whom the consumer had existing relationships prior to the admission, in order to facilitate not only timely follow-up appointments, but to ensure continuity of service for the consumer.
- Upon discharge, the behavioral health outpatient providers and Primary Care Physician are faxed a copy of the discharge summary by a Cenpatico Care Coordinator. This discharge summary is a system-generated document which includes the consumer’s diagnosis, medication, behavioral health provider names and follow-up appointments. In 2009, we are enhancing this process to include the names of the Primary Care Physician with telephone and fax numbers and the Behavioral Health provider with telephone and fax numbers on the fax cover sheet to encourage communication between the providers of care.
- Our Care Coordinators make telephonic outreach to consumers discharged from inpatient settings within 1 to 2 days prior to their first outpatient appointment, to encourage consumers to follow their discharge plans and to assist in problem solving any barriers. If a consumer has been discharged without a follow up appointment scheduled, a Care Coordinator call the consumer immediately upon receiving notice of the discharge in order to offer assistance with scheduling an outpatient appointment.
- Appointment attendance is subsequently verified with the provider. If the consumer has not attended, outreach is again made to encourage the consumer to keep the appointment within 30 days, or to reschedule as needed, as well as again working to develop solutions to any potential barriers.
- Children ages 4 through 18 receive an incentive for attending their appointment. Once the appointment is verified, the child receives either a build-a-bear with a story book on managing emotions and/or a Wal-Mart Gift Card.

Since HEDIS data is prepared on an annual basis, Cenpatico prepares its own monthly claims driven data report on the status of consumers’ outpatient follow-up allowing actions to be taken on a timely basis.

**Improved substance abuse quality – functional or clinical outcome measures:** Cenpatico of Arizona utilizes the output from the Substance Abuse and Prevention Treatment Block Grant (SAPT) monthly report

to assess improvements in substance abuse treatment. This report is required of each contracted treatment provider allocated SAPT funding. Providers are required to submit this report identifying financial expenditures and program effectiveness, according to guidelines for the Federal SAPT Block Grant. The report collects data relating to ten domains, four of which are the main SAPT eligible categories. They are: (1) Pregnant substance using women; (2) IV drug users; (3) Women with dependent children; and (4) All other participants in need of treatment, but not eligible for funding through Medicaid or other funding streams.

The report has two sections: financial expenditures for each of the four main SAPT eligible categories and quantitative data concerning program development, program capacity, barriers to providing treatment and service gaps. We analyze the data submitted by the treatment providers regarding financial expenditures to determine under or over utilization of funds for each category. The importance of this analysis is to determine providers’ success in appropriate funding allocation to priority services. This information is also summarized into a quarterly report to the state. In addition, we review the required data relating to program development, program capacity, barriers to providing treatment and service gaps to assess whether any under/over-utilization is impacted by deficiencies in program development. Combined, the two categories of data provide a variety of indicators for substance use treatment quality in terms of financial responsibility and program effectiveness. This measure and analysis process is applicable to the IDPH contract portion of the Iowa Plan for management of SAPT Block Grant funded services.

**Improved mental health quality – consumer-reported outcome measures:** Cenpatico of Arizona collects and analyzes consumer reported outcome data using the Mental Health Statistical Improvement Project (MHSIP) survey for both children and adults. Results are summarized in the following Table, where GSA 2 and GSA 4 refer to the two Geographic Service Areas managed by Cenpatico of Arizona:

Adult Survey Domains	Positive Responses					
	GSA 2			GSA 4		
	2006	2007	2008	2006	2007	2008
General Satisfaction	85.0%	86.8%	84.8%	88.0%	87.4%	87.3%
Access to Services	82.0%	79.3%	82.0%	82.0%	85.7%	83.0%
Participation in Treatment	74.6%	78.1%	81.8%	80.6%	80.1%	81.0%
Service Quality and Appropriateness	86.0%	84.9%	88.5%	86.3%	89.0%	91.1%
Outcomes	72.3%	70.5%	74.0%	66.9%	71.9%	74.7%
Improved Functioning		70.1%	78.1%		72.9%	70.1%
Social Connectedness		72.7%	75.7%		71.8%	67.5%
Youth & Family Survey Domains	Positive Responses					
	GSA 2			GSA 4		
	2006	2007	2008	2006	2007	2008
General Satisfaction	78.9%	88.9%	80.6%	84.8%	78.4%	76.2%
Access to Services	84.4%	86.2%	82.3%	86.2%	85.5%	78.6%
Participation in Treatment	91.2%	87.9%	86.6%	91.1%	92.4%	86.0%
Cultural Sensitivity	93.3%	95.5%	92.7%	94.9%	9105%	89.4%
Outcomes	75.3%	76.0%	66.0%	74.7%	66.4%	56.2%
Improved Functioning		77.9%	68.0%	6803%	60.6%	
Social Connectedness		89.1%	87.9%		82.2%	84.8%

We then provide our data to the State for analysis and comparison of results between years and among the Regional Behavioral Health Authorities (RBHA), of which Cenpatico of Arizona is one. Joining efforts with other RBHA, we share our methods to improve results in the spirit of overall quality improvement for the state wide service delivery system.

For the Iowa Plan, assessing the National Outcome Measures collected through the I-SMART database jointly with the MHSIP outcome data will provide broader identification of areas for improvement.

**Improved substance abuse quality – consumer-reported outcome measures:** To obtain consumer reported outcome measures for the substance abuse population, Cenpatico of Arizona developed the Participant Interview tool. Linked to the MHSIP survey process discussed above, we send survey participants who have a substance use diagnosis an invitation to fill out a Participant Interview form. This form is two pages in length, narrative in format, and asks the following questions:

- What do you like about the services you receive here (treatment agency)?
- What could be improved about the way you receive services?
- Is there any other feedback you would like to provide?

Cenpatico will review all completed Participant Interview forms and summarize them into a report for further analysis. The Participant Interview form was instituted in January, 2009 for immediate use across our Cenpatico of Arizona organization. These forms will be completed twice a year with each intake treatment provider. Preliminary outcome results are pending an initial review and analysis.

Cenpatico also is experienced in data collection for the Correctional Officer Offender Liaison (COOL) program. While not specifically consumer reported outcome activity, it is an example of data that is used to track outcomes for consumers. The COOL database was designed to monitor and track all referred COOL participants that receive substance use treatment. This process begins when an Arizona Department of Correction’s Parole Officer refers a parolee for substance use treatment. The referral is entered into the COOL database by the Cenpatico COOL program coordinator. The parolee is referred to a contracted treatment provider located near their residence. The treatment provider contacts the parolee to schedule an intake appointment to assess the participant for the appropriate level of substance use treatment. Treatment recommendations can include outpatient counseling, intensive outpatient counseling and residential based treatment. Throughout the duration of the participant’s treatment episode, providers are required to submit a COOL program monthly progress report which is uploaded to the COOL database. The COOL database collects data on twelve domain areas, five of which are listed below:

- Total number of COOL referrals received
- Number of Clinical intake appointments completed
- Total number of participants eligible for Arizona Health Care Cost Containment System (AHCCCS) plan
- Participants who receive treatment services
- Number of participants who completed treatment

Cenpatico of Arizona: COOL program FY 08								
Table 2								
Number of referrals	Clinical Intakes Completed	% of total	Number of total placed on AHCCCS	% of total	Participants who received treatment services	% of total	Treatment completed	% of total
<b>509</b>	<b>375</b>	<b>75%</b>	<b>120</b>	<b>34%</b>	<b>278</b>	<b>54%</b>	<b>82</b>	<b>16%</b>

Information summarized in the table above is generated each quarter and submitted to the Arizona Department of Health Services. Cenpatico completes analysis of the data to determine a wide range of

outcomes from the aggregate, for example attendance and the percentage of participants who completed treatment. Outcomes are shared with the providers through bi-monthly meetings, regional trainings and one-on-one sessions.

### References:

State	Program	Name	Title	Phone	E-Mail
Georgia	Peach State Health Plan; <i>MH Process Measures</i>	Bobbi Crimm	Quality Improvement Director	(800) 218-7453	<a href="mailto:bcrimm@centene.com">bcrimm@centene.com</a>
Texas	Superior Health Plan; <i>MH Clinical or Functional Outcome Measures</i>	Tom Wise	President & CEO	(800) 218-7453	<a href="mailto:twise@centene.com">twise@centene.com</a>
Arizona	Quality Management Operations, ADHS/DBHS; <i>SA Consumer-Reported Outcome Measures</i>	Carolyn Dempsey	Performance Improvement Specialist	(602) 364-4644	<a href="mailto:dempsec@azdhs.gov">dempsec@azdhs.gov</a>

**b) Describe the Bidder’s experience with implementing instruments in publicly funded managed care programs that assess changes in functional status and/or recovery. Specify the tools, the populations and subpopulations of consumers with whom the tools were applied, the size of the sampled groups, the nature of the findings, and what was done with the captured information.**

**Mental Health Satisfaction Survey:** Cenpatico has experience in implementing instruments to assess changes in functional status as well as general satisfaction with mental health services. Cenpatico of Arizona (Cenpatico) has administered the Mental Health Statistical Improvement Project (MHSIP) survey annually in 2006, 2007 and 2008. The survey measures effectiveness of treatment services using measures of symptom reduction or management and measures of functional status. The survey consists of an Adult version, the MHSIP Consumer Survey and a child version, Youth Services Survey for Families. The adult version is a twenty question satisfaction survey with eight additional questions asking about outcomes of care. The satisfaction segment of the survey asks about: the satisfaction with services received; staff willingness to help them; accessibility and availability; cultural sensitivity; their perception of staff belief that they can grow, change and recover; their rights; assistance with finding information related to consumer run programs such as support groups, drop-in centers, crisis phone lines. Choice of responses for each question is: Strongly Agree, Agree, I am Neutral, Disagree, Strongly Disagree and Not Applicable. The outcome questions ask, as a direct result of the services received: I am better able to deal with daily problems; better able to control my life; better able to deal with a crisis; getting along better with family; do better in social situations; do better in school and /or work; my housing situation has improved; and my symptoms are not bothering me as much. Adults are asked to provide their age, gender and ethnicity. The same response choices are provided for this segment of the survey. Additionally, there is a space provided for comments.

The Youth Services Survey for Families is similar in its question structure and responses but is limited to fifteen questions related to general satisfaction and six questions related to outcomes. The time period the consumer is asked to evaluate is the past six months for both survey instruments.

Cenpatico is responsible for the behavioral and substance abuse services to consumers in two geographic service areas (GSA) in the State of Arizona. The State provides the sampling and then Cenpatico is responsible for management of the survey process through its provider network who administer the survey. Results are passed through to the state for data entry and a report by GSA is produced. The entire process takes a year from generation of samples to distribution of the report.

In 2008, we determined that to achieve performance improvement based on key elements captured in the survey, a more timely response was needed. The survey samples were routed by the State of Arizona to Cenpatico with results forwarded back to the State after the survey was completed. We began compiling results prior to routing the surveys to the State therefore expediting their response to the survey results.

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Results were plotted over three years and are available in the Table above (see response “a” of this section under the heading “Improved mental health quality – consumer-reported outcome measures”).

Because results declined in 2008, we sought additional information from consumers to better understand why. Our Quality staff interviewed a sample of one hundred thirty two consumers asking the questions on the survey then asked them to verbalize why they had selected their response. Through analysis of the interview data, we received clarification related to the data and are now working with the State of Arizona to improve results.

With the Departments’ approval, we will use the two versions of the MHSIP to collect data on satisfaction and functional outcomes for members of the Iowa Plan. We recognize this survey is a change from current the process; however, we feel the MHSIP will provide the Iowa Plan a cost effective method for measurement of both satisfaction and outcome data while allowing comparability of results with other states. Sampling would be completed in two phases. First, a sample of Iowa Plan members who had received services for six months or less will be surveyed. This data will demonstrate outcomes early in the cycle of service. The second survey will use a sample of members who had been receiving services for eighteen months or greater. This will provide comparative data as you would anticipate outcomes for this population of people would be improved. Comparative data would also be available through other States using this survey instrument.

This survey instrument provides satisfaction data as well as outcome data for use by Cenpatico and the State. Satisfaction data can be correlated with complaint data to ascertain how well the contractor is performing in meeting its obligations to promote the recovery model. The survey would be administered through the provider network with Cenpatico administering the survey if the sample is inadequate.

**Substance Abuse Satisfaction Survey:** For substance abuse services, Cenpatico proposes to use a survey based on the Oklahoma Department of Mental Health and Substance Abuse Services survey instrument. This survey is ideally administered by the provider of services when there is a service plan update, a program change, or a discharge from services. Ongoing provider training will ensure providers understand the survey process, complete the survey process when indicated, and forward results when necessary to Cenpatico for processing. Cenpatico staff may administer the survey as needed to achieve an appropriate sample size. The service setting is also requested: outpatient, residential, or other. The instrument asks for gender, race, and ethnicity data to assess delivery of culturally competent services. The main body of the survey is seventeen questions that assess general satisfaction with services as well as asking the individual to assess if they will remain clean and sober after leaving treatment, if they plan to attend self-help support groups on their own after treatment, and if they think the length of the treatment program was too short, about right, or too long. Twelve of the questions are rated on a five point scale of Strongly Agree, Agree, I do not know, Disagree and Strongly Disagree.

The survey will be provided to all substance abuse providers to be completed by the IDPH Participant on discharge from services. The provider may elect to administer the survey at other times as appropriate. The survey is completed on discharge then mailed to Cenpatico in a self addressed stamped envelope to maintain confidentiality. Results will be aggregated and shared with the providers of service to improve the program and will be shared with the Departments to supplement National Outcome Measures data received through I-SMART.

**c) Describe how the Bidder would involve Eligible Persons and family members in the quality assessment and performance improvement programs.**

Our model of managed behavioral health care is grounded in the concepts of recovery, resiliency, and results, and as such, consumer and family and broad stakeholder involvement is integral to our quality assessment and performance improvement programs. The Recovery Advisory Committee for Consumers and Families (Recovery Advisory Committee) will play a key role in integration of consumer and family input into the

Iowa Plan QAPI initiatives. Through the Recovery Advisory Committee, Eligibles and families will have input into development of the annual Quality Improvement Program, annual work plan, development of performance measures and the establishment of benchmarks or thresholds for performance and operational issues impacting quality of service and quality of care. They will also participate in a review of the annual Quality Program Evaluation to gauge success and opportunities for improvement and to set the direction for the next year. Recovery Advisory Committee members will have input as well as assist in the development and structure of performance improvement projects. Members of the committee will evaluate results of the annual provider satisfaction survey to inform them of operational issues key to providers that may impact their availability and accessibility and their general satisfaction with Cenpatico.

In addition to participation in the Recovery Advisory Committee, consumers and/or their families have alternative avenues to provide input: the grievance process, participation in consumer surveys, focus group, and/or community forum participation. The grievance process allows Eligible Persons and family members to submit their concerns individually and receive a response within fourteen days. Grievances are then utilized to inform our Quality processes. For example, grievances related to access will be addressed individually but also will be assessed aggregately as they may pertain to the adequacy of the provider network. A grievance related to a quality of care issue or a critical incident may be viewed independently; however, our process of reporting compiled quality of care complaints and critical incidents each quarter allows us to identify trends that may indicate whether action needs to be taken to resolve patterns of poor quality from specific providers.

Our Member Services team will host focus groups for Eligible Persons and family members at least quarterly. These are open forums for discussion of any item that is of concern to the participants. Member services staff will communicate identified issues/concerns regarding service provision/gaps, accessibility, capacity, and quality of care to the Quality team for appropriate follow up.

**d) Describe the way in which the Bidder would utilize state pharmacy data to:**

- **Identify utilization that deviates from clinical practice guidelines for schizophrenia and major depression, and**
- **Identify those Enrollees whose utilization of controlled substances warrants intervention either because of multiple prescribers, excessive quantities or prescribing that is inconsistent with the clinical profile of the Enrollee.**

Cenpatico would utilize Iowa pharmacy data similar to the way it does for the StarHealth (Foster Care) Program in Texas. We have developed an automated pharmacy claims analysis process which identifies members who are outside specific medication utilization parameters (“outside parameters”). Our current key triggers include members who are prescribed psychotropic medications for more than 60 days and:

- are under the age of 4 years
- are prescribed 5 or more psychotropic medications
- are prescribed 2 or more stimulant medications from different classes
- are prescribed 2 or more atypical antipsychotic medications
- are prescribed 3 or more mood stabilizers.

The automated process is able to screen thousands of prescriptions, physical health and behavioral health claims on a monthly basis. Members who are identified as being “outside parameters” by the automated screening process are reviewed by Cenpatico clinical staff. They obtain the most recent information regarding the member’s diagnoses, medication regimen, response to treatment, copies of psychological evaluations, psychiatric evaluations, and treatment progress notes. If this information reveals that a member’s medication is outside parameters, accepted practice, or is causing significant side effects, the case is forwarded for a formal Psychotropic Medication Utilization Review (PMUR). Cenpatico medical management triages the PMUR request to consultant psychiatrists who review the available information, do peer-peer outreach with the prescribing physician, and make one of the following determinations:

- PMUR not Needed
- Medication regimen is within parameters
- Medication regimen is outside parameters but within standard of care
- Medication regimen is outside parameters and there is opportunity to reduce polypharmacy
- Medication regimen is outside parameters and there is evidence of inappropriate prescribing or significant side effects

In cases where medications regimens are outside the parameters, and there is evidence of inappropriate prescribing, we initiate a Quality of Care (QOC) review, and facilitate the member obtaining a second opinion or care with a new provider. In cases where the medication regimen is outside set parameters, the case is triggered for re-review in 60 and 90 days to determine if there have been changes to the medication regimen to bring it within parameters. Since implementation last year of PMUR for Texas foster children, there has been a 13% decline in the number of foster children prescribed psychotropic medications overall and specifically a 74% decline in polypharmacy.

Reporting from our current automated system can be modified to generate prescribing profiles for specific diagnoses such as Schizophrenia or Major Depression, utilizing parameters that can be defined specifically for the Iowa Plan, and provide a profile of physicians' prescribing patterns over time. Additionally, we can modify or add additional triggers to identify members who are receiving prescriptions above a specific limit for controlled substances (stimulants, narcotics, etc), or are receiving overlapping prescriptions from more than one provider.

**e) Identify what the Bidder believes to be the greatest opportunities for quality improvement in public managed behavioral health programs like the Iowa Plan. Discuss the approaches the bidder would pursue to realize two such opportunities in Iowa.**

We believe that the general areas of greatest opportunity for quality improvement of public managed carve out behavioral health programs are:

**(1) Transformation of behavioral health delivery systems to recovery-oriented systems**

**and**

**(2) Physical-mental-substance abuse healthcare integration.**

*The financial impact of moving forward in realizing these opportunities is that consumers who have access to and utilize the most appropriate services for their stage in recovery, ultimately recover sooner and are able to maintain successful recovery within their communities, resulting in less costly care over their lifetimes.*

Realization of a recovery-oriented service delivery system that provides integrated care begins with restructuring the existing network to include Comprehensive Service Providers (CSP) for each region. A CSP is a locally focused multi-service agency that in addition to offering access to a full continuum of outpatient and waiver services will function as a service coordination hub for high needs individuals. We will negotiate with existing Community Mental Health Centers (CMHC) and other multi-service agencies in the six IDPH regions of Iowa to develop at least two CSP per region. Our regionally focused network model will provide the structure to build statewide availability for required services; it starts by developing the strengths of existing local assets and focuses targeted resources to address specific local service gaps.

Our contracts with CSP, and all network providers, will require them to operate within the context of a recovery model of service delivery. We will give preference to providers who offer mental health services *and* are IDPH licensed substance abuse treatment agencies in developing each CSP, in order to facilitate integrated treatment and service planning and ease of access for Eligible Persons. We will negotiate contracts

with CSP that require direct access and/or coordination of access to the full continuum of the Iowa Plan's Covered and Required Services, and thus provide a viable structure for increased integration and coordination of services. Optional Services will be defined and included in the service continuum based on regional/local need, in order to increase access to community based services that promote recovery. CSP will be required to offer adequate levels of peer support services to meet the locally-defined need.

By year two of the contract we will negotiate with at least one CSP per region to offer onsite services of a medical professional to further move toward true integration of healthcare. Another specific contractual requirement for CSP will be the implementation of consumer-driven coordinated service planning processes that support individuals' recovery by collaboratively assessing all life domains, and providing connections to needed services and resources outside the Iowa Plan benefit structure, including with FFS medical providers, MCO, and MediPASS providers. This will be accomplished through memorandums of understanding, business agreements, and informal collaborative efforts with other providers and community resource agencies. We will ensure that CSP meet contractual requirements by providing training, technical support, monitoring and auditing, data analysis and feedback, and initiating data-driven quality improvement activities as needed when deficits are identified.

Another approach to realizing integrated services for Iowa Plan Eligibles is an innovative product known as **Health Passport** which supports increased sharing of information resulting in improved integration and coordination of services and greater overall quality of care and cost efficiencies. In partnership with Superior Health Plan and the Texas Health and Human Services Commission, we implemented *Health Passport* to serve the foster care population in Texas. *Health Passport* features a secure web based application that houses data from various sources, including: demographic data from the State's foster care delivery system, pharmacy data for the state's pharmacy benefits manager, immunization data from both the state's immunization registry and data from the medical home, visit based data input into the system by the medical home, medication and environmental allergies, behavioral health assessments, treatment summaries, service plans and crisis plans from the various behavioral health providers participating in the care of the consumer. Role-based accessibility options are available to registered service providers with appropriate processes in place to obtain required consents for release of confidential information when needed. Providers who currently use the *Health Passport* have identified the ability to view a snapshot of the consumer's history and the issues covered with past clinicians as the most helpful feature. Second to that, providers also highlight reviewing the medication history as a useful tool in identifying previous treatment successes and failures. For the Iowa Plan, participation in *Health Passport* will be offered to Eligibles on an opt-in basis during year two of the contract, with an intensive outreach and education campaign during the first year targeted at engaging Eligible Persons and service providers.

**f) Describe the bidder's experience in adapting policies or sources based on input from publicly funded consumers and from advocacy groups. Describe the measured impact of the changes based on quality assessment studies, feedback from affected groups, or other data.**

**Include the names of programs and provide the names, telephone numbers, and e-mail addresses of consumer advocacy groups that can be contacted to verify the description submitted by the bidder.**

We have significant experience integrating input from publicly funded consumers, families and advocacy groups into the quality program to make meaningful changes in our policies, processes, and procedures. Because our Cenpatico of Arizona contract allows us the most latitude to do this, we have numerous relevant examples from that market which are readily applicable to the Iowa Plan:

Upon being awarded our Arizona contract in 2005, we began convening separate community advisory council meetings, with participation by consumers, families, advocacy groups and providers, in each of two geographic service areas (GSA). During the first year of the contract we learned from these meetings that the geographic (rural and non-rural) and cultural diversity of the communities across these GSA was significant and therefore we increased the number of community meetings from two to six to allow more local

focus. We also convened specific consumer and family advisory council meetings in addition to the more general community advisory council meetings to ensure that we clearly hear the voices of the publicly funded consumers and their family members in obtaining input to help adjust and adapt our policies and procedures to meet their needs. In addition to expanding the number of locally-focused venues to increase opportunities for consumers to provide input within the context of their geographic and cultural diversity, other specific changes made in response to consumer and advocacy group feedback include:

- Supported a provider agency in the development of a juvenile sex offender program.
- Provided technical assistance and support to local providers and judicial system for the development of a Mental Health and Drug Court.
- Supplied grant writing and technical assistance resulting in obtaining funding for Level IV treatment facility for treatment of consumers using methamphetamine.
- Collaborated with local community agencies to develop and fund a training program, called Meth 101, that has produced 120 trained community members who each committed to do at least two presentations each across the county of basic education regarding methamphetamine use and its impact

### References:

Program	Name	Title	Phone	E-Mail
United Way of Pinal County, Meth 101	Charity Russell	Executive Director	(520) 836-0736	<a href="mailto:charity@unitedwayofpc.org">charity@unitedwayofpc.org</a>
Mental Health and Drug Court	Ron Harris	Assisted Living Facilities Coordinator	(520) 866-6271	<a href="mailto:ron.harris@co.pinal.az.us">ron.harris@co.pinal.az.us</a>

In addition to actively seeking input from consumers, families, and advocacy groups, we employ consumers within our organization. We employ a self-identified prior recipient of mental health services as our Recovery and Resiliency Advisor. His input has resulted in the development of a broad-based Community Advisory Committee that includes members of National Alliance on Mental Illness, Mental Health America, and other community based groups. Input received from the perspective of the consumer drives our quality program from the need for peer support services to opportunities for integration with the medical health care received by consumers. Active consumer representatives will bring the value of their personal recovery story and their real-life experience to the Iowa Plan QAPI processes. The consumer representative will be asked to address: cultural competency aspects of the QAPI program, engagement and information offered to consumers, availability and accessibility of the network, outreach methods and practices used by the Contractor staff, and access availability and cultural competency of the organization.

**g) Describe the process by which the Bidder would conduct retrospective monitoring of all substance abuse service providers in accordance with Section 5.D.1.2. The description should include:**

- **The source of the evaluation tool with which the Bidder would assess the appropriateness of clinical services delivered, and**
- **What actions the Bidder would propose to take with a provider who it has determined does not deliver services or follow contract guidelines appropriately, both in the event of an initial finding and of a repeated finding.**

**Retrospective Monitoring Process:** Cenpatico will retrospectively monitor substance abuse service providers on a quarterly basis using EBP fidelity audit tools, CPG, utilization management guidelines, and other data collection tools as necessary to review clinical records. This monitoring process is operationalized via on-site record reviews, by CADAC or ACADC Clinical Quality Assurance Coordinators and/or by CADAC or ACADC Utilization Managers. These Cenpatico staff members collect data related to: access to care; claims/encounters and service mix; complaints; appropriateness of levels of care and use of evidence-based practices (EBP) and/or clinical practice guidelines (CPG); decision-making opportunities for Eligible Persons and their families to guide their recovery; integration and coordination of services; contractual compliance; accuracy of I-SMART data reported; use of IDPH funds as payment of last resort for IDPH participants; and other program requirements.

The Director of Quality Assurance and Performance Improvement (QAPI), with support from data analyst staff, then compiles and analyzes the data. The Director reports summary data to our internal QAPI Committee, the Recovery Advisory Committee, the Clinical Advisory Committee, and the Iowa Plan Advisory Committee for review and recommended action. The Director will also have responsibility for overseeing the process of developing and implementing data-driven quality improvement activities for internal process improvement and to address systemic issues, and for communicating provider-specific deficiencies to the Network Management department to be addressed via education, training and corrective action planning as appropriate.

**Evaluation Tools to Assess Appropriateness of Clinical Services:** For substance abuses services provided to Iowa Plan Eligibles, we will use the American Society of Addiction Medicine’s (ASAM) Second Edition – Revised Patient Placement Criteria (**ASAM PPC-2R**) to assess whether clinical services delivered were at the appropriate level of care for individual need. We will use our internally-developed **Cenpatico Chart Audit** tool to gather data regarding screening, assessment, service planning, and treatment processes. We will also implement **fidelity audits** developed first by Cenpatico of Arizona, related to key components of recovery and resiliency, including consumer leadership and family involvement in service planning. These fidelity audits also include a review of organizational charts, interviews with provider staff involved in the service planning process, interviews with managers and leadership within the provider agency, review of program descriptions, and “spot” audits of charts.

Fidelity audits are part of an overall provider monitoring system aimed at ensuring consumers receive the right services to support their individual recovery goals. Cenpatico of Arizona designed and implemented a tour fidelity audit process for the two Service Delivery Areas for which it serves as the Regional Behavioral Health Authority. The process has been so successful that the State of Arizona now requires all Regional Behavioral Health Authorities statewide to utilize the fidelity audits as designed by Cenpatico of Arizona.

**Actions to Resolve Inappropriate Service Delivery or Contract Non-Compliance:** Cenpatico follows a formal process to correct provider performance issues. Performance issues are discovered through audits, complaints, quality of care reviews, and analysis of key data as described above, as well as by ad hoc reports of service deficiencies or provider non-compliance by any Cenpatico employee. When an initial performance issue is identified, a Corrective Action Letter, reviewed by the Director of Network Management and signed by the Director of QAPI, is sent to the provider. This Letter defines the problem and requests that the provider review the issue and take corrective action. A Clinical Provider Liaison then contacts the provider and together they develop an Individualized Provider Performance Work Plan to address the issues identified in the Corrective Action Letter. The Work Plan is then reviewed with the provider two times per month, and against additional data collection and analysis, to ensure that the actions taken remedy the identified issue. The Provider Liaison provides technical assistance and arranges for training as appropriate to ensure the provider understands the compliance issue and has the resources to take appropriate corrective action.

In the event the provider is unsuccessful in addressing the compliance issue, the Director of Network Management issues a letter indicating the provider is in violation of the contract with Cenpatico and provides a timeline in which the issue must be corrected and the consequences if the issue is not corrected within the state timeframe. Failure to remedy the issue may result in termination of the contract. Providers with contracts in excess of \$250,000 per year include sanctions for non-compliance with contract requirements. Sanctions offer a step prior to termination of contract to achieve compliance. It has been our experience that these progressive compliance actions produce contract compliance and ensure accountability. Providers who demonstrate a pattern of recidivism after repeated identification of same or similar non-compliance issues are subject to termination. Our Network Management department is always involved in these decisions and aggressively pursues additional providers or expansion of services by remaining providers to resolve any service gaps that might result from provider terminations.

h) Provide a copy of a 2008 QA Plan that the Bidder developed for a publicly funded client.

Please see: *Attachment – 2008 QA Plan for Cenpatico of Arizona* located in the Attachments Appendix at the end of this proposal.

**7A.2.16 Prevention and Early Intervention**

- a) Describe the strategy that the Bidder will invoke in order to increase access to and utilization of prevention and early intervention services. Describe the Bidder’s experience in implementing such strategies under other contracts. Describe the measured impact of such programs in terms of changes in the process and outcomes of care. Include the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

**Assessment of Iowa’s Needs for Prevention and Early Intervention:** Access and utilization of prevention and early intervention programs are hindered by lack of collaboration and coordination; Cenpatico’s strategies of Asset Mapping, Strategic Prevention Framework, and our Comprehensive Service Provider network model will address these barriers. Program ownership, funding issues, absence of a common vision and strategy for implementation become barriers for prevention and early intervention programs when there is no mechanism to require a cross-system approach to effect real improvements for communities. Cenpatico will use *Asset Mapping* to improve access and utilization for prevention and early intervention programs. Asset Mapping is a structured approach to gathering data. It builds on identified community strengths and utilizes local coalitions to achieve buy-in and involvement for overcoming gaps in services or accessibility and then works to build community. Community buy-in develops into a shared vision for implementing plans and programs that address gaps in service accessibility. Cenpatico will coordinate with established local coalitions to meet identified local needs.

We will support and enhance Iowa’s existing prevention community coalitions such as the Drug-Free Communities programs which are currently funded by the Substance Abuse Mental Health Services Administration (SAMHSA). These programs identify needs and develop opportunities for general and specific outreach and communication, based on population and utilization analysis. Toward this end, we will employ SAMHSA’s *Strategic Prevention Framework (SPF)* logic model to build on the successful components of the current system including existing programs targeted towards youth substance abuse prevention and under-age drinking. We will expand on these programs through community reinvestment funding and targeted outreach and education.

Strategic Prevention Framework (SPF) facilitates community-based action and works to reduce community-based risk while increasing resiliency factors. This approach to prevention uses the principles, depicted in the graphic<sup>29</sup>, to guide programmatic activities. While these principles are a requirement for SAMHSA State Incentive Grant recipients, Cenpatico will utilize this framework for advancing all prevention and early intervention programmatic development goals as they are easily adapted to any community to improve collaborative solutions and increase prevention activities. The SPF logic model builds on the cultural strengths of communities to develop programs that are sustainable beyond an initial funding phase. To achieve this, communities must systematically:



<sup>29</sup> SAMHSA Strategic Prevention Framework: Overview [http://download.ncadi.samhsa.gov/csap/SPFSIG/spf\\_overview.doc](http://download.ncadi.samhsa.gov/csap/SPFSIG/spf_overview.doc)

1. **Assess** their prevention needs based on epidemiological data,
2. Build their prevention **capacity**,
3. Develop a strategic **plan**,
4. **Implement** effective community prevention programs, policies and practices, and
5. **Evaluate** their efforts for outcomes.<sup>30</sup>

With coalition support, we will implement successful prevention and early intervention programs in Iowa that Cenpatico has employed in other areas targeting suicide prevention, anti-stigma programs for elementary schools, methamphetamine/substance abuse prevention, perinatal depression, and behavioral health outreach programs for seniors.

We believe that through our *Comprehensive Service Providers (CSP)* system we will be in a unique position to implement these specific strategies aimed at effecting system transformation. Utilizing the CSP model will increase access and utilization for prevention and early intervention programs as the CSP will act as a clearing house for all information about prevention and early intervention programs in the region. CSP will be contractually obligated to Cenpatico to maintain business or referral agreements with all other agencies, services, or programs in their region, for services covered or non-covered. This will increase ease of access as one agency is able to coordinate service needs with other agencies, individual providers, and community resources. The CSP offers a choice that simplifies access for consumers who require multiple services or participate in several programs to meet their recovery needs.

Cenpatico's local approach to care allows for responsiveness to specific needs identified within the culture of our communities. As a result, Cenpatico is poised to develop, collaborate, and facilitate prevention and early intervention services that have the most impact for the needs of the consumers in each market.

**For Iowa:** Cenpatico will continue its progress with prevention for Iowa Plan Eligible Persons. Through a collaborative approach with Eligible Persons, CSP, other providers, community supports and state agencies, Cenpatico can deliver a comprehensive prevention initiative targeting at-risk populations. We will identify local needs with input from the community and develop a strategy to address priority needs based upon consensus and best practices. Upon contract award, and with the support of community coalitions, we will support, implement, or develop prevention and early intervention programming including but not limited to:

- **Perinatal Depression Program** in Iowa to improve access and utilization of services at a critical impact point for the mental health wellness of both mother and child,
- **anti-stigma and anti-bullying programs for children and adolescents, and**
- **Meth 101 Training** for communities and schools.

**Cenpatico will also seek to implement or support programs for suicide and substance abuse awareness prevention program for older Iowans.** As the focus of the Iowa Plan for Behavioral Health has expanded to include prevention and early intervention needs for older Iowans, we are uniquely qualified through our experience supporting and developing programs for this high needs population. Our Iowa program will be similar to the **Ambassador program in Arizona**. Cenpatico will collaborate with Iowa's thirteen Area Agencies on Aging to train "Ambassadors" which will then train and work closely with Area Agency on Aging staff in implementing educational strategies that work towards increasing awareness regarding the risks associated with substance abuse, depression and suicidal behaviors. This strategy of older adult peer educational outreach ensures caregivers, health care professionals, and direct care staff for the older Iowan are aware of the needs of this population and can then make an appropriate intervention.

**Arizona Experience:** Cenpatico of Arizona contracts for primary prevention programs designed to change behaviors, increase knowledge or skills. All programs are based on identified community needs using

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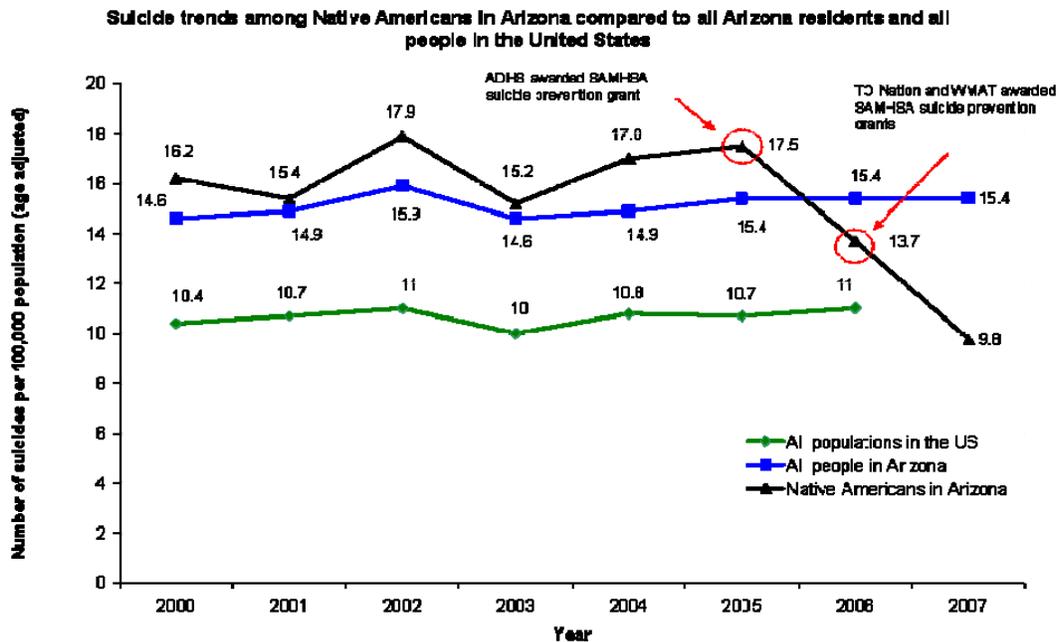
<sup>30</sup> SAMHSA Strategic Prevention Framework: Overview [http://download.ncadi.samhsa.gov/csap/SPFSIG/spf\\_overview.doc](http://download.ncadi.samhsa.gov/csap/SPFSIG/spf_overview.doc)

primary and secondary data, evidenced based with measurable outcomes evaluated by an independent evaluator. We use, and support programs designed using, the **Strategic Prevention Framework** (SPF) logic model and have measurable outcomes using National Outcome Measures (NOM) and program measures.

**Ambassadors:** The *Ambassadors* program recruits and trains community volunteers to identify and help address behavioral health, access to services, and other needs for older adults. Training includes learning community resources, referral processes, building partnerships, identifying depression, mandatory reporting, listening skills, and confidentiality. The *Ambassadors* program was awarded the Center's for Substance Abuse Prevention (CSAP) *Service to Science* award. This Cenpatico funded program has become an evidence-based program meeting the criteria for SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). By the end of 2008, 40 community members were actively engaging in mobilizing their respective communities. An additional 17 Ambassadors are now trained and working closely with community stakeholders to reduce depression and isolation and improve safety and health factors by mobilizing community resources to meet the needs of older adults. Supported by the Pinal Gila Council for Senior Citizens, "Ambassadors" are trained on educational strategies that increase awareness of the risks associated with depression and suicidal behaviors among the elderly. One measured impact of these educational programs is a 7.53% increase in risk-behavior knowledge between pre- and post-testing following educational interventions.

**Suicide Prevention among Tribal Communities:** Cenpatico recently received recognition from the state of Arizona for its role in the Arizona Suicide Prevention Coalition. We were awarded grant funding to address the historically high rate of suicides among Native Americans in Arizona due to the need for, and our expertise in, implementing programs. Working with the community coalition, the group identified infrastructure development as a primary need to address the rate of suicide in the tribal communities. In response, Cenpatico staff completed the Columbia University Teen Screen certification training and provided six training sessions to teach this evidenced based suicide prevention screening method for implementation in tribal communities in Arizona. Funds were also used to provide Living Works *Applied Suicide Intervention Skills Training (ASIST)* and to expand public information and social marketing efforts.

The impact of these efforts is a significant decrease in suicides among Native Americans. According to ADHS/DBHS, "The suicide rate among Native American populations has dropped below the state mean for the first time in Arizona history. According to data from the Arizona Department of Health Services (ADHS), the total number of suicides among Native Americans in Arizona decreased from 49 in 2006 to 35 in 2007. The age-adjusted suicide rate among Native Americans in Arizona reached a historically lowest level in 2007. Among Native American adolescents 15-19 years old, the number of suicides declined from 13 in 2006 to 5 in 2007, resulting in a 61.5% decrease. Among young adults ages 20-44 years the number of suicides also decreased from 28 to 23, for a decline of 17.9% for this age group." The graph below illustrates trends in suicide completions among Native Americans in Arizona.



Working with broad-based community groups to assess the most critical prevention and early intervention needs, Cenpatico contracted with agencies to further develop the prevention capacity with multiple community-based prevention programs. Two areas agreed upon for support by community stakeholders, including consumers and families, and Cenpatico were depression and suicide prevention programs for older adults and methamphetamine use/abuse prevention. Cenpatico offered a request for interest (RFI) to determine program interest and appropriateness for funding. Cenpatico scored the responses and presented these to the community stakeholders for final approval of successful bidders. Prevention programs not offered specifically through Cenpatico CSP maintain business or referral agreements with CSP to optimize referrals for the programs.

**Kansas Experience:** In 2008, Cenpatico supported the Mental Health Association of South Central Kansas for their prevention program, **I.C. Hope**. I.C. Hope is a program geared towards elementary school children and currently serves the Wichita/Sedgwick County area in Kansas. This is an educational program focused on preventing bullying, reducing the stigma of mental illness, and encouraging kids to seek help for difficult feelings. The purpose of the program is to:

- **Promote good mental health.**
- **Provide a definition of mental illness.**
- **Erase stigmas associated with mental illness.**
- **Identify mental health resources**

In a recent interview with the I.C. Hope program administrator, she reported that one impact of prevention programs in Sedgwick County has been a reduction in the number of disciplinary referrals. In 2007-2008 school year, I.C. Hope gave over 190 outreach and education presentations in Sedgwick County Schools, and in 2008-2009 has so far reached 4,769 students.

**Organization-wide Experience:** Cenpatico provides an organization-wide preventative program for women who are pregnant or in the post-partum stage called the **Perinatal Depression Program**. This program is also an example of an integrated health care initiative as it is coordinated between Cenpatico and Health Plan Medical Management. The purpose of the program is to educate members in the perinatal period about the risks of depression, the signs and symptoms of depression, and to educate the member about accessing services for treatment of depression.

Screening materials are distributed to members identified as pregnant or newly delivered. The screening tool utilized for this program is the Edinburgh Postnatal Depression Scale, which measures likelihood of prenatal or postnatal depression. Our Intensive Clinical Management and Care Coordination staff utilize these tools to identify early indicators of depression, and link Eligible Persons with services before they experience behavioral health crises.

The following is an excerpt from a letter from Kate\*. Kate's letter exemplifies the needs of individuals in the Perinatal Depression Program.

*...I am a twenty-eight-year-old single mother. My son is three and I'm 22 weeks pregnant...The father of my son and unborn baby left us two weeks after I decided not to have an abortion. About a week later, I started to have car trouble and I could not afford to fix the car and make car payments. So, my car has been repossessed. About a week or so later I was terminated from my job because of illness due to my pregnancy. In the midst of it all, my landlord presented me with a statement informing me I that I owe \$727.00 in back rent. My son started Head Start and it was then that I noticed he has grown out of all of the winter clothes that I saved from last year which were very big for him at the time. I'm completely overwhelmed and very depressed. I'm looking for help. If there is any way possible you can help or point me in the direction of someone who can, I would be definitely grateful.... (\* Kate's name has been changed for confidentiality reasons).*

Our Intensive Clinical Manager located community resources that provided Kate help with rent, furniture for her child, clothing, and even food. The ICM contacted Kate regularly to monitor behavioral health progress throughout the pregnancy, note possible physical health risks, and provide resources as requested. In January 2009, Kate gave birth to a healthy baby, and in her last contact with our ICM, she reported that she had no further behavioral health concerns. Early intervention resulted in reduced symptoms and an improved quality of life for the mother and her family. This is the impact our Perinatal Depression Program has on the lives of the people we serve.

#### References:

Program	Name	Title	Phone	E-Mail
Mental Health Association of South Central Kansas, I.C. Hope	Connie Fahrback	Director of Development	(316) 685-1821	<a href="mailto:cfahrbach@mhasck.org">cfahrbach@mhasck.org</a>
Pinal Gila Council for Senior Citizens, Ambassador Program	Olivia Guerrero, MSW	Executive Director	(520) 836-2758	<a href="mailto:oliviag@pgcsc.org">oliviag@pgcsc.org</a>
Buckeye Community Health Plan, Perinatal Depression Program	Shelia Smith	QI Director	(866) 246-4356	<a href="mailto:ssmith@centene.com">ssmith@centene.com</a>

#### **7A.2.17 Management Information System**

**a) Describe in detail the management information system the Bidder would implement for the Iowa Plan. The description should emphasize the way in which the MIS system would function to gather required data and produce required reports as well as providing detail on hardware capabilities.**

Cenpatico, a subsidiary of Centene Corporation, considers a strong Management Information System (MIS) to be a critical element in managing health services for the Iowa Plan. Since 1984, our MIS has supported the data collection, processing, access, and reporting needs of nine publicly funded managed care contracts that serve high needs populations. Our MIS encompasses our organization delivering computing assets, dependability, and innovation for over 1.2 million managed Medicaid beneficiaries throughout the nation. We provide a MIS that will fully support the Iowa Plan data collection and reporting requirements, and which provides *Health Passport* capabilities. *Health Passport* is an innovative technology solution that

provides a consumer-driven recovery-oriented approach to integration and coordination of services and continuity of care.

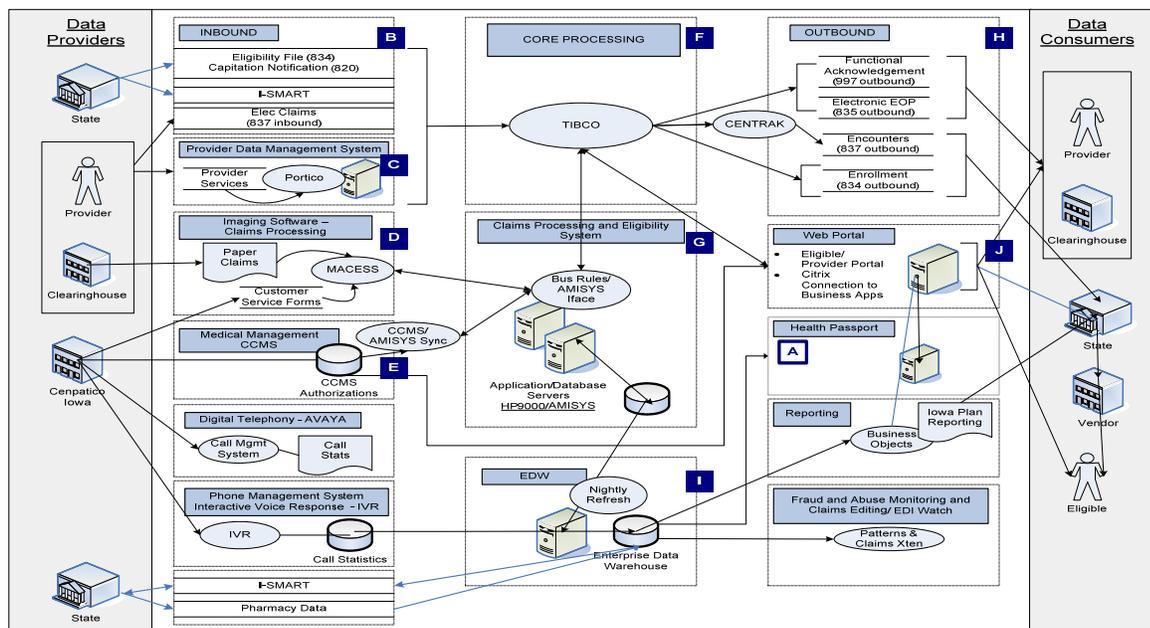
**Overview - IT Team and Technology with Proven Experience:** Our 300+ IT professionals ensure our ability to implement our program solution for the Iowa Plan. We have made significant investments in MIS customizing and implementing applications to better meet public sector needs. We leverage our technology to improve: operational effectiveness; care access; care coordination including use of a patient centric health passport; and overall customer satisfaction. A differentiating factor for us is that our IT staff is solely focused on publicly funded programs; thus creating a specialized knowledgebase from which the Iowa Plan will benefit.

The Cenpatico Iowa IT Program Overview (figure A.1) provides a view of our technology solution for the Iowa Plan. We have labeled our core components including:

- A – Continuity of Care/Health Passport,
- B – Eligibility Management,
- C – Provider Management/Portico,
- D – Inbound Claims Management,
- E – Clinical Management/CCMS,
- F – File Handling and Translation/Tibco,
- G – Claims Processing/AMISYS Advance,
- H – Encounter Delivery/CENTRAK
- I – Reporting and Data Integration/EDW & Business Objects, and
- J – Eligible & Provider Access/Web Portal.

These components as well as our technology infrastructure will be detailed in the following sections. Our response will start by reviewing the reporting/information technologies and then will describe our input or inbound applications and core processing technologies.

**Cenpatico Iowa IT Program Overview (figure A.1)**



**Figure A.1 flow description:** This is a high level example of how the Iowa Plan data will flow through our system. Eligibility data (B) is loaded through our data translation application Tibco (F) and into our core processing system AMISYS Advanced (G). Provider data is loaded into Portico (C) which does a direct feed to AMISYS Advanced (G). An inpatient provider calls for authorization and the clinical notes and authorization details are placed in CCMS (E). CCMS downloads the authorization to AMISYS Advanced (G). Provider sees an Eligible and can view their integrated history in our *Health Passport* (A). A claim is received either via paper, from a clearinghouse or from the web portal (J). A paper claim is scanned into MACESS (D) and then claims data from all sources is passed through Tibco (F) and into AMISYS Advanced (G). AMISYS Advanced adjudicates the claim. Claim, Eligible and provider details are sent to our enterprise data warehouse EDW (I). From there reports can be created either as pre-programmed or on an ad hoc basis. Encounter data is later submitted to the State via the Centrak (H) software. Details of these core applications and technology infrastructure follows beginning in section B below.

**Cenpatico’s master applications map to Iowa Plan Services (figure A.2):** Our IT application architecture emphasizes a best-in-class, fully-supported vendor package strategy integrated with a world-class system architecture delivering a highly inter-operable integrated applications environment.

Application	Vendor	Application Description	Supported Iowa Plan Requirement
Health Passport	Cerner and Centene Corporation	Care Coordination	<ul style="list-style-type: none"> <li>Maintain data to support medication management activities</li> </ul>
MACESS.exp	SunGard Workflow Solutions	Appeals, grievances and complaints and quality management - Imaging, OCR, workflow management, customer support, and document management for Members and Providers	<ul style="list-style-type: none"> <li>Maintain data on clinical reviews, appeals, grievances and complaints and their outcomes</li> </ul>
Portico Provider Management	Portico Systems	Provider network management, credentialing & data repository (2009)	<ul style="list-style-type: none"> <li>Maintain information and generate reports required by the performance indicators established to assess the Contractor’s performance</li> <li>Ensure that data received from providers is accurate and complete by               <ul style="list-style-type: none"> <li>verifying the accuracy and timeliness of reported data;</li> <li>screening the data for completeness, logic, and consistency, and</li> <li>collecting service information in standardized formats to the extent feasible and appropriate</li> </ul> </li> </ul>
Emptoris Contracting	Emptoris, Inc.	Contract Management and Reporting	<ul style="list-style-type: none"> <li>Ensure that data received from providers is accurate and complete by               <ul style="list-style-type: none"> <li>verifying the accuracy and timeliness of reported data;</li> <li>screening the data for completeness, logic, and consistency, and</li> <li>collecting service information in standardized formats to the extent feasible and appropriate</li> </ul> </li> </ul>
CENTRAK	Centene Corporation	Encounter tracking, history and resubmission system	<ul style="list-style-type: none"> <li>Provide encounter data to DHS in a format specified by DHS</li> </ul>

Application	Vendor	Application Description	Supported Iowa Plan Requirement
AMISYS Advance	DST Health Solutions, Centene Corporation	Eligibility and enrollment, referrals/authorizations, claims processing, provider status/eligibility, pricing, and provider payments	<ul style="list-style-type: none"> <li>• Maintain an Enrollee database, using Medicaid state ID numbers, on a county-by-county basis which contains eligibility begin and end dates; enrollment history; utilization and expenditure information (Enrollees only)</li> <li>• County of legal settlement for Enrollees shall be included in the Contractor’s management information system subsequent to a written agreement with a county or a county’s representative to provide and update such information as well as to provide required consumer releases (Enrollees only)</li> <li>• Conduct Claims Processing and Payment</li> <li>• Maintain data documenting distribution of the capitation payment according to the proposal submitted by the Contractor</li> <li>• Maintain data on third party liability payments and receipts</li> <li>• Maintain data on the time required to process and mail claims payment</li> <li>• Maintain a database, using I-SMART, state ID number, on a county-by-county basis which contains information</li> <li>• Maintain all data in such a manner as to be able to generate information specific to mental health and substance abuse services; and for substance abuse services, between services to Enrollees and IDPH Participants</li> </ul>
CareEnhance Clinical Management Software (CCMS)	McKesson Health Solutions	Care Management (case, disease, authorization, incident reporting and utilization management)	<ul style="list-style-type: none"> <li>• Maintain a database which will incorporate required clinical information (from Section 6.3) on those Enrollees who access mental health and substance abuse treatment</li> <li>• Maintain critical incident data</li> <li>• Maintain clinical and functional outcomes data and data to support other QA activities such as provider profiling and Iowa Plan Eligible Persons and provider satisfaction surveys: CCMS for outcomes data, AMISYS for claims behavior and protected desktop databases for survey results</li> <li>• Maintain data on services requested, authorized, provided and denied</li> <li>• Maintain data on incurred but not yet reimbursed claims</li> <li>• Maintain data on all service referrals for mental health and substance abuse treatment outside the Iowa Plan</li> <li>• Maintain all data in such a manner as to be able to generate information on Enrollees by age of Enrollees and to identify Enrollees who are referred to CW/JJ services: CCMS will capture the clinical referral, AMISYS Advanced with have a system code for CW/JJ services, EDW will capture the system code for reporting</li> </ul>

Application	Vendor	Application Description	Supported Iowa Plan Requirement
Enterprise Data Warehouse (EDW)	Centene Corporation	Enterprise Business Intelligence and Reporting platform	<ul style="list-style-type: none"> <li>• Maintain information and generate reports required by the performance indicators established to assess the Contractor's performance</li> <li>• Maintain data to support medication management activities</li> <li>• Maintain data documenting distribution of the capitation payment according to the proposal submitted by the Contractor</li> <li>• Maintain the capacity to perform ad hoc reporting, with a turnaround time to average no more than five working days</li> <li>• Make all collected data available to the Departments and to the CMS, upon request</li> </ul>
People Soft Financial	Oracle	Financial Reporting	<ul style="list-style-type: none"> <li>• Maintain data on incurred but not yet reimbursed claims</li> </ul>

**Infrastructure Supporting Data Analysis and Reporting:** Data access is critical to delivering the best care in the most efficient manner. Towards this goal, we have several features built into our management information system that not only provides information and reporting to our staff and the State, but also to our providers. The key features for data access are the *Health Passport*, the Enterprise Data Warehouse (EDW) and our web portal.

**Health Passport:** Cenpatico's *Health Passport* (component A on figure A.1) delivers a consumer-driven recovery-oriented approach to integration and coordination of services and continuity of care through key features such as collection of patient demographic data, clinician visit records, treatment/service plans and/or crisis intervention plans, pharmacy data stratification with interaction alerts and other appropriate documentation, both electronic and scanned from paper. Providers who currently use the *Health Passport* have identified the ability to view a snapshot of the eligible's history and the issues covered with past therapist(s) as the most helpful feature. Second to that, providers also highlight reviewing the medication history as a useful tool in identifying previous treatment successes and failures.

The *Health Passport* is a web based application that will reside on the Cenpatico Iowa Eligible and Provider Portal with access anywhere and anytime to authorized individuals. Our *Health Passport* application integrates with all of our applications and most information is filtered through our Enterprise Data Warehouse (EDW). The data is loaded in the data integration layer where data transformations and validations are performed to enhance data quality before sending it to the *Health Passport* repository and made available to the end user interface. It is supported by advanced single sign-on and role-based security, and provides access to our Provider Directory, as well as eligible reference, education, and health information tools. With the Iowa Plan's pharmacy data loaded to our EDW and then to *Health Passport*, providers will be able to utilize reference tools such as medication and allergy interaction checking, as well as medication educational materials. Eligibles and their designated *Passport* users are able to load and/or enter information to *Health Passport*.

Final features will be determined between the Iowa Plan and Cenpatico through final contract negotiations, and can include:

- **Overview Section.** Summarizes an Eligible snapshot of recent activity and newly-added information.
- **Vital Information.** Comments regarding concerns, treatment plans, and progress notes. Areas for comments/treatment plans, which can be edited by Eligibles and Providers is included.

- **Visit History.** Derived from provider input information entered into the system or faxed for inclusion into the system.
- **Medications.** Supported by the Iowa Plan's pharmacy data. This feature will allow Eligibles and Providers to enter over-the-counter, sample, and unfilled medications online for detailed tracking. Other functions include advanced drug interaction checking, allergy alerts, medication pamphlets, warnings, and contraindications. All information will also be available in Spanish.
- **EClipboard.** Will allow Eligibles to complete their health and family histories online and capture other insurance information, supporting our third party recovery activities.
- **EDocument.** Using this feature, Eligibles, Providers and Cenpatico's Iowa service coordinators can update information in the eligible's *Health Passport* account by either direct entry online, or by fax or mail to Cenpatico Iowa. A new option will also allow Eligibles and Providers to upload documents (including scanned documents) from their personal computer directly into their Passport record.
- **Security and Privacy Protection.** The *Health Passport* and our secure web portals will provide the multi-layered security functionality to protect patient privacy. This includes our access management, intrusion detection, and ongoing login monitoring controls. Eligibles will be able to authorize who can have access to their Passport Account, and defined user agreements executed with the Eligible at opt in will allow designated Cenpatico Iowa staff to review/update records.
- **End User Support.** Help Desk support is available Monday through Friday 8am to 5pm Central Time. We will also provide dedicated email address links on the web portals; online training tools for Eligibles and Providers and 24/7 monitoring of Health Passport security, uptime, and performance.

**Enterprise Class Data Warehouse (EDW) Toolset:** Our EDW (component I on figure A.1) is a collection of data from all of our core applications. Due to this integration, Cenpatico is able to generate the required performance indicator reports detailing our delivery of services to the Iowa Plan. Capitation data as well as information regarding child welfare and/or juvenile justice system involvement will be collected allowing reporting against these categories. Our EDW is a proprietary business intelligence and data management platform, utilizing Informatica and Oracle 10g, to provide improved decisions, managed finances, compliance, and better health outcomes by extracting near real-time data from our core and supporting applications. The front-end extraction tool, BusinessObjects, eliminates the need for users to understand complex query rules. Our EDW offers a wide range of existing reports as well as ad hoc reporting capabilities to enable medical management, provider contracting and finance to target opportunities for recovery, resiliency, and results. Reports can be scheduled and automatically placed on a secured server with access through our remote Citrix software where they can be viewed by authorized Iowa Plan resources directly. Cenpatico can meet the requirements of ad hoc reporting turnaround time of no more than an average of five working days with collected data available to the departments and CMS based upon agreed to security rules.

**Access.** Ad hoc analysis tools from BusinessObjects are available at the users desktop providing secured access to information needed to support the business. PHI access is limited to appropriate business users, and both table and row level security is in place to maintain a secure information environment. Real time analysis, scheduled reports, and alerting capabilities are supported through BusinessObjects end user tools. State reports are made available directly to state agencies through a BusinessObjects portal, and external providers can access standard reports through the provider portal.

**Encounters.** The enterprise data integration service provided in the EDW supports the extraction, validation and submission of encounters in conjunction with our custom developed encounter tracking application, CENTRAK. A graphical user interface provides Cenpatico, Encounters Business Operations, and Finance with day to day insight into encounters results. Financial reconciliation of encounters data is further

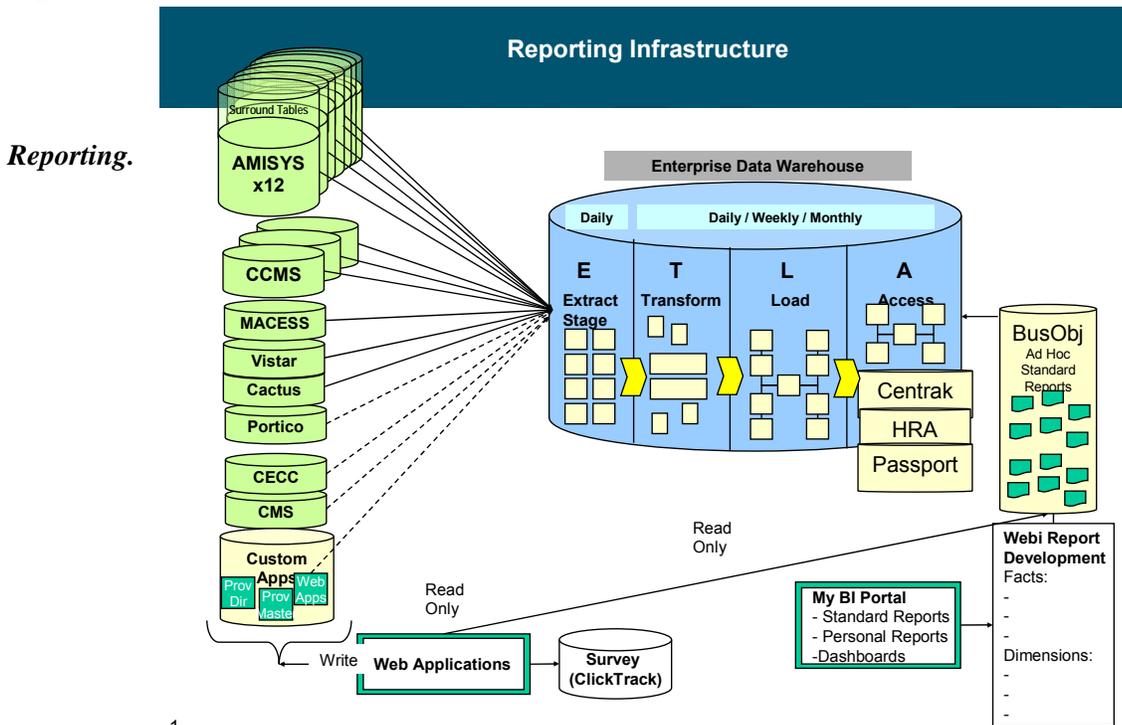
supported with closed loop data analytics re-integrating the results of the encounter process back into the EDW to provide management insight.

The EDW will store medical and integrated pharmacy information, member eligibility and provider data, authorization, care management and risk assessment, appeals and grievances and encounters information. These subject areas contain pre-defined metrics for analysis, as well as drive data for individualized data marts for custom applications in support of care management and operational oversight.

*Infrastructure.* Cenpatico utilizes the internally developed Enterprise Data Warehouse (EDW) and BusinessObjects as the foundation of our enterprise data integration and reporting strategy. In order to optimize on-line and batch transaction performance, Cenpatico’s data management reporting architecture is separated from the transaction processing of the other three core applications. A near real time extract developed using Informatica’s Power Exchange software moves new and changed transactions from AMISYS Advance, CCMS, Maccess, and supporting applications to the EDW staging area. Raw transactional information is then integrated and validated using the Informatica’s Power Center software and loaded nightly for end user analysis into a dimensional data model stored in Oracle 10g and tuned for high speed ad hoc analytics utilizing Oracle SQL, based on the ANSI SQL-99 standard. Security is maintained at the database level by user login; and support both PHI and non-PHI access restrictions, as well as further limitations for care management data, specific health plan data and specific vendor data.

Figure B.1 below, illustrates a high level overview of the EDW data flow from core applications to the reporting layer.

**Figure B.1**



BusinessObjects XI R3, Xcelsius Enterprise dashboarding tool, and Crystal Reports are leveraged for end user standard reports and ad hoc analysis through Centene’s Intranet. End users are able to develop and schedule their own reports, share with other users, and answer “what if” questions using ad hoc analysis tools. This robust reporting tool offers world class functionality to easily extract data and produce reports. BusinessObjects allows business users to easily create queries and create ad-hoc reports without having to understand complex database languages and structures; allows users to easily configure and generate reports in various formats, such as Microsoft Excel, Microsoft Word, and Adobe Acrobat PDF; and enables external

data access via a Secured Web Portal. BusinessObjects provides business users with a web-based analytical reporting tool through a user-friendly, folder-driven interface. Business users need only to have an understanding of the available data or information in order to drill down and view different levels of detail. Through BusinessObjects, a number of business intelligence toolkits have been assembled to continually monitor service utilization and care opportunities. Trigger reports track clinical and administrative events, ensuring care and outreach opportunities are identified as soon as the data is available. Cenpatico shall develop a number of reports such as Claims Aging Summaries, utilization and practice patterns, and provider profiling reports to meet specific Iowa Plan requirements and operational objectives

Enterprise data has been historically used, not only for reports that meet the data requirements or compliance requirements of state and federal authorities, but also to enhance care through identifying those consumers at a high risk. EDW has been used to create reports that identify potential conditions, disorders, and historical trends. In addition to compliance reporting and identifying consumers with potential high risk, the EDW is also the source of many operational reports, including inpatient census data, discharge planning, workload and inventory reporting, and historical trend analysis of claims and clinical data.

**Member and Provider Internet Web Sites:** The Cenpatico Iowa web portal, (component J on figure A.1) is a tool that allows Eligibles and providers to access important information regarding the Iowa plan. Usability reviews and end user feedback have been incorporated in the design of our websites including the user interface (UI) and its functionality. The user interface allows for fast access to content, used by both Eligibles and providers delivering an enhanced user experience.

**Eligible Functions.** Eligibles can use the Cenpatico Iowa portal to obtain information about the Iowa Program. They can download handbooks, forms where applicable, perform online provider searches and obtain health education materials promoting healthy practices. Information and functionality available to include:

Function	Details
Online Forms submission	<ul style="list-style-type: none"> <li>Forms for Eligibles and providers to download and complete offline or submit online electronically if preferred.</li> </ul>
Online Provider Search	<ul style="list-style-type: none"> <li>Search for providers by location or by Provider/Facility Name. Distance to provider or medical facility is calculated in real time and is shown from a starting location or zip code. Search can be refined by specifying detailed parameters such as provider name, distance to the medical facility, language-spoken by the provider, facility type, provider specialty, or healthcare products.</li> </ul>
Secure email to Plan Representative	<ul style="list-style-type: none"> <li>Eligibles are able to correspond directly with Plan representatives via secure email</li> </ul>
General Member Information	<ul style="list-style-type: none"> <li>Information about Health Plan Programs</li> <li>Frequently Asked Questions (FAQ)</li> <li>Calendar of Events</li> </ul>
Special Purpose Information	<ul style="list-style-type: none"> <li>Health education materials</li> <li>Handbooks</li> <li>Policies and Procedures</li> <li>Important phone numbers and contact points</li> </ul>
General Self-service Features	<ul style="list-style-type: none"> <li>How to get help in an emergency</li> </ul>

*Provider Functions.* Providers can access all the information and functions available to Eligibles as well as additional business functions through the interactive, secured portal. These functions streamline provider’s administrative processes and lower the cost of doing business while improving customer service. These functions continue our commitment to Eligibles and providers and put the focus on enabling quality member care.

<b>Member information Functions</b>	
Eligible eligibility search	<ul style="list-style-type: none"> <li>Providers can search for eligibility and information by last name, date of birth, and date of service. Providers can also search for Eligibles by Medicaid ID or Eligible ID and the date of service. Each returned result contains detailed related information such as COB (coordination of benefits) and Eligibility History</li> </ul>
Member Benefits coverage inquiry	<ul style="list-style-type: none"> <li>Providers can verify member benefit coverage online</li> </ul>
Searchable Patient List	<ul style="list-style-type: none"> <li>Providers can view, print, or export to Excel all the patients for a given provider or groups</li> </ul>
<b>Claims Functions</b>	
Claims status search	<ul style="list-style-type: none"> <li>Providers can search for the status of a claim by specifying parameters such as Member Information, Claim Information, and/or Provider Name. Each returned result contains detailed claim status information including service level information</li> </ul>
Claims adjustment submittal	<ul style="list-style-type: none"> <li>Providers can submit requests for claim adjustments online</li> </ul>
Claims Submission	<ul style="list-style-type: none"> <li>For professional providers as well as for institutional providers</li> </ul>
Batch claims submission	<ul style="list-style-type: none"> <li>Providers can submit a batch of claims online in addition to submitting a single claim.</li> </ul>
<b>Online Authorization Functions</b>	
Authorization/referral requests	<ul style="list-style-type: none"> <li>Providers can view Behavioral Health Authorization requests</li> </ul>
Authorization/referral status inquiry	<ul style="list-style-type: none"> <li>Providers can submit inquiries regarding status of Behavioral Health Authorization requests</li> </ul>
<b>EOP and Payment History Functions</b>	
Online Explanation of Payment	<ul style="list-style-type: none"> <li>Providers can view and download Explanations of Payment information</li> </ul>
Payment History	<ul style="list-style-type: none"> <li>Providers can view and download payment history information</li> </ul>
<b>Online Provider Search Functions</b>	
Provider directories	<ul style="list-style-type: none"> <li>Online Provider directories with multiple search options</li> </ul>
<b>Administration Functions</b>	
Website registration	<ul style="list-style-type: none"> <li>Providers will be able to conduct the registration process online. Multiple secured accounts per provider ID are allowed. Everyone in the office or group will be capable of having their own account.</li> </ul>

Formulary List	<ul style="list-style-type: none"> <li>We can load the Iowa Plan formulary for convenience reference for providers.</li> </ul>
Network application submittal	<ul style="list-style-type: none"> <li>Providers can submit network applications online</li> </ul>
Contact Us Form	<ul style="list-style-type: none"> <li>Providers can fill out an online form, submit it, and then correspond directly with plan representatives via secure email.</li> </ul>
<b>General Information</b>	
Training Information	<ul style="list-style-type: none"> <li>Training program topics, schedules, and locations</li> </ul>
Provider manuals	<ul style="list-style-type: none"> <li>Online Provider manuals</li> </ul>
Quality improvements standards	<ul style="list-style-type: none"> <li>Files of Standards and Guidelines</li> </ul>
Downloadable forms available in PDF format	<ul style="list-style-type: none"> <li>Various Forms available</li> </ul>

### **Inbound Applications**

Eligibility, provider and claims data are received on the front end and transferred to AMISYS Advanced, the core processing system for Centene. The following sections detail the infrastructure of each application.

**Membership (Enrollment/Eligibility Subsystem)** Our eligibility subsystem (component B on figure A.1) has the ability to interface with all of the Iowa Plan systems for enrollment capabilities including MMIS and Title XIX eligibility system as well as I-SMART. We receive and transmit enrollment rosters via the HIPAA 834 transaction set or proprietary format. Our TIBCO (component F on figure A.1) iProcess Suite (data mapping and translation application) automates the steps in eligibility processing, while providing visibility into the status at any process step. Efficiencies gained with iProcess have allowed us to better handle the specific membership processing needs and are fully automated through our TIDAL job scheduling software. Utilizing these processes allows us to differentiate between different eligibility groups and funding streams. Our mapping/translation programs validate and map each data item including Medicaid state ID on a county by county basis and begin/end dates to the AMISYS Advance (core claims, eligibility and process application covered later in this section) standard Membership batch input file format; and apply edits such as duplicate eligible record validation, date criteria validity, field data integrity, and valid date spans. Error reports are produced that identify any records with failed edits. Errors that prevent records from loading are modified using error correction routines. Corrected, clean original records are loaded into AMISYS Advance Member tables through Add, Delete, and Modify transactions with accurate begin and end dates. The new or changed eligibility records are loaded into AMISYS Advance through batch routines, and automatically distributed to all appropriate subsystems. Retroactivity and future enrollments are maintained within the enrollment history table within the AMISYS Advance Membership data structure by capturing date span records for processing. During the membership load to AMISYS Advanced, unique product codes will have been setup to differentiate between Medicaid as well as substance abuse Eligibles. As claims are processed within our system this information is cascaded down thereby allowing for reporting by these categories. Data is also captured allowing for identification of Enrollees as well IDPH participants.

**Portico Provider Management.** Portico (component C on figure A.1) is an innovative provider data management system. Portico will be the single repository for all core provider information for the Iowa Plan. Portico supports Provider Prospecting and Recruiting; Provider Contracting via interface with Emptoris (described below); Provider Enrollment; Provider Credentialing; Provider Financial Affiliation Configuration; Provider Data Management; and Provider Directory Management (online and paper). All relevant provider data is entered, updated, and archived within the Portico application, eliminating redundant data entry processes. Portico enhances our ability to ensure that all provider data comes from one governing source, and is fully audited and reconciled before entering our other systems. With this audit and

reconciliation process, Cenpatico is able to ensure that all data is standardized, complete, timely, accurate and therefore able to deliver the required performance reports to the Iowa plan. We have automated interfaces between Portico and our other core systems for tighter data integration, including: AMISYS Advance; TIBCO; MACESS; WebSphere J2EE based web services for EDI, Paper, and web claims; CENTRAK for outbound encounter validation; EDW for data integration and reporting; Emptoris for provider contracting; and with our Provider and Member web portals through Portico Provider Web Directory. Portico also has built in web based geo mapping and Google map capabilities to assist call center and outreach staff in matching Eligibles with providers.

***Emptoris Contract Management.*** Emptoris will allow for full electronic storage and archival of Provider contract information, and will track relevant data in an easily reportable manner. It also will be used to closely monitor and manage provider contracts, issuing relevant reminders to contracting staff when documentation, approvals, and other such contract updates are needed.

***MACESS.exp.*** Maceess (component D on figure A.1) will handle the claims flow operations for the Iowa Plan. This core application allows us to deliver administrative efficiencies through document work-flow management, claims pre-processing, imaging, Optical Character Recognition (OCR), scanning, and customer service. Maceess is used for paper claims administration and for grievance process resolution as well as electronic claims via the Provider Portal, at the option of the provider. Claims that successfully pass upfront edits are processed through custom pre-adjudication edits in order to prepare claims for loading into AMISYS Advance for adjudication. The MACESS system also includes: process modeling; advanced work-flow routing; electronic queuing and tracking of claims; on-line communications between departments; image storage and retrieval of documents; creation and maintenance of standard forms; event triggered correspondence; production of dashboard operations metrics; and superior management and operations reporting. MACESS.exp allows documents to be tagged with image records and is tightly integrated and inter-operable with our other core systems. New claims records are loaded into AMISYS Advance each day from an interface with MACESS. Claims employees are able to retrieve an image of the claim as it is processed in AMISYS. MACESS records are updated to reflect the changing claims adjudication status of each claim.

***CareEnhance Clinical Management Software (CCMS)*** CCMS (component E on figure A.1) will be the toolset that will drive Cenpatico's clinical decision support and work-flow management. CCMS allows our clinical team to provide service coordination efforts; proactively identify, stratify and monitor high-risk populations; consistently determine appropriate levels of care; and efficiently document the impact of the our care programs and targeted interventions. Our system provides a holistic approach to an Eligible's care as it has built bi-directional inbound and outbound process interfaces with AMISYS Advance for automated exchanges of Provider, Member and authorization data.

CCMS also stores critical incident data, clinical and functional outcomes data; requested, authorized and denied services; and service referrals outside of the Iowa Plan. To capture Eligibles who have been referred to CW/JJ services, we will setup a category or note type in CCMS that would indicate a CW/JJ referral resulting in our ability to identify the eligible as well as the Eligible's age. Reporting on all the above mentioned services is available to the Iowa Plan through CCMS.

All information is maintained in CCMS for clinical reviews, appeals, grievances and complaints. Complaint information is also tracked in a secured desktop database with letter generation capabilities documenting the complaint as well as the resolution. Reporting is available to the Iowa Plan from both CCMS and the secured desktop database for all of the clinical reviews, appeals, grievances and complaint services.

***Integration of Pharmacy Data*** Cenpatico has expertise in integrating pharmacy data into our applications. We will integrate the pharmacy information into our *Health Passport*, EDW and our web portal will also include the Iowa Plan's formulary list. Through integration with our *Health Passport*, providers as well as

the Cenpatico clinical staff will see prior prescribing patterns as well as other pharmacy related indicators including drug interactions. This overall integration and reporting provides support for the medication management activities and requirements for the Iowa Plan.

***Highly Operable Technology Infrastructure.*** The Iowa Plan can be assured that our technology and applications reside on a solid foundation. Our technical foundation is based on four design principles: ***Reliability***—providing High Availability through redundancy in our entire computing infrastructure; ***Scalability***—the ability to expand the capacity of our operations without affecting current business operations; ***Flexibility*** – being agile in our IT Architecture, allowing for quick changes based on business demands; and ***Integration*** – using common data across processes to power our unified behavioral care model. We adhere to these principles through an annual review of all computing related equipment, in which we assess our current IT deployment compared with the latest product versions from our vendors and the projected needs of our business for the following year. We then produce a Technology Refresh Plan aligning architecture with our business needs. Together this forms our IT Infrastructure strategy. To execute against this strategy we have established strategic partnerships with recognized leaders in the market to ensure quality solutions in each area. Some of the vendors used in our infrastructure include: Cisco networking, Hewlett-Packard, IBM, Microsoft, Verizon, AT&T, Avaya and others.

Our datacenter is located in St. Louis, Missouri and is home to all of our application services. The datacenter is equipped with four Uninterruptible Power Supplies (UPS) providing redundant, battery backed up power to all IT equipment, designed to mitigate the risks associated with power fluctuations and local incidents. In addition to this, the entire building is backed up with a 3 MegaWatt, 6,600 gallon diesel generator capable of supporting all IT services in the event of a prolonged power outage. A full load test, switching all power loads to the generator, is executed each year to validate its effectiveness. The time to automatically switch to backup generator power is less than 15 seconds resulting in zero downtime for the IT infrastructure.

The datacenter also has three separated Leibert HVAC cooling systems providing zoned equipment cooling. The loss of any one unit, either due to failure or because of maintenance, will not affect our ability to maintain safe operating temperatures. The entire datacenter is protected with an advanced fire suppression system utilizing the clean agent chemical, Novec (or FM-200), in conjunction with a full pre-action sprinkler system creating a complete fire protection system.

***Claims Adjudication Architecture.*** All claims processing and adjudication takes place at the central corporate datacenter in a series of Clustered servers. These servers, fully redundant at each point of failure, store Enrollee, Provider and claims information in an Oracle Enterprise Server® database. They are integrated together, forming a highly available application cluster, using Symantec’s Veritas and Oracle’s Real Application Cluster (RAC) technology. If any node, application, or database experiences a problem within this cluster, the claims processing service automatically redirects to one of the surviving nodes in less than 5 minutes. This same technology is used to facilitate scheduled maintenance activities, eliminating downtime for routine servicing.

***Business Continuity Program (BCP).*** Our BCP is comprised of Business Continuity Planning, Crisis Management, and Disaster Recovery. The BCP addresses recovery requirements including an appropriate location for each business unit based on their priority. The Plan includes mobile recovery solutions that provide flexibility when work force constraints limit geographic relocations. SunGard Living Disaster Recovery Planning Software (LDRPS) manages all pertinent information in a common repository. Annual reviews maintain an evergreen recovery status. Our virtual command center for Crisis Management is the nucleus of information flow after an event is declared.

**System Controls and Balancing** We use Maestro to monitor production data loads. In the case of a job failure, Maestro notifies IS/Operations personnel in the form of an email and a visual alert within the application, and identifies the production job and the reason for failure. In addition, Remedy software is used

to help track end-user computer related inquiries and issues. Remedy tickets are assigned to help desk personnel and resolved in a timely manner.

**Backup, Archiving and Restoring Data** Our backup strategy allows us to manage a recovery scenario in the most efficient and reliable way possible through:

- Automated backups & restores,
- Fast online backups to an automated high speed tape library,
- Fast single file, database or full system recovery,
- A robust Tape Management facility to manage the location and protection of all tape media,
- complete historical cataloguing of all backup data at its location on Tape Media, and
- Automated tape copies for offsite storage and Disaster Recovery needs.

System backups are performed on all servers on a nightly basis using IBM’s Tivoli Storage Manager (TSM). In addition, all database transactions are logged and written to tape multiple times per day, providing a fast and secure online backup for critical business data. All data is written to high speed tapes in a secured, robotic controlled tape library. In addition, AMISYS Advance includes a module that allows us to archive “old” claims, authorization, and membership data. Each morning a full copy of all backup tapes are automatically created and then sent to a secure, climate-controlled, fireproof offsite tape vault.

**Core Processing System Features:** This section details the core processing that will support the Iowa Plan consisting of AMISYS Advanced for overall claims processing/operations, Tibco our translation application handling inputs and outputs for the Iowa Plan, CENTRAK responsible for encounter delivery, Cenpatico Iowa website and our Enterprise Class Data Warehouse (EDW). Cenpatico recognizes data access is critical to delivering the best care in the most efficient manner. Towards this goal, our EDW has several features built into our system that not only provides information and reporting to our staff and the State, but also to our providers.

***Financial Management.*** Centene uses PeopleSoft Financial software to record and report financial data including incurred but not reported claims. All financial transactions are auditable per GAAP guidelines and historical data can be obtained from PeopleSoft through the use of queries and reports. PeopleSoft is integrated with Oracle’s Hyperion Planning and Reporting System which we use to perform advanced analytical reporting, budgeting, and forecasting activities. We also use Freedom software to report quarterly/annual statutory filings to NAIC and applicable Stage agencies. Freedom interfaces with Centene’s SunGard Enterprise Portfolio System (EPS) software for Schedule D reporting on our statutory filings. We support receipt and processing of the HIPAA 820 Premium Payment Remittance Advice transaction, should Iowa Plan wish to add this additional level of integrity and auditability surrounding capitation payments to Cenpatico.

***AMISYS Advance*** AMISYS (component G on figure A.1) our core transaction processing system (AMISYS Advance) will store and process Membership activities; manage and monitor service delivery operations; perform claims and encounter processing activities and administer to funding requirements for the Iowa Plan program. AMISYS Advance is fully integrated with all of our other clinical front-end subsystems, it provides measurable data integrity, accuracy and is built to support complex administration and public sector business. Following are the main AMISYS Advance modules that will meet Iowa Plan requirements and a brief description of each:

1. Enrollment/Eligibility	8. Third party recovery (TPR)
2. Provider management	9. Provider Payments
3. Encounter/claims processing	10. Benefits management
4. Financial management	11. Pricing

5. Utilization/quality improvement	12. Batch processing
6. Reporting	13. Archiving
7. Interface management	14. Security/Audit

1. *Enrollment / Membership and Eligibility Processing:* AMISYS Advance will support the member eligibility requirements as defined by the Iowa Plan. The AMISYS Advanced eligibility process, built to optimally process large batches of membership data, can process daily, weekly, and monthly workloads. Upon receipt of HIPAA 834 membership transaction data from our TIBCO (component F on figure A.1) translation application, edits and controls such as validation for duplicate member records, date criteria and data integrity rules are applied. Member data is linked to claims data, benefit definition and authorization records. AMISYS interfaces with our CareEnhance Clinical Management (CCMS) application (detailed later in the section). The CCMS application will administer the authorization process for the Iowa Plan.
2. *Provider Administration:* Provider records are linked to provider ID numbers. Our system provides the ability to manage multiple office locations and group practices to which a provider may belong. The provider subsystem also accommodates providers who have multiple financial arrangements. The financial affiliations capability provides flexible management of provider IDs and license numbers.
3. *Encounter/ Claims Processing:* AMISYS Advance is the core system of record for the Iowa Plan managing claims/encounter data and resides on a flexible Oracle database that performs as a warehouse for our system. Well defined data dictionaries allow encounter tracking from claims receipt through final disposition. By leveraging best practices and improvements and enforcing controls and safety nets, we will manage, report, and reconcile encounter data in an accurate and timely manner. As an additional safeguard, AMISYS Advance contains flags indicating whether a provider has been suspended from participating in state programs in which case his or her payments are rejected and denied. Similarly, a provider may be placed on payment hold for a variety of reasons, in which case payments are rejected, adjusted, or denied. Once claims are loaded into AMISYS Advance, they proceed through six levels of adjudication to a paid, denied, or pended status. Covered Services are determined by application of AMISYS configured eligibility, provider, and benefits management rules during claims processing. AMISYS determines whether services are covered by applying defined tables of valid procedure codes/ranges, diagnosis codes, Member age range, Member gender, provider type, location of service, and benefit limitations to define exactly which services are covered (and not covered), and at what levels. Once claims are processed, they are placed either in a pending status or a “final” adjudication status for payment or denial.
4. *Financial Management:* Our system is highly configurable and therefore very adaptable in handling the Iowa Plan requirements. We support a wide variety of payment methodologies, including capitation, block payments, DRG, fee for service, case rate, or various hybrid methodologies. The system supports accurate reporting/tracking and distribution of payments by designating the responsible funding entity at the claim or encounter level.
5. *Third Party Reimbursement Processing/Liability Recovery:* AMISYS has robust functionality and can manage many levels of third party reimbursement processing. Even though this is not a requirement for the Iowa plan, this functionality does provide the ability to identify any third party liability. Cenpatico will conform to the state’s requirement to notify the Iowa Plan in the event of any other coverage identified.
6. *Provider Payments.* Providers are paid through AMISYS Advance by application of the correct fee schedule and reimbursement methodology during the adjudication of claims. AMISYS Advance accommodates a wide variety of reimbursement methods such as fee schedules, Usual and Customary Rates (UCR), capitation, case rates, DRGs, and hybrid methodologies, applying each in a date sensitive manner according to the provider contract in effect when the service was rendered. We closely monitor federal and state reimbursement guidelines to ensure that providers are paid correctly pursuant to applicable rules and regulations. The AMISYS Pricing Subsystem allows Cenpatico to define contractual and financial agreements comprised of fee schedule data, per diem or per stay rates, DRG data, Member data, treatment type data, etc. It also determines the correct affiliation for the servicing Provider and the

associated pricing arrangements according to the date of service on the submitted claim, thus ensuring accurate payments. Our Portico and Emptoris provider management systems (detailed below) allow our Health Plans to enhance our ability to track historical payment scenarios and other demographic changes affected by contract amendments. In addition, we will be implementing a complementary new service, Payformance, to assist with managing provider payments with a comprehensive service. Our providers will be able to receive EFT payments either directly (which is done today), or via their Payformance subscription. Among the many attractive features, Payformance has an online capability for viewing the detailed remittance information behind an EFT payment, and supports online enrollment and activation of providers, including bank depository accounts and remittance preferences. While we feel that Payformance offers an improved experience for our providers using EFT, we believe it is important to allow providers to continue using our traditional, robust EFT mechanism.

7. *Security:* All individual systems security change requests are managed through a security authorization and implementation process. This process includes changes to security for employees, contractors, and key business associates. Role based security templates allow the Security Department to maintain access consistently. Our information management system incorporates extensive audit capabilities such as date span logic, historical change tracking, operator ID stamping, and parameter setting.

***Centene ENcounter TRAcKing (CENTRAK)*** CENTRAK (component H on figure A.1) was designed to provide the Iowa Plan with comprehensive encounter data in a quality and timely fashion. Cenpatico is acutely aware of the importance of reporting quality encounter information to the Iowa Plan. All encounter and claims transactions for services rendered are processed first through AMISYS Advance. Once adjudicated, claims are extracted into the EDW which in turn feeds the data as HIPAA formatted transactions into CENTRAK, where encounter errors and rejects are viewed through a web enabled graphical user interface that supports error correction and resubmission. Groups of encounters can be viewed and analyzed by: encounter status; claim type; error code; provider or provider group; paid date; service date; submission batch; submission date; age;; service type or service category as defined by the Iowa plan. The query functionality allows us to compare capitated vs. non-capitated encounters by all the factors in the query. HIPAA edits are applied to validate encounters prior to submission using EDIFECs compliance checking software. Cenpatico will deliver the encounter files in the designated DHS format.

**b) Describe adaptations to the Bidder’s MIS which would be made to allow reimbursement for covered, required and optional services provided even if the Enrollee’s Medicaid eligibility and Iowa Plan enrollment effective date were determined subsequent to the Eligible Person’s month of application.**

Our MIS system allows for retroactivity of eligibility, thus providing retro coverage based upon the information determined on the eligibility file. In public sector business, it is very common for people to roll in and out of eligibility, even shifting between a Title XIX benefit and a gap benefit such as a CHIP program. AMISYS Advance differentiates the periods of eligibility on the member’s record. If a claim is received for a date of service that does not match the status in the system, the claim would initially deny. However, utilizing the reporting tools of EDW and BusinessObjects, reports can be programmed to identify members who have changed benefit programs or who have since been retroactively made eligible. Claims can be adjusted as necessary based on the reporting data.

**c) Describe the process the Bidder would put into place to ensure appropriate allocation of reimbursement in the following situations:**

- **services were being provided to a person who was an Enrollee and whose Medicaid eligibility terminated and the person then, during the same treatment episode, became a IDPH Participant, and**
- **services were being provided to a person who was an IDPH Participant receiving services and, during the same treatment episode, became an Enrollee.**

Each membership type, IDPH and Medicaid, would be set up as a separate division within the Amysis system. Each division has its own rules which include reimbursement procedures. As enrollment files are received from the state the Amysis Advance system checks for duplicate enrollment. Amysis allows only one active record for a member. When a member is dis-enrolled from one benefit and is enrolled in another, date

spans are applied and historical eligibility is maintained. Therefore, our system will recognize an Eligible Person's eligibility date span for each benefit, Medicaid or IDPH, even during the same episode of treatment. When a claim is received for a particular service, the system verifies the group, division, contract, and member are eligible for coverage and would be able to allocate the appropriate reimbursement and benefit limits based on the coverage specified and the date spanning logic. If a claim is received utilizing a member ID for a coverage plan that does not match the member's status for a date of service, claim would initially deny. However, utilizing the reporting tools of EDW and BusinessObjects, reports can be programmed to identify members who have changed benefit programs or who have since been retroactively made eligible. Claims can be adjusted as necessary based on the reporting data.

**Provide as references the name, telephone number and e-mail addresses of three publicly funded clients that can be contacted to discuss the Bidder's MIS performance under similar contracts.**

**References:**

State	Program	Name	Title	Phone	E-Mail
Texas	HHSC - Medicaid/CHIP	Susan Gibson	Plan Manager	(512) 491-1859	<a href="mailto:Susan.Gibson@hhsc.state.tx.us">Susan.Gibson@hhsc.state.tx.us</a>
Ohio	Bureau of Managed Care, Ohio Department of Job & Family Services	Sam Assoku	Contract Administrator	(614) 446-4693	<a href="mailto:Samuel.Assoku@jfs.ohio.gov">Samuel.Assoku@jfs.ohio.gov</a>
Arizona	Arizona Department of Health Services	Susan Ross	Information Technology Project Manager	(602) 364-4695	<a href="mailto:ROSS@azdhs.gov">ROSS@azdhs.gov</a>

**7A.2.18 Financial Requirements**

**a) Disclose the financial instruments the Bidder would use to meet the requirements of all fund and accounts required in Section 6.6. Disclose the source of the capital required.**

The following accounts will be created prior to the first scheduled capitation payment. The initial capital resource will be from unrestricted cash reserves from Cenpatico and/or our parent organization. These accounts will be held in Iowa-based financial institutions. In addition, Cenpatico will submit account verification reports of each account to the Departments within 30 days following the end of each calendar quarter. To maximize the value of interest income on required accounts, Cenpatico will require a competitive bid of locally-based banks including interest rates and investment mechanisms. Doing so will allow maximum return of interest to the reinvestment account and/or the State.

**Insolvency Protection Account and Surplus Fund**

The Insolvency Protection Account will be a restricted account with funds greater than or equal to two months of the anticipated annual Medicaid capitation amount. Funds in this account will only be accessed through authorized signatures of two persons designated by DHS and two persons designated by Cenpatico. In addition, this account will serve as the required Surplus Fund of 150% of the average Medicaid claims fund (83.5% of the capitation payment) for the most recent quarter.

**Working Capital**

Cenpatico will maintain cash or equivalent liquid assets greater than or equal to the total amount of the designated Medicaid administrative fund from the most recent three-month period of the cap payments. This capital will be controlled by DHS.

**Community Reinvestment Account**

We will establish and maintain a Community Reinvestment Account to which 2.5% of the monthly capitation amount will be deposited. This account will be used upon approval by the Departments for additional member services under the 1915(b)(3) waiver and for provider development and customer

outreach. This will be an interest bearing account, and all interest earned will be paid to DHS at the end of each quarter.

**b) Demonstrate that the Bidder's organization is in sound financial condition and/or that appropriate corrective measures are being taken to address and resolve any identified financial problems. The Bidder must attach the most recent three (3) years of independently certified audited financial statements of the Bidder's organization as well as the most recent two years of financial statements for the Bidder's parent company, if applicable. These financial statements are not included in the page limit established for this section.**

Cenpatico is a wholly-owned entity of CenCorp Consulting Company, Inc. (CenCorp), which is a wholly-owned subsidiary of Centene Corporation® (Centene). Since inception, both Centene and Cenpatico have been financially solvent and have never filed bankruptcy. Cenpatico operates as an independent, fiscally responsible entity and has not required cash infusion from our parent. As a subsidiary of a publicly-traded entity, Cenpatico does not maintain independently audited financial statements; however, *Attachment - Consolidated Financials* includes the 2006, 2007 and 2008 audited financial statements for Centene Corporation. The audits conducted gave unqualified, or "clean," opinions on the financial statements, in accordance with accounting principles generally accepted in the United States of America. Complete 10K filings which include these financial statements are also available at [www.centene.com/investors/sec\\_filings](http://www.centene.com/investors/sec_filings).

As of December 31, 2008, Centene had \$1.45 billion in assets, \$950 million in liabilities, and \$501 million in stockholders' equity. For the year ended December 31, 2008, Centene generated \$3.4 billion in revenue, incurred \$3.2 billion in total operating expenses (includes medical and administrative expenses), and had working capital in excess of \$25.4 million. The financial results of Centene and Cenpatico indicate that we have sufficient assets and reserves for contingencies, that we generate sufficient cash flow to pay claims and other obligations timely, and that we generate positive income to continually reinvest in our operations. Centene will unconditionally guarantee the performance of Cenpatico on each and every obligation, warranty, covenant, and condition of the contract.

At this time there are no judgments, pending or expected litigation, or other real or potential financial reversals which might materially affect the viability or stability of the organization.

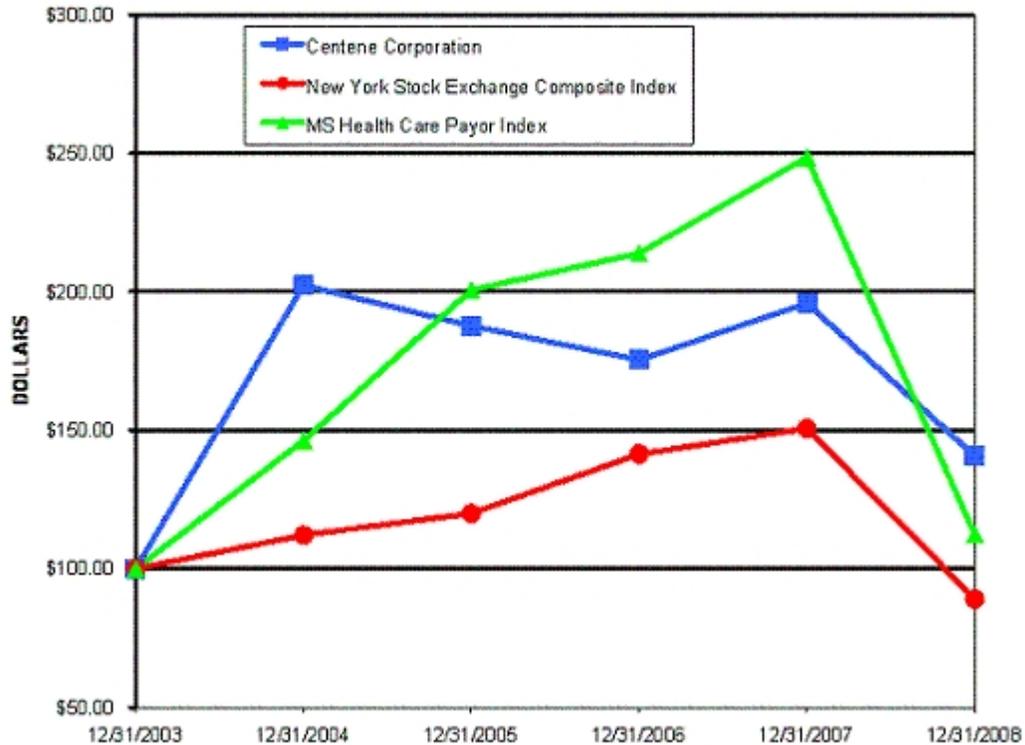
**c) Discuss what impact the recent declines in the stock market have had on the Bidder's financial stability, how the Bidder has responded, and any implications for the Bidder's ability to meet the requirements of this RFP.**

Despite the declines in the stock market, Cenpatico's and Centene's financial stability has remained strong and will not have any negative impact on our ability to meet the requirements of this RFP. As stated in Centene's press release dated October 14, 2008:

"Centene Corporation (NYSE: CNC) announced today that its results for the third quarter of 2008 will include impairment losses on its investment portfolio that are expected to reduce reported diluted earnings per share by \$0.07. The impairment losses represent less than 1% of Centene's investment portfolio as of June 30, 2008 and are primarily related to investments in the Reserve Primary money market fund whose Net Asset Value fell below \$1.00 per share due to its holdings of securities backed by Lehman Brothers Holdings, Inc. The Company expects to recover approximately 95% of its Reserve Primary Fund investments and has more than adequate liquidity to fund its operations in the meantime."

At June 30, 2008, Centene had a diversified portfolio of cash and investments totaling \$709.9 million that currently puts the Company well in excess of capital adequacy levels under pertinent state insurance regulations. After giving effect to the impairment losses noted above, the Company's remaining exposure to securities of financial services entities such as banks, broker-dealers and other non-bank financial firms currently approximates \$15 million. Centene continues to monitor and assess the status of these investments."

Also, as noted in Centene’s 2008 10K filing: “The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2003 to December 31, 2008 with the cumulative total return of the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index over the same period. The graph assumes an investment of \$100 on December 31, 2003 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index and assumes the reinvestment of any dividends.”



	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
Centene Corporation	\$ 100.00	\$ 202.36	\$ 187.65	\$ 175.37	\$ 195.86	\$ 140.69
New York Stock Exchange Composite Index	\$ 100.00	\$ 112.16	\$ 119.96	\$ 141.38	\$ 150.69	\$ 89.06
MS Health Care Payor Index	\$ 100.00	\$ 146.27	\$ 200.56	\$ 213.90	\$ 248.53	\$ 112.32

Each of Cenpatico’s state and health plan contracts are financially sound, including our largest state behavioral health contract in Arizona. Neither Centene nor Cenpatico has declared bankruptcy and we continue to meet all of our financial obligations without exception.

### **7A.2.19 Claims Payment by the Contractor**

a) Describe the process the Bidder would implement to ensure compliance with the required time frames for claims processing. The Bidder may suggest more restrictive time frames than those required in Section 6.7 of this RFP for the processing of claims that the Bidder wishes to implement.

**Triple-layered quality review will ensure compliance.** Cenpatico’s claims are processed by an internal vendor, Centene Management Company (CMC). This arrangement allows three layers of quality control and compliance testing. The **first layer** is with CMC itself and this layer has three stages, outlined below. Through regular procedures, which always place the oldest claims first in the queue for processing and daily monitoring by supervisors of aged claims, CMC ensures that claims processing timelines are met. This process also quickly identifies any claim that needs special consideration from Cenpatico, thus greatly reducing the volume of outlying aged claims. The 3-stage CMC process is as follows:

**Stage 1.** Each day claims analysts begin processing claims from their queue. The queues are date aged thereby calling for the oldest claims to be worked first.

**Stage 2.** There are multiple queues in the system and as a second level of review, claim supervisors run daily aging reports across all of the queues to verify all of the oldest claims are being worked first. Claims supervisors have the ability to adjust workflow based on claims aging and will adjust the claims flow as needed.

**Stage 3.** The Claims Manager requires the Claims Supervisor to meet the turn-around-time standards as part of their monthly goals. Charts are produced that show our progress and posted as daily reminders of our commitments to our clients.

The **second layer** of oversight is our Internal Claims Audit department which is an independent department outside the reporting structure of CMC or Cenpatico. They review daily samples of claims for processing, financial, and payment accuracy. The auditor’s results are reviewed by Cenpatico to verify if any claims errors have occurred and to identify what solution has been put in place for correction. The **third layer** of oversight is with Cenpatico itself. Cenpatico employs a Support Services Manager who conducts a formal oversight review monthly of the claims processing center, the electronic data interchange (EDI) area, and the Claims Customer Service department. In addition to the formal monitoring of performance measures and process accuracy, the Support Services Manager coordinates vendor management as needed to facilitate solutions to special projects or issues. In addition to the Support Services Manager, Cenpatico’s Compliance department monitors the claims processing times monthly. If issues arise with meeting state requirements, the Cenpatico Compliance department creates and oversees a corrective action plan with CMC. On a daily basis, the Operations department at Cenpatico reviews the claims run for accuracy. Prior to release, the Operations team flags any claim that has not processed correctly. These claims are returned to the claims area for reprocessing. The Operations team then requests system changes so that the system processing errors are corrected.

This triple-layered oversight process has been in place for one year. Over the course of that year, Cenpatico has seen significant improvements in claims processing accuracy and a decrease in claims processing time. In the Indiana market (as illustrated below) for example, in February 2008, the rolling 12-month results for processing accuracy, financial accuracy and payment accuracy were 88.9%, 94.5% and 90.6% respectively. By February 2009, the rolling 12-month results had improved to 96.3%, 99.1% and 97.5% respectively. With this new oversight, Cenpatico improved claims processing time from an average of 10.1 days to 7.8 days for all types of claims. Cenpatico currently processes electronic claims within 5 days.

	Claims Audited	Processing Acc.	Financial Acc.	Payment Acc.
Feb '07-Jan '08	2,179	88.9%	94.5%	90.6%
Feb '08-Jan '09	1,909	96.3%	99.1%	97.5%

Cenpatico’s current timeliness standards call for claims to be loaded into AMISYS Advance within 24 hours of receipt; 90% of claims to be processed within 14 days; 98% of claims to be paid within 30 days, and 99%

of clean claims to be paid within 60 days. To comply with the Iowa Plan's requirements, Cenpatico will adjust the first measure to 90% of claims processed within 12 days. Current average is 91.2% processed within 12 days.

One factor is most significant in increasing claims processing time: automation. Accurate auto-adjudication of claims is dependent upon two primary factors: provider load and system build. In the past two years, Cenpatico has enhanced two departments, Internal Provider Relations (IPR) and Operations, to take ownership of provider load and system build to increase Cenpatico's claims accuracy and timeliness. Internal Provider Relations is the central point of receipt for all provider data, contracts and credentialing materials. They ensure that providers have met all the requirements to become a participating provider. This team also loads the provider into the Amisys Advance system. The provider load is audited by the Operations staff to ensure accuracy and reduce claims problems due to provider setup. In addition to its claims monitoring role, the Operations department also defines all the system specifications for Amisys, submits the specifications to the programmers, and performs all the user acceptance testing (UAT). When the Operations team began system testing, 58% of requests failed UAT once, and 11% failed multiple times. Over the last two years we have conducted internal training sessions resulting in Cenpatico now only failing 42% of requests once, and less than 2% fail multiple times. Generally the failures now relate to a typographical error in the coding versus a missed concept.

Electronic submission of claims also reduces claims processing time. While Cenpatico has arrangements with several clearinghouses such as Emdeon and Availity, we also have our own web portal that providers may use to submit claims and monitor their progress.

In order to ensure timeliness standards are not interrupted due to staffing or weather problems, we have measures built into our business continuity plans that provide cross-trained claims staff who can work fluctuating claims volumes as needed. Additionally, the Operations staff is cross-trained by market to handle volume fluctuation for claims review. Our claim payment process utilizes the CMS Healthcare Common Procedural Codes System (HCPC) and conforms to level I, II and III requirements of the Iowa Plan. Cenpatico currently accepts CMS-1500 and UB-04 claim forms and does not anticipate any modifications and will comply with the Iowa Administrative Code Chapter 441-80.2 for paper as well as electronic claims processing. All of our electronic claims capabilities are HIPAA compliant and conform to CMS handling guidelines.

#### **Industry leading technology and best practices deliver on timeliness standards.**

Below is the claims process that will support the timeliness standards of the Iowa Plan. The sections include:

- Electronic and paper claims administration
- Claims adjudication
- Systems Claims Audit

**Electronic Claims:** Our EDI Program performs basic edits on claims originally submitted electronically to verify all pertinent information is present and accurate. If a claim is submitted with incomplete, inaccurate, or missing data, it is rejected and returned to the FTP site in the form of an error file. Error files are then returned to the provider or clearinghouse for resolution. This process is monitored by our EDI staff to validate that all claims received are processed according to industry standards. Cenpatico Operations' staff also monitors EDI rejections to identify provider billing errors. These examples are given to Provider Relations for outreach and training. Clean claims are loaded into the AMISYS Advance database and a detailed report of claims loaded is generated.

**Paper Claims:** Within 24 hours of receipt, claims are scanned, and made available for entry through the Optical Character Recognition (OCR) process within our MACCESS application. The OCR technology is used

to read information from paper claims and is quick, efficient, and highly accurate. When the OCR does not read all the fields, the claim is routed to a claims processor to manually enter the required claim information. Once claims are entered, they are ready for processing through the translation programs or routed to reject queues where letters are generated to communicate the specific state-approved edit that caused rejection in this front end processing. All paper claim images are housed in MACESS for easy filing and recovery. After claims are processed through the translation programs, which checks for HIPAA Level 5 edits, they are loaded into AMISYS Advance for adjudication.

**Claims Adjudication:** Our claims adjudication system AMISYS Advance is an industry leading system that is supported by our Centene information technology group. Our platform processes 1.2M claims per month, uses a combination of the MACESS workflow system and the AMISYS Advance Claims Processing subsystem. Our rule-based processing engine provides flexibility that allows us to easily accommodate changes when claims-related policies change.

**Systems Claims Audit:** To ensure compliance to the Iowa Plan we will monitor each step of the claims adjudication system. Reports are generated to document system performance and provide record balancing throughout the process. This includes the number of claims received, entered, paid, denied, and pending. In addition, our systems feature a comprehensive Claims Audit Function with definable parameters enabled to allow for tracking of all changes to a claim or service in the transaction system.

**b) Describe the Bidder's experience in implementing contracts in which the claims payment process supported the accurate and timely payment of claims as of the first day of operations.**

**Include the names of the programs, the number of covered lives in each, and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.**

Cenpatico's internal quality improvement processes have rectified past challenges we have had paying claims timely and accurately as of the first day of operations for a new account. In March of 2007, we implemented a new strategy to identify barriers and effectively overcome these challenges. We invested over one million dollars in additional personnel and training. The new staff in the Operations department became accountable for all claims outcomes, including timely and accurate claims payment for new business. By developing relationships with the system programmers, training corporate vendor staff on the Cenpatico business model, and becoming system experts, the Operations department has improved claims accuracy, reduced system error, and increased claims auto-adjudication. Now, prior to the start date of an implementation, Cenpatico develops all the system specifications to build the Amisys Advance platform for the new market. The Operations team vigorously tests the new build, specifically trying to break the setup. The Operations team uses an extensive database of test claim scenarios, loading as many as 45,000 claim scenarios to ensure authorization, benefit, and pricing rules will work correctly. Because the test environment and the live environment do not always match, the Operations team monitors 100% of claims for a new market. Claim errors are corrected prior to release and the error is used to flag a system correction. We continue increased monitoring for approximately 5 months to ensure the system is consistently running with 98% accuracy without any intervention. At this point, a new market is considered stable and claims reviews are shortened to a weekly sample and a monthly full review. In addition to the testing conducted by the Operations team, Cenpatico implemented a rigorous project management process. This included detailed task development, so nothing was missed, and strict timeline adherence.

Cenpatico's first new account roll-out since implementing this strategy was in Texas with 30,000 Foster Children that generated 25,000 claims per month. The Foster Care product went live on April 1, 2008 and we exceeded requirements for the prompt payment of claims. For the period 4/1/08 to 1/31/09, we processed 99.35% of clean claims received within 30 days and 99.97% within 90 days. The Texas required processing timelines are 98% within 30 days and 99% within 90 days.

Cenpatico also monitors the accuracy of its claims processing through internal audits and a review of claims prior to their release. For the same period as referenced above, internal audits confirmed the accuracy of our claims processing as follows:

	<b>Claims Audited</b>	<b>Processing Acc.</b>	<b>Financial Acc.</b>	<b>Payment Acc.</b>
<b>April 08- Jan 09</b>	<b>2,529</b>	<b>97.0%</b>	<b>98.4%</b>	<b>98.1%</b>

However, since this product had never been subjected to managed care before, the first year was a learning year for providers, Cenpatico, and the State. Over the course of the year, requirements were modified as the State reviewed data. With every modification, system changes were necessary. We had to manually confirm that the new requirements were met while the system changes were programmed.

Because of these changes, Cenpatico has not yet fully met its internal standard of 98% accurate system claims processing without intervention; however due to the rigorous reviews, we continue to make improvements on our performance in meeting the accuracy standard and strive to exceed the 98% accuracy goal on an ongoing basis, despite the manual interventions.

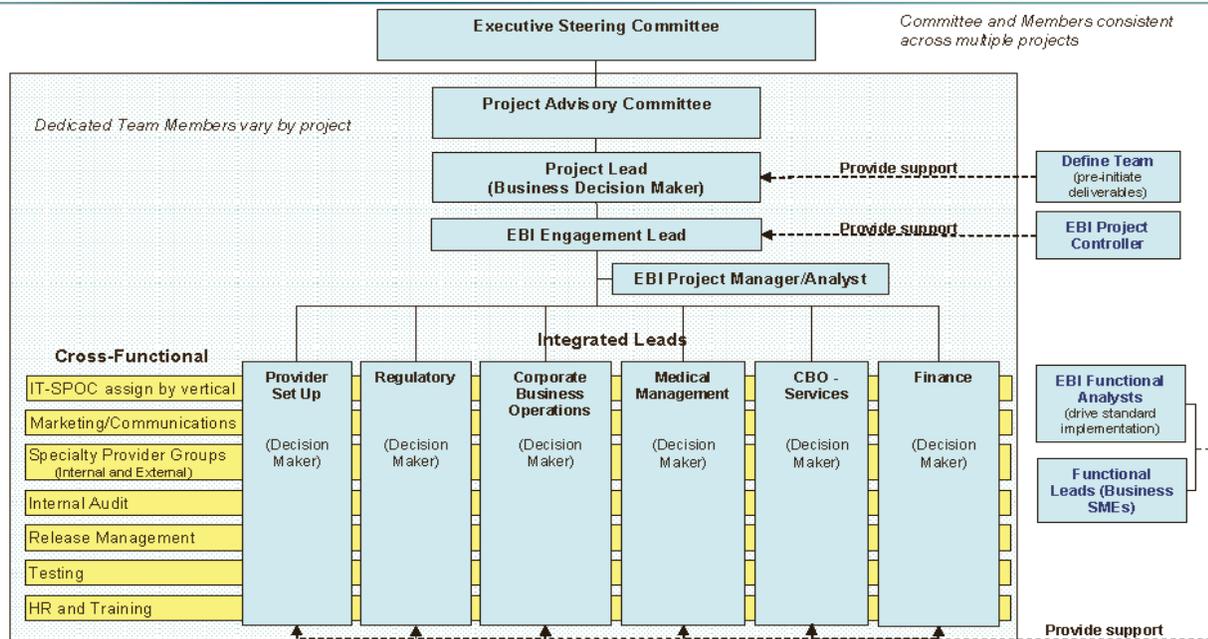
Two additional markets are just now entering the post go-live phase, Cenpatico Florida and Cenpatico South Carolina. The Operations team is following the same process that was used for Star Health in the review of the claims and system accuracy for these two new implementations, however as these markets began February 1<sup>st</sup> and March 1<sup>st</sup> respectively, not enough data has been gathered to demonstrate the effectiveness of the process.

**Our adaptable methodologies drive on-time implementations.**

We have built adaptable methodologies that allow Cenpatico to implement new clients on time while keeping quality and timeliness at the forefront of our mission. Our organization has a team of professionals that are at the core of our responsibilities to the Iowa Plan for an effective implementation. This team, the Enterprise Business Implementation (EBI) team, is a resource leveraged through our corporate parent, Centene, and it manages key implementations for our organization. They provide project management driving overall project controls including financials, quality, resource management, and overall schedules/project plans.

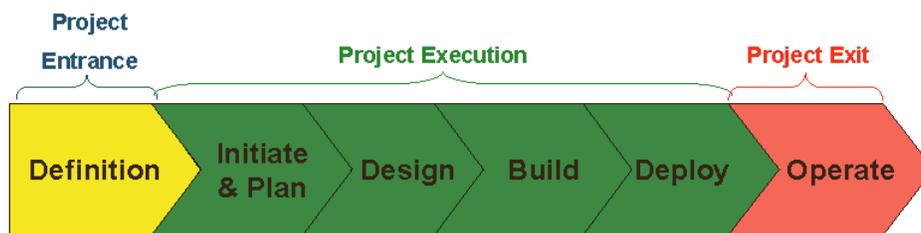
Upon award, the EBI team will engage with the state as well as internal resources to form a project structure (detailed below) comprised of subject matter experts representing the core disciplines of the project. These resources will represent the projects overall governance and serve as resources in the successful implementation of the Iowa Plan. After the overall project approach and governance has been defined and is in place, the various teams consisting of member/provider, marketing, technology/technology operations, audit, compliance, human resources, finance, claims, benefits, testing/quality, reporting, release management, eligibility, encounters, call center/health plan operations, clinical management as well as executive management will start the process of defining the business rules that will drive the overall scope and definition of the Iowa Plan implementation.

### Project Structure:



All key stakeholders are involved from day one of the planning process and stay involved through implementation. There are six main phases of the overall project structure that will drive a quality/successful project for the Iowa Plan as defined below:

1. Project Definition. Operating and technical models defined.
2. Project initiation and planning. Teams build work plans and business rules.
3. Project Design. Teams refine business rules into technical designs, policy and procedure, operational considerations, and readiness review definition.
4. Project Build. Technology build and testing, training definition, and readiness review build.
5. Deployment. Health plan operations, production validation, training, communications, and all operation units ready for operations.
6. Operate. All services available.



#### Key Components:

- Clinical Model
- Operating Model
- Technical Architecture
- Implementation Team
- Implementation Budget
- Work Plan
- Business Requirement
- Technical Design Document
- Specialty Provider Group Contracts
- Policies & Procedures
- Readiness Review
- Coding & Configuration
- Testing (Unit, Integration, and User Acceptance)
- Training
- Readiness Review
- Production Install
- Cutover Activities
- Health Plan Transition
- Training
- Call Center
- Claims Processing
- Eligibility Processing
- Medical Management
- Encounters
- Finance
- Reporting
- Web Services
- Provider Services
- Member Services
- Training

**Cenpatico’s Operations team drives quality results.**

In addition, Cenpatico’s operations team, consisting of contract implementation managers (CIM), contract implementation specialists (CIS), system configuration testers, and a support services manager can assure the Iowa Plan that the claims payment process will be accurate and timely as of the first day of operations. As part of the implementation process, the CIM develops the specifications for the Amisys platform build out and works with the programmers to ensure all specifications are met. After the information systems team completes their quality review, the Cenpatico system configuration tester has the final oversight and sign-off that the systems build is correct. Any system errors are flagged and addressed before the platform (eligibility, authorization, benefits, pricing rules, and overall claims processing) is considered complete. By adding this layer of validation, Cenpatico can assure the Iowa Plan of an effective implementation.

As part of Cenpatico’s quality process and to ensure the Iowa plan of operational excellence, Cenpatico conducts a post go-live review of the weekly check run prior to distribution to providers. This review, conducted by the contract implementation specialist, looks for payment errors, benefit errors, and authorization errors. Incorrect claims are flagged and returned to the claims management group for reprocessing before the check run can be released. After the incorrect claims have been reprocessed, the contract implementation specialist validates the reprocessed claims to ensure correction. When satisfied, Cenpatico submits the final approval to release the check to the providers. After the check run has been released, the contract implementation manager and contract implementation specialist meet with the clinical management and with network/provider relations to determine root causes for system errors and also to look for opportunities for provider education if the issue was a billing error. When provider training opportunities are identified, Cenpatico pro-actively reaches out to the provider to inform them they will be receiving denials and instruct them on how to resubmit the claim for correct payment. Contract implementation specialists will also provide the network contractors with a list of nonparticipating providers that received claims payment. This list is used for recruiting in the event the provider has not yet responded to Cenpatico’s contracting efforts. Results of the check run are also used to validate the total quality management process of the provider and overall system configuration for the Iowa Plan. This process continues weekly for approximately 5 months. Management will not discontinue this process until they are satisfied that the Iowa Plan is functioning at high quality levels. After this determination, Cenpatico moves to a spot audit weekly and a full review monthly in order to ensure system continues to function correctly. This intensive audit process ultimately results in a platform from which more than 90% of claims can be adjudicated correctly without manual intervention. This greatly increases the claims processing turn-around time.

**References:**

State	Program	Covered Lives	Cenpatico Contracted Provider	Contact	Title	Phone	E-Mail
Georgia	Peach State Health Plan	294,000	Cascade Medical Group	Debora S. Johnson, MD, PC	Psychiatrist	(404) 699-9600	<a href="mailto:djohnson@coolmindsgroup.com">djohnson@coolmindsgroup.com</a>
Texas	Superior; (Star/Star+/Chip/ FC)	292,000	Rodney Rousett, M.A., LPC, P.A.	Rodney Rousett,	Owner	(210) 393-1882	<a href="mailto:roussettlpc@aol.com">roussettlpc@aol.com</a>
Kansas	Health Wave XXI	40,000	KVC Behavioral HealthCare	B. Wayne Sims	President and CEO	(913) 322-4901	<a href="mailto:bwaynesims@kvc.org">bwaynesims@kvc.org</a>

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### **7A.2.20 Fraud and Abuse**

**Describe how the Bidder will comply with the Departments' Fraud and Abuse requirements and provide examples of how your internal controls successfully work to prevent such Fraud and Abuse.**

Cenpatico has created a Waste, Abuse and Fraud/Program Integrity Plan (“Compliance Plan”), which is intended to prevent and reduce waste, abuse and fraud as committed by Providers, behavioral health service recipients and subcontractors. This Plan reflects the Departments’ fraud and abuse requirements and includes four major components, as summarized below:

#### **1. Education and Training**

We recognize the importance of education and training. A systematic means to identify and report suspected waste, abuse and fraud cases to the individual responsible for managing the Compliance Plan will be communicated to providers, Eligible Persons, subcontractors and employees. We will utilize various means for educating these groups, including: providers will receive waste, abuse and fraud information within the approved Provider Manual, in newsletters, and during training sessions. Eligible Persons will receive information via the approved Consumer Handbook. Employees will receive an initial overview of the Compliance Plan requirements and expectations during new hire training, which includes but not limited to information about the False Claims Act, whistle blower protections and organizational conduct. Training sessions will also be held on an annual basis for all employees and subcontractors and includes departmental specific examples. All training sessions will be logged and dated for staff attendance, and these logs will be maintained by Cenpatico and reported to the Departments, upon request. We will also send periodic email reminders to employees, which contain information about Compliance Plan requirements and expectations. In addition, we will conduct an annual compliance survey to measure the effectiveness of the Compliance Plan, identify any issues or concerns and promote the Compliance Plan expectations.

#### **2. Hotline**

An external toll-free hotline number will be made available to report potential waste, abuse and fraud issues. The hotline helps to identify potential provider and consumer issues such as card sharing and prescription abuse by Eligible Persons, provider ‘free’ billing issues, etc. This line will be administered by an external vendor, which specializes in providing confidential assistance to corporations. By using a third party, it is easier for informants to remain anonymous; however, it is our policy not to retaliate against any person for reporting waste, abuse and/or abuse. All cases of suspected waste, abuse and/or fraud will be logged and forwarded for immediate review and disposition. Employees may also report any issues or concerns to their supervisor, the designated Compliance Office and/or a member of senior management.

#### **3. Detection/Investigation Process**

We use several tools to identify a potential concern. Once identified, the potential concern is reviewed to determine whether it is a billing error that can be corrected with education or if it appears to be an issue of waste, abuse and/or fraud. In connection with its Special Investigation Unit, we will evaluate individuals’ claims histories by reviewing other Providers’ or Eligible Persons billing practices, reviewing state regulations, evaluating the number of claims causing potential concern, reviewing addresses of Eligible Persons and Providers, and asking opinions of Medical/Clinical Directors and/or peer review committees.

If any item minimally indicates a potential waste, abuse and/or fraud, our Compliance Officer will, within 10 days, notify the Departments using the approved forms. The Compliance officer will forward, at a minimum, the following elements:

- Name and ID number;
- Source of the complaint;
- Type of provider (e.g. CMHC, psychiatrist, etc);
- Nature of waste, abuse and/or fraud complaint;

- Approximate dollars involved; and
- The legal and administrative disposition of the case.

Cenpatico will not disclose the existence of any investigation conducted by the Departments. We will cooperate fully with all investigations and will not proceed with any activities, such as recoupment, if warranted, until obtaining approval from the Departments. We will also implement corrective actions in instances of waste, abuse and fraud detected by the Departments, or other authorized agencies or entities.

#### 4. **Prevention**

With experience managing a Compliance Plan in several states, we are confident that we will be able to prevent many issues that are prevalent in the health and behavioral healthcare industry. In addition to pursuing leads identified by external and internal informants (reactive), Cenpatico will take additional steps to prevent waste, abuse and fraud (proactive).

Preventive measures include, but are not limited to the following:

- Determining areas of high impact;
- Developing reports that monitor Member and Provider activities;
- Providing annual department-specific staff training;
- Notifying staff of changes in the program;
- Initiating regular Provider, Member and subcontractor education; and
- Maintaining best practices that are identified throughout the industry.

The designated Compliance Officer is located in Iowa and reports to the Executive Director, who chairs the Compliance Committee. This Committee oversees monitoring and auditing activities which are intended to confirm compliance with contract requirements, legal and regulatory rules, policies/procedures and written standards of conduct.

The Cenpatico Compliance Plan and associated policies, including – but not limited to, those addressing (i) the detection and prevention of waste, abuse and fraud, (ii) conflict of interest, (iii) whistleblower protections, (iv) compliance training requirements and (v) Enforcement Standards are available upon request.

**Tools to detect potential waste, abuse and fraud:** The above referenced four core components of the Compliance Plan support Cenpatico’s administration of ongoing waste, abuse and fraud detection and prevention activities. Specifically, Cenpatico uses several tools to detect potential waste, abuse and fraud issues:

- The Claims Audit Department performs a comprehensive review of a sample equaling approximately 2% of all processed claims including paid, denied and adjusted claims.
- EDIWatch is used for Provider profiling. By using EDIWatch, we can easily identify upcoding, over utilization, unbundling, transportation services without an associated service, etc.
- Business Objects is an extract tool utilized to review Members claims. Semi-annually, a review of the number of provider visits per patient and the number of emergency room visits per patient is conducted. Member specific queries may be written to help identify potential provider shoppers, ER abusers and card sharing.
- Compliance Coding Management (CCM) staff also review claims requiring special consideration (per the authorization), which are billed with high intensity codes or outdated codes and high dollar payments. In most cases, the CCM reviews claims prior to payment and has been known to detect possible trends in the abuse of modifiers, system configuration issues, potential upcoding and misuse of units/quantities billed.

Based on this activity, we will work proactively to detect suspected waste, abuse and fraud and refer cases to the Departments, as appropriate. We will also respond “reflexively” by reacting to referrals of suspected waste, abuse and fraud from employees and other sources. Ongoing internal education about this topic and options for reporting suspected cases will help keep staff aware of their obligation to report cases, even if they are unsure as to whether there is actual waste, abuse or fraud.

The above tools have helped to successfully prevent waste, abuse and fraud in our existing markets. Specifically, we have identified and targeted providers who (i) unbundled procedure code 90862 for pharmacy management, (ii) billed using codes with greater than the allowable number of units (96101, H2012) and (iii) billed without the appropriate modifiers (H0043, H2011 and H2012). Cenpatico conducted outreach to these providers and, where applicable, initiated recoupment for any claims which were overpaid or paid in error based on these findings.

In addition, in response to internal referrals and claims review activities, we have identified opportunities to reconfigure our claim payment system to edit payment on claims submitted with procedure codes 90805 and 90807 when billed with 90801 for the Psychiatric Diagnostic Interview Examination.