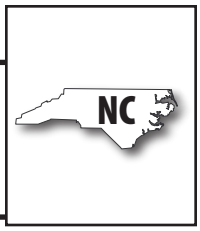
North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria



Overview

The North Carolina public behavioral health system is organized by Area Offices, which operate as local management entities (LMEs). The LMEs are charged by the State with many of the functions of managed care organizations, including organization of the provider network, service authorization, and utilization management, and they bear financial risk for service provision within their catchment areas. Managed care functions are relatively new to North Carolina's Area Offices. Historically, the Area Offices provided direct services. In an effort to improve quality and consistency of care across the State and to control costs, the State is now in the process of transitioning its Area Offices from their historic role as service providers to one of managed care entities.

North Carolina has identified several target populations for priority service provision, including: "seriously emotionally disturbed child with out-of-home placement;" "seriously emotionally disturbed child;" and, "homeless child." The State mandates the use of the Child and Adolescent Functional Assessment Scale (CAFAS) by LMEs and their contracted providers to determine whether a child meets eligibility under one of these categories as well as the child's eligibility for different service clusters (or levels of care). Once a child is determined eligible for service provision by virtue of his/her CAFAS score, then the LMEs and their contracted providers must use Child Level of Care (LOC) Criteria and Initial and Continuing Authorization Criteria, developed by the State, to guide clinical decision making and for initial and continuing service authorization. State informational material indicates that, "together, the Levels of Care Criteria and the Initial and Continuing Authorization Criteria create a protocol to guide the decision-making process for making initial authorization, continuing authorizations, and facilitating appropriate care management."[65] The guidelines are for use qualitatively, rather than to create an overall quantitative score, although they do incorporate the quantitative scoring associated with the CAFAS.

Goals

The State utilizes its Child Level of Care Criteria to support its movement toward use of managed care technologies in the provision of behavioral health services. Its goals are to improve consistency across the State in access to services and to contain costs. State informational materials describe several reasons for utilizing level of care criteria in a managed care environment, including: providing tools for supporting decisions about placing consumers in different levels of mental health care; increasing the predictability of level-of-care decisions;

65 For more information about North Carolina's Child Level of Care Criteria and their larger systems change reform, see the State's website at: http://www.dhhs.state.nc.us/mhddsas/childmentalhalth

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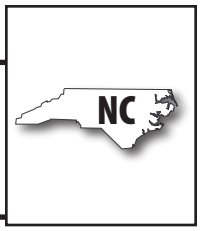

reducing wide variability of services provided to consumers with similar needs; providing justification for authorization decisions; helping ensure that consumers are assigned to services in an equitable manner; and allowing for authorization of services based upon a consumer's individual needs.[66]

Background

The State has used Level of Care Criteria for some time, which it has revised several times primarily in response to system changes, such as conversion to the Rehabilitation Services Option in Medicaid and, more recently, movement to managed care implementation. State informational material indicates that the criteria were developed through an extensive committee and consumer feedback process.

State-level stakeholders described their current status as "having a foot in two worlds." They are transitioning to a system in which local area offices bear risk for ensuring services to a designated population, must divest themselves of direct services, and have to learn how to implement the functions of a managed care entity. At the same time, the State is developing or refining statewide tools, such as the Child Level of Care Criteria, monitoring protocols, and technical assistance approaches to support and oversee the Area Offices in this transition. The most recent version of the Child Level of Care Criteria are those revised in March 2002, although the State is in the process of further refining the criteria for issuance in July 2005.

Description

The State's informational material describes the following key characteristics of the Child Levels of Care Criteria:

- "Provide a framework for making initial and continuing authorization decisions about medically necessary services for the treatment of MH/SA disorders
- Describe the clinical indicators which should exist in order for authorization to occur at each level of care
- Provide guidelines for determining the level of care a child needs and the services appropriate for each level
- Consist of five levels ranging from mild to severe dysfunction
- Each level requires a CAFAS score within a corresponding range of overall dysfunction
- A child is eligible for the assessed LOC and less intensive services when appropriate
- Some services can be accessed at several different levels of care
- Each level of care has a recommended review period and criteria for reauthorization."[67]

66 Ibid.
67 Ibid.

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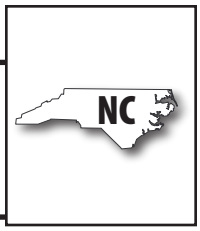

State informational material further describes that "initial authorization decisions are based upon the determination that:

- There is a reasonable expectation of improvement in condition
- The level authorized is necessary and appropriate to the child's present condition
- The child is at-risk of requiring more restrictive levels of care if the appropriate treatment is not provided
- There is not an equally effective service that is less restrictive or substantially less costly."[68]

According to the State literature, reauthorization (continuing authorization) decisions are based upon:

- "The persistence of severe symptomatology or problem behaviors
- The initial treatment goals not reached
- The treatment plan needs to be modified to introduce new treatment interventions
- New symptoms or behaviors have arisen
- There is a reasonable expectation that the child's condition will improve
- There is evidence of relapse if treatment is discontinued."[69]

The Child Levels of Care Criteria include medical necessity criteria (including discharge criteria) for a range of services. These include core services, which do not require pre-authorization up to specified limits, as well as services that do require pre-authorization. Core services include: case consultation; screening (up to six visits); evaluation; case management (up to 90 days); outpatient treatment (up to 24 visits); facility-based crisis intervention (up to 72 hours). Services requiring pre-authorization include: community-based services (e.g., behavioral aide services); day treatment/partial hospitalization; assertive community treatment team; and, five levels of residential treatment, ranging from family treatment homes to secure residential treatment facilities. The State also has developed definitions of each of these service types, which are available on the State's website. Currently, the State is developing definitions for a number of new services planned for July 2005, including community support, intensive in-home services, and Multisystemic Therapy. These new services will be included in the State's revised Child Levels of Care Criteria as well.

The current Child Levels of Care Criteria encompass four levels:

- **Level A**—encompasses case management, outpatient treatment (group), or community-based services (group), with total CAFAS score equal to or greater than 10 and other factors.

68 Ibid.
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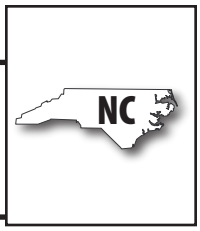

- **Level B**—encompasses case management, outpatient treatment (group or individual), community-based services (group or individual), residential treatment (family type), with total CAFAS score equal to or greater than 30 or other factors present (such as suicide attempt) and other factors
- **Level C**—encompasses case management, outpatient treatment (group or individual), community-based services (group or individual), day treatment/partial hospitalization; residential treatment (family or program type), with total CAFAS score equal to or greater than 60 or other factors present and other factors
- **Level D**—encompasses assertive community treatment team; facility-based crisis intervention; residential treatment (highest level or secure RTC), with total CAFAS score equal to or greater than 90 or other factors present and other factors.[70]

State informational material indicates that, when disagreements arise about level of care decisions, resolution can be pursued by obtaining a second opinion, peer to peer review, or negotiating with the state.

Individualized, Culturally Competent Family Focus

State-level stakeholders indicated that the Child Levels of Care Criteria as currently formulated do not address issues related to culture and are not designed specifically for an individualized, family-focused approach to care. While providers in the State are familiar with and often utilize a Child and Family Team (i.e., individualized) approach to service planning, the LOC criteria determine whether a child gets to a Child and Family Team in the first place. State-level stakeholders indicated that they are trying to figure out how to adapt the current criteria to support system of care practice goals, something they want to see reflected in the revised Levels of Care Criteria slated for July 2005. In addition, efforts also are underway to develop protocols for Person-Centered Planning for individuals with developmental disabilities, and the State is interested in ensuring consistency between the LOC criteria and the Person-Centered Planning protocols. In effect, the State is trying to develop and reconcile system of care practice guidelines for children's behavioral health, person-centered planning protocols for children with developmental disabilities and the existing Levels of Care Criteria for eligibility and service authorization purposes.

Impact of Service Availability

State-level stakeholders indicated that service capacity issues are huge. Over time, waiting lists for different types of services have changed. Two years ago, stakeholders indicated that the major demand was for residential treatment and special needs, such as treatment for sexual offenders. Today, demand (and wait lists) is for community-based services, such as behavioral aides. There are not supposed to be waiting lists for Medicaid-eligible children (who thus receive a priority for service provision).

70 For a full description of the Child Levels of Care Criteria and the Initial and Continuing Authorization Criteria, see: Child levels of care criteria for mental health and substance abuse treatment services. Revised edition, March 2002. North Carolina division of mental health.

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Training, Fidelity and Oversight

The State conducted an initial round of training for the LMEs on the Levels of Care Criteria, and the LMEs are charged with conducting ongoing training of new staff and providers. State-level stakeholders believe there has not been sufficient training on the criteria or on system of care practice. However, there is widespread use of the Levels of Care Criteria nonetheless because the criteria drive service authorization and utilization management. State-level stakeholders believe additional training of LMEs and providers would help to break down some of the rigidity that has developed around use of the criteria. The State is in the process of developing new technical assistance materials related to utilization management and the LOC criteria and system of care practice—for implementation in July 2005.

The State has invested with a Child Mental Health Implementation Team the responsibility for revision, training and monitoring activities related to LMEs' use of the LOC criteria. Essentially, the LMEs have a contract with the State, which currently is focused on broadening access to services for populations of children (as well as adults) with serious disorders. Recently, a child psychiatrist with experience in systems of care was hired to serve as clinical policy director for the children's system, and he is now chairing the Implementation Team. State-level stakeholders noted that, while the Team is charged with monitoring implementation at the LME level and has conducted some on-site audits, much of the monitoring approach is still under development. They stressed that conversion of the old Area Offices to LMEs constitutes a major systems change that is still very new.

Experience To Date

At present, the Child Levels of Care Criteria are being used primarily for eligibility determination and service authorization purposes by care coordinators in the Local Management Entities. Noting that the LMEs essentially are at risk for paying for services that are found in hindsight to not be medically necessary, State-level stakeholders believe that the criteria are being applied fairly rigidly at this stage at the LME level. They are hoping that the revised criteria slated for July 2005, including several new services, and the technical assistance materials from the State will help to promote use of the criteria within a "system of care" practice model (e.g., individualized, strengths-based).

With respect to their impact on access to services, State-level stakeholders reported that the criteria serve both to keep children in and out of services. For example, use of the CAFAS reportedly has helped to improve access for children who need them the most, that is, children with serious behavioral health disorders, those who are in or at risk for out of home placement, and children who are hearing impaired or homeless. On the other hand, LMEs reportedly complain that the LOC criteria frustrate access to certain types of services, such as Community-Based Services (e.g., in-home).

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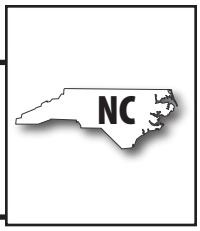

Major Benefits, Concerns and Lessons Learned

State-level stakeholders described the major strength of their Child Levels of Care Criteria as creation of some level of statewide consistency in child behavioral health service delivery. At the same time, however, they noted that there is still variance across the LMEs in their interpretations about medical necessity, and that the criteria as presently written may not incorporate sufficient flexibility at the clinical decision-making level to support individualized care. State-level stakeholders emphasized the importance of training to ensure consistency and prevent rigidity in use of the criteria. Based on their experience to date, they stressed that ongoing training and technical assistance to the localities and their providers is critical.