Managed Care Organizations (MCOs):
The Basics and Emerging Issues

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Who is Disability Rights NC?

- We are the protection and advocacy system (P&A) for North Carolina. By federal law, each state and US territory has one P&A. We are an independent 501(c)(3), non-profit organization.

- **Our Mission:** To protect the *legal rights* of people with disabilities through individual and systems advocacy.

- **Our Vision:** Disability Rights NC values the dignity of ALL people and their freedom to *control* their own lives. We work for justice, upholding the fundamental rights of people with disabilities to *live free from harm* in the *communities of their choice* with the opportunity to participate fully and equally in society.
What are LME/MCOs?

• Local Management Entity/Managed Care Organizations (LME/MCOs) are quasi-governmental entities that contract with the NC Department of Health and Human Services (NC DHHS), to provide management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level.

• LME/MCOs are publicly funded entities that are subject to both state law and federal managed care regulations.

What are LME/MCOs?

• LME/MCOs are accountable to NC DHHS/DMA, which retains oversight of the administration of the State’s Medicaid program and is ultimately responsible for ensuring compliance with Medicaid rules and regulations.

• Currently, there are 9 LME/MCOs operating within NC: Alliance, Cardinal Innovations, CenterPoint, Coastal Care, East Carolina Behavioral Health, Eastpointe, Partners, Sandhills, and Smoky Mountain Center.
Why Did the State Transition to a Managed Care Model?

- The transition was the result of a decision made by the N.C. General Assembly in 2010 in an effort to control costs.
- Since April 1, 2013, all Local Management Entities have transitioned to a Managed Care model.
- The idea was that managed care would allow for more efficient delivery of care and generate cost savings which could be used to fund additional services and supports.
What is Managed Care?

• In NC’s managed care system, the LME/MCO manages the local operations of the Innovations Waiver for individuals who have intellectual and/or developmental disabilities as well as state-funded mental health and substance abuse services.

• LME/MCOs provide Utilization Management (authorization of services), care coordination, provider network credentialing, and provider reimbursement.

What is Managed Care?

• In return, the LME/MCO gets a per member, per month payment from the State, referred to as the “capitated” rate, which is set in the contract between NC DHHS and the LME/MCO.
  
  – The LME/MCO bears the risk of loss that the cost of services may exceed the capitated rate that the State has agreed to pay.

  – If the LME/MCO provides services for less than the capitated rate, they are allowed to keep the savings and are supposed to use the savings to provide additional services known as B3 services.
### What Services are Under the Managed Care System?

- Innovations Waiver Program (formerly CAP-MR/DD)
- State-Funded (IPRS) MH/DD/SA Services (e.g., Developmental Therapy)
- Medicaid Mental Health State Plan Services (e.g., Psychosocial Rehabilitation, Community Support Team, Assertive Community Treatment Team, Residential Services for Children)
- B3 services

### What Services are Not Under the Managed Care System?

- Community Alternatives Program for Children (CAP/C)
- Community Alternatives Program for Disabled Adults (CAP/DA, CAP Choice)
- Medical services offered under the Medicaid State Plan (e.g., Hospital, Nursing Home, Private Duty Nursing, PT, OT, ST, Dental, Durable Medical Equipment)
- Medicaid State Plan Personal Care Services
How is Managed Care Different from Traditional Medicaid?

**Traditional Medicaid or “Fee for Service”:**

- Providers bill the state Medicaid agency directly for reimbursement of a service.
- Any “willing and qualified” provider is permitted to provide services.
- Authorization for services is provided by a State contractor, other than the LME, (e.g., The Carolinas Center for Medical Excellence, Value Options).
- Case management was a separate service provided by an independent, third party provider.

**Managed Care:**

- LME/MCOs receive a fixed amount of money per consumer, per month (capitated rate).
- LME/MCOs can and do limit their provider network.
- Utilization management (UM) functions are internal functions of the MCO, and they decide whether to approve or deny requests for services.
- Care coordination has replaced third-party case management, and is now an internal function of the LME/MCO.
### What are the Key Differences of the Waiver Under Managed Care?

**• Hour limitations on sets of services**
- 84 hours per week of any combination of Community Networking, Day Supports, Supported Employment, In-Home Skill Building, and Personal Care Services.

**• Exceeding Limitations on sets of services: In-Home Intensive Support Services (IHIS)**
- Provides habilitation, support and/or supervision services for individuals that require more than the 84-hour waiver limitation due to exceptional medical and behavioral needs.

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### What are the Key Differences of the Waiver Under Managed Care?

**• No “Enhanced” services**
- LME/MCOs may approve an *individualized rate* (higher pay rate) for Personal Care, Respite, or other services when the enrollee has exceptional medical and/or behavioral needs.
- Provider generally makes this request and must prove the need for exceptional care or more skilled staff.
What are the Key Differences of the Waiver Under Managed Care?

- More supporting documentation for service requests
  - LME/MCOs are requiring more clinical assessments and evaluations from enrollees to support the medical necessity of requested services.
  - LME/MCOs are requiring very specific and measurable short-term and long-range goals in the Individual Support Plan.

How Do I Access Services in NC?

Physical Health Services:
- Contact a Medicaid-enrolled provider
- Fee for Service

Behavioral Health Services:
- Contact your LME/MCO to obtain prior approval
  - Mental Health Services
  - Substance Abuse Services
  - Intellectual/Developmental Disabilities
- Capitated Rate
EMERGING ISSUES RELATED TO MANAGED CARE:

What are Common Concerns Expressed by Our Callers?

What are the Major Issues?

- Reduction in service hours and the replacement of In-Home Skill Building (IHSB) service hours with Personal Care Service (PCS) hours;
- Authorization periods for certain services that are for less than the entire plan year;
- Loss of Waiver slots, or the failure to receive a slot because an individual’s “IQ is too high” despite the existence of substantial functional/developmental limitations;
What are the Major Issues?

• Reductions in Relative/Parents providing direct care hours;

• Failure of LME/MCO to approve/deny requests for service within 14 days of receipt of authorization request; and

• Increased focus on fading plans by the LME/MCO.

Replacement of IHSB with PCS

Problem:
• Waiver participants have experienced either: (1) a reduction in the total number of habilitative service hours being authorized; or (2) a reduction in the number of habilitative service hours and then a substitution of the lost hours with PCS hours.

Recommendation:
• IHSB focuses on training and skill building that enable an individual to acquire and maintain skills supporting greater independence (e.g. training in interpersonal skills, development and maintenance of personal relationships, shopping, recreation, banking, etc.).
Replacement of IHSB with PCS

- IHSB is distinguished from PCS by the presence of training.
- It is crucial to demonstrate the medical necessity of all IHSB hours requested and how those hours will be used to train/develop new skills and/or maintain current skills, as opposed to performing the task for the person.
- The individual should use letters from their treating physicians; make a clear connection between the service definition and the stated goals in the ISP; and demonstrate how failure to approve the services will result in harm to the enrollee.

Less Than Annual Authorization Periods

**Problem:**
- Many services require prior authorization and are being limited to 30, 60, or 90 days instead of annual authorizations, resulting in continuous re-authorization requests that require extensive documentation and potentially repetitive and time consuming appeals (e.g., IHIS, IHSB, Individual Day Supports, RDSEs).

**Recommendation:**
- Push to get a service authorized for the entire plan year.
- Clarify from the LME/MCO what documentation will be necessary for the service to continue for the entire plan year and/or be reauthorized at certain intervals.
IQ as the Determining Factor for Waiver Eligibility

Problem:

• Individuals are losing their Waiver slots or are being denied placement on the Waiver waitlist (Registry of Unmet Needs) based strictly on IQ (LME/MCO suggests it is too high).

• Once this decision has been made, individuals are not being granted appeal rights from the LME/MCO to contest the decision.

Recommendation:

• Serious *functional behavioral limitations in the areas of self-care (including personal safety), use of language, learning, mobility, self-direction, and capacity for independent living* are part of the criteria for whether an individual is eligible for the Waiver, regardless of IQ score.

• Functional behavioral limitations are generally determined during a psychological evaluation, and participants should ensure that those who know them best complete the Adaptive Behavioral Assessment paperwork.
IQ as the Determining Factor for Waiver Eligibility

• It is essential that individuals make sure the evaluator receives all records that demonstrate the participant’s functional limitations (e.g., medical records, school records, letters from care providers (parents, CAP workers, teachers).
• Losing a slot, failure to be given a slot when available, or refusal of the LME/MCO to place an individual on the waitlist based on IQ are “actions” that trigger appeal rights because the individual is being denied the opportunity to ever receive Waiver services without any type of adaptive behavioral assessment.

Relatives as Direct Service Employees (RDSEs)

Problem:
• LME/MCOs are limiting RDSEs (e.g., parent providers) to 40 hours or less per week, despite there being no other qualified and willing service providers available.
• LME/MCOs have taken the position that when an enrollee is denied their choice of a relative provider, or the number of service hours the relative may provide, the remedy is to file a grievance internally with the LME/MCO with no right of appeal to the Office of Administrative Hearings (OAH).
Relatives as Direct Service Employees

Recommendation:

• There is no hard and fast rule in the Waiver and related policies limiting RDSEs to 40 hours or less.

• When RDSEs request to exceed 40 hours:
  – The participant/provider should provide additional detailed justification as to why other providers are not available or qualified, and
  – Information on why it is necessary for the RDSE to provide the hours in order to assure the participant’s health and welfare.

Relatives as Direct Service Employees

• Disability Rights NC takes the position that the participant has a right to appeal a denial when the LME/MCO’s refusal to permit the RDSE to serve as the provider acts as an effective denial of services. There is an effective denial when there are no other available and/or qualified, unrelated staff to perform the authorized services.

• However, in situations where outside staff is available and qualified, the participant may not have the right to appeal to OAH because the participant does not have a right to choose one particular provider at the exclusion of all others, although they are entitled to a choice among qualified providers.
Timely Authorization Decisions

Problem:
• LME/MCOs failing to approve or deny services within 14 days of the service request being submitted to the LME/MCO, resulting in an interruption in services for the enrollee.

Recommendation:
• For standard authorization decisions, the 14 day time period begins to run when the LME/MCO receives a completed request for services—not at the point when Utilization Management receives the request.

Increased Emphasis on Fading Plans

Problem:
• LME/MCOs denying requests for In-Home Intensive Services (IHIS) for failure to include a fading plan or a plan for obtaining assistive technology. Alternatively, LME/MCOs will authorize the IHIS, but only for one, 90-day period.

• Recently, there has been an increased emphasis on fading plans for In-Home Skill Building despite the service definition explicitly stating that a formal fading plan is not required.
Increased Emphasis on Fading Plans

Inconsistencies in the policies discussing the necessity of a fading plan as a prerequisite to receive IHIS:

- Both the NC Innovations Waiver Technical Guide and Clinical Coverage Policy 8P (Innovations Waiver), state that authorization for IHIS requires an “Assessment, and if indicated, a fading plan or plan for obtaining assistive technology to reduce the amount of In Home Intensive Supports need by the participant.”

- The Waiver states that authorization for IHIS requires that, “The ISP includes an assessment and a fading plan or plan for obtaining assistive technology to reduce the amount of intensive night support needed by the participant.

- Disability Rights NC takes the position that an argument can be made that a fading plan is not always required because, in some cases, it may not be “indicated” (where the severity of the disability is so great that this service can never be “faded” out) or it should only be applied to an individual using IHIS for overnight staff.
Increased Emphasis on Fading Plans

**Recommendation:**

- Nothing in the Waiver requires IHIS to be discontinued after 90 days (even though it must be reauthorized every 90 days).

- Fading plans should be action-based as well as outcome-based. They should discuss specific actions that the family, treatment team, or participant will take to locate alternative support services in lieu of the IHIS, as opposed to just focusing on what types of things the participant will achieve with the IHIS.

Future of Managed Care in NC

- NC DHHS hopes to eventually reduce the number of LME/MCOs from nine to four within the next couple of years.

- The LME/MCOs that are expected to remain are: Smoky Mountain Center, Cardinal Innovations, Alliance Behavioral Health, and East Carolina Behavioral Health.

- Coastal Care will merge with East Carolina Behavioral Health by July 2015.
Proposed New Managed Care Organization Map

Additional Resources

• Innovations Waiver: http://www.ncdhhs.gov/dma/lme/Innovations_Amendment_5.pdf

• Clinical Coverage Policy 8P: http://www.ncdhhs.gov/dma/mp/8P.pdf

• Medicaid State Plan Services (mandatory & optional): http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html
Additional Resources

• North Carolina Medicaid Services: http://www.ncdhhs.gov/dma/mp/index.htm


Additional Resources

• Dave Richard, Deputy Secretary of Behavioral Health and Developmental Disabilities Services, DHHS, dave.richard@dhhs.nc.gov, (919) 855-4800

• Courtney Cantrell, Director of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services, DMH/DD/SAS, courtney.cantrell@dhhs.nc.gov, (919) 733-7011
Additional Resources

• Deb Goda, IDD Manager, DMA, deborah.goda@dhhs.nc.gov, (919) 855-4290

• Kathy Nichols, Lead Waiver Contract Manager, DMA Katherine.Nichols@dhhs.nc.gov, (919) 855-4290

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