Changes to Your LME: Transitions to Managed Care

What is managed care? What happens to CAP-MR/DD or CAP-I/DD services? What if my family member does not receive CAP-MR/DD or CAP-I/DD? How will the services be different?

Disability Rights NC created this document to provide general answers to the above questions and provide further information about the differences families may encounter as they transition to receiving services from managed care organizations (MCOs) for Medicaid-funded mental health, developmental disability, and substance abuse services. Although Local Management Entities (LMEs) serving all counties in the State are transitioning to MCOs, each MCO will have some flexibility in how they operate their 1915(b)/(c) waiver program. The information in this document is intended to be a generalization of how services should transition and what the differences will be. It may not reflect some of the differences in how any particular MCO may operate. Some of the inherent LME functions, such as the appeals process, should remain consistent, but others, such as internal care coordination instead of external case management, may reflect choices made by a particular MCO.

Why are LMEs changing to MCOs?

By April 2013, all Local Management Entities (LMEs) in North Carolina will transition from the traditional LME model to become Managed Care Organizations (MCOs). This means that each MCO will be administrating its own Medicaid 1915(b)/(c) waiver and all current MH/DD/SA services, including CAP-MR/DD, will transition to Innovations services. The MCO will only manage behavioral health services. Services such as medical services, non-waiver personal care, CAP-C, CAP-DA, PT/OT for non-waiver recipients, private duty nursing, etc. will still be managed by NC DHHS and its contractors.

The transition to managed care is the result of a decision made by the N.C. General Assembly during the 2010 legislative session to replicate throughout the state what was previously a demonstration project by Piedmont Behavioral Healthcare (a/k/a PBH or Cardinal Innovations). This decision transfers the responsibility of managing certain services from the State to the LME/MCOs.

Some LMEs have become a part of PBH. These LMEs (Five County, Alamance-Caswell, and OPC) are under the direct supervision and control of PBH, and will use service definitions and limitations found in PBH’s Cardinal Innovations program.

The remaining MCOs will not be under the control of PBH, but based on direction from the General Assembly, the North Carolina Department of Health and Human Services (NC DHHS) will require the MCO to maintain “fidelity to the PBH model.” Each MCO will interpret this language differently, and it is unclear how much variation between MCOs that NC DHHS will allow, especially in the beginning.
Before they transition to MCOs, non-PBH LMEs will continue to use the CAP MR/DD program. In November 2011, the State planned to transition those on CAP MR/DD to CAP I/DD, which would have been similar to the Innovations programs. However, CMS granted extensions of CAP-MR/DD and now only those in Eastern Coastal Care (Brunswick, New Hanover, Pender, Onslow and Carteret County), Guilford Center, and Mecklenburg County will transition to CAP-I/DD before the LME transitions to a MCO. A Medicaid Special Bulletin from October 2012, available on the NC DHHS website, discusses the process for transitioning to CAP-I/DD. For those LMEs not becoming part of PBH, when the LME transitions to an MCO it will immediately begin using the N.C. Innovations program. The transition to MCOs apparently will be phased in as follows:

- Western Highlands Network (effective Jan. 1, 2012)
- East Carolina Behavioral Health (effective Apr. 1, 2012)
- Smoky Mountain Center (effective Jul. 1, 2012)
- Sandhills Center/Guilford (Sandhills will transition Dec. 1, 2012, Guilford Center will merge with Sandhills on Jan. 1, 2013 and Guilford County will be added under the MCO effective Apr. 1, 2013)
- Partners Behavioral Health Management (formerly Pathways, Mental Health Partners, and Crossroads LMEs—effective Feb. 1, 2013)
- CenterPoint Human Services (effective Feb. 1, 2013)
- Eastpointe/Southeastern Regional/Beacon Center (effective Jan. 1, 2013)
- Alliance Behavioral Healthcare (Durham/Wake/Johnston/Cumberland) (effective Feb. 1, 2013)
- *CoastalCare (formerly Southeastern Center and Onslow-Cartaret Behavioral Health Services LMEs—effective Feb. 1, 2013)
- *MeckLink Behavioral Healthcare (effective Feb. 1, 2013)

*MeckLink and CoastalCare may need more time, but there will be readiness reviews in November for all transitioning MCOs that will provide more information about possible delays.

The Cardinal Innovations and N.C. Innovations waiver are substantially similar and contain many of the same services, so we will refer to them together as the “Innovations” waiver. Please consult your MCO waiver handbook for specific information about services under your particular waiver program.

**What services are different under the Innovations waiver?**

Many waiver services will undergo significant changes with the MCO transition. Some services will be combined into one or two new services, others will be split up amongst several other services, and a few others will be eliminated entirely. An individual must still document his/her medical need for a particular service, even if fewer overall service hours are required to meet that need. As of January 2012, the following services will undergo a major change as each LME transitions to an MCO:
• **Home Supports and Home/Community Supports**
  ○ Skills education, otherwise known as “habilitation,” that was formerly provided by Home Supports will now be covered under a new service called **In-Home Skill Building**
  ○ **Personal Care** may still be requested to provide non-habilitative support/supervision
  ○ Under Home Supports, the person received a mix of habilitative/skills training and personal care services; the rate for this service was intended to reflect this blend. The Innovations waiver separates the habilitative (In-Home Skill Building) and personal care hours with different rates for each of these services.
  ○ Individuals with extensive needs can request additional services under a new service called **In-Home Intensive Support**
    ■ This service is likely to be much more difficult to obtain than the standard In-Home Skill Building service. It provides habilitation support and/or supervision to assist with positioning, intensive medical needs, elopement and/or behaviors that would result in injury to self or others.
    ■ In-Home Intensive Support is **not** intended to become a permanent part of a individual’s plan
    ■ This service requires an assessment and “fading plan” to gradually reduce the service over time or, where appropriate, transition to assistive technology

• **Enhanced Personal Care and Enhanced Respite**
  ○ Each of these is eliminated as a separate service under the waiver
  ○ Nursing Respite is still available for individuals with exceptional medical (not behavioral) needs
  ○ Individuals with exceptional behavioral needs may request **In-Home Intensive Support**
  ○ Some LMEs/MCOs will approve a provider’s request for an enhanced rate for either Personal Care or Respite services, if the provider can prove the need for exceptional care or more skilled staff. This varies among MCOs as some allow care coordinators to request enhanced rates when necessary while others have stated they will not allow enhanced rates, in particular for the first year of the transition. If an individual needs an enhanced rate, they may try to request it or work with a provider to request it. Such a request may be particularly difficult at the initial transition stage and may be more effective after you can demonstrate difficulty in keeping or finding appropriate staff.

• **Community Guide, Community Networking, and Community Transition**
  ○ These are new services under the Innovations waiver
  ○ **Community Guide** services help an individual locate resources and activities in the community
  ○ **Community Networking** services assist an individual with participating in those community activities
    ■ Also covers membership fees or classes, up to $1,000/year
  ○ **Community Transition** services cover start-up costs (i.e. rent deposits, moving services, etc.) to allow an individual to transition from an institution to a licensed
community placement such as an Alternative Family Living (AFL) home or group home
  ■ Limited to $5,000/year

● **Long-Term Vocational Supports**
  ○ This service is eliminated, but many individuals who require assistance with conventional job skills will receive **Supported Employment** services.
  ○ Individuals who require some job coaching, but are not ready for conventional employment, will be served by **Day Supports** services

● **Individual Caregiver Training and Education**
  ○ Covered under a new service called **Natural Supports Education**

● **Crisis Respite**
  ○ Service is now covered under a service called **Crisis Services**, but can only be provided for 14 days at a time

● **Transportation**
  ○ Eliminated as a separate service, but the rate for other waiver services is supposed to include transportation so as to allow the individual to access the services. Transportation is excluded for some services for specific purposes, such as medical transportation or transportation to and from school under personal care. Community Networking also covers transportation for inclusive activities in the community.

To illustrate the difference this makes in an individual’s plan of care, imagine the following scenario:

You know a 24-year-old individual who has autism and a moderate intellectual disability. When agitated, this individual may exhibit some verbal aggression or engage in minor property destruction. This individual lives at home, but likes to go out in the community. This individual has a tendency to wander away from his caregivers when not closely supervised. This individual receives 40 hours per week of Home Supports and 28 hours per week of Personal Care.

Under the new Innovations service array, this individual’s plan of care may instead look like this:

The 40 hours per week of Home Supports will no longer appear on the plan of care. Instead, it will be split into a portion of habilitative hours (e.g., 24 hours/week of In-Home Skill Building) and another portion of non-habilitative hours (e.g., 38 hours/week of Personal Care). To address the wandering issue, a certain amount of intensive support (i.e. 10 hours/week of In-Home Intensive Support) may be approved, but that request would involve a plan to “fade” this service out of the plan and, if appropriate, transition this individual to some form of assistive technology to address the need (i.e. door or window alarms that would alert staff). If the individual does not participate in any community activities, a very limited amount of Community Guide may be approved to assist with finding community
activities. While the hours may not be the same under Innovations as under CAP, the goal of both waiver programs—to keep an individual in the community—will still be met.

What do I do if I am on a wait list for waiver services?

The MCO is also responsible for identifying services for individuals who do not participate in the Innovations waiver, such as individuals currently waiting for waiver or CAP-I/DD services. Each MCO may use different criteria for statewide non-Medicaid services, such as developmental therapy. Additionally, individuals may request medical services under standard Medicaid; the NC Division of Medical Assistance (DMA) will continue to review and act upon these requests. Some MCOs may authorize a limited amount of external case management services for individuals who do not receive waiver services, while others may authorize care coordination services from their own employees.

There will continue to be a waitlist for waiver services from an MCO; many MCOs refer to this list as the “Registry of Unmet Needs.” Some waiver slots are reserved for specific populations of individuals, including:

- Individuals at “significant, imminent risk of serious harm;”
- Individuals moving from another waiver program (e.g., CAP-C);
- Individuals eligible for Money Follows the Person funding;
- Children aged 0-17 who are moving from an institution;
- Individuals receiving waiver services in another state who were transferred to NC for military service.

Previously, LMEs used a prioritization tool, which looked at level of need and time on the waitlist, to establish a person’s position on the CAP waitlist. With the transition to MCOs, the registry of unmet needs is generally based on time, with the exceptions listed above. How an MCO defines individuals at “significant, imminent risk of serious harm” will be decided by the MCO.

Under the old LME system, many individuals on the waitlist for CAP services received a limited amount of state-funded services such as Developmental Therapy or Respite. Individuals who do not participate in the Innovations waiver may also ask about “state-funded services” and “(b)(3) services” from an MCO. Under section 1915(b)(3) of the Social Security Act, MCOs in North Carolina may allocate some of the savings from the managed care system into additional services, such as Respite or Community Guide, for non-waiver participants. It may take some time for new MCOs to offer (b)(3) services because the services are based on savings incurred over a period of time. There may also be differences among MCOs as to which (b)(3) services they offer because the system is intended to allow each MCO flexibility or innovation in this area. This means one MCO may use (b)(3) services to try a new service, while another may provide additional services of a service they already offer. The (b)(3) and state-funded services are only available when the MCO allocates funding to support them. As a result, individuals might find that the MCO authorizes these services in very limited amounts, especially in the initial years of an MCO’s operation.

Who will provide waiver services? Can I keep the same service provider?

Unlike standard Medicaid or CAP, MCOs operate a closed provider network. This means that every agency who wants to provide services in that MCO’s catchment area must undergo a separate
enrollment and credentials process. The MCO decides whether or not a particular agency will be authorized to provide services within the network. MCOs must have sufficient capacity to allow individuals to access services. In our experience, many agencies that provided CAP services have been granted permission to provide Innovations services. If your provider is not allowed to provide Innovations services, your care coordinator will direct you to other options. So far, LMEs have not always completed the provider enrollment/credentials process before they become MCOs, so transitions between providers may not necessarily occur at the same time the LME becomes an MCO.

Who will provide case management?

Until LMEs become MCOs, a private third-party case management agency will remain responsible for providing case management services to an individual. As an LME becomes an MCO, the “case manager” may be replaced by a “care coordinator” for Innovations waiver participants. As opposed to “case managers,” the care coordinator will be employed by the MCO, rather than an independent agency, and the role care coordinators play is different. Most of the MCOs have followed PBH’s example and are using internal care coordination, although Western Highlands Network has maintained external case management. While care coordinators assist with the preparation of an individual’s plans of care, individuals and families may find that their care coordinators rely more on information about guidelines and limits on services in guiding a plan compared to their experience with case managers. Case coordinators gather assessments, develop person centered plans, and link and refer to appropriate services, but they generally do not play as active a role in problem-solving or advocacy when compared to case managers. As a result, individuals must be pro-active and obtain documentation of the individual’s needs from his/her caregivers, physicians and/or therapists. Individuals or their guardians should keep their care coordinator/case manager well-informed of problems with the individual’s services and document any conversations with the care coordinator.

For individuals on the registry of unmet needs, the MCO may offer Community Guide services, maintain third-party case management, or provide care coordination. If additional services are needed, individuals or the guardians should take care to articulate and document specific needs, behaviors, or problems that necessitate additional services.

Who will approve or deny a request for services?

MCOs likely will not contract with an outside agency, such as ValueOptions, to review requests for services from individuals who are and are not Innovations waiver participants. Instead, each MCO could have an internal approval process (also known as “utilization review,” “utilization management,” or “care management”) that will make the decision to approve, deny, reduce, or terminate a service.

What do I do if the MCO denies my request for services?

If the MCO makes the decision to reduce, deny, or terminate an individual’s services, the MCO must provide written notification of that decision and provide for an opportunity to appeal. LMEs will continue to use the existing system for appeals until they become MCOs. At that time, individuals or their guardians have thirty (30) days from the date of the notice to begin the appeals process by making a request for the MCO to reconsider its decision. In order for services to
continue pending appeal, the request should be made within ten (10) days. This phase of an appeal is strictly an internal review of documentation of an individual’s needs and appropriate services to meet those needs. If it is available, additional documentation should be submitted with any request for internal reconsideration, along with a detailed explanation of the basis for the request. The MCO has forty-five (45) days to make a decision from the date they receive the reconsideration request. If an individual’s health or safety requires urgent reconsideration of the MCO’s decision, s/he may request an expedited review; the MCO must act on these requests within three (3) business days. If the MCO does not reverse its decision, the individual/guardian may appeal to the state Office of Administrative Hearing (OAH), where similar, strict deadlines still apply. An appeal must be made within thirty (30) days, and within ten (10) in order for services to be maintained. A mediation teleconference will be held, at which time the parties can attempt to settle the appeal. If mediation is unsuccessful, the individual/guardian will have an opportunity to present their case in an informal hearing (either in person or by phone) at OAH.

What new limitations are in the Innovations waiver?

- **Restrictions on the Number of Habilitative Service Hours a Participant Receives per Month**
  - Adults or Children (non-school days) receiving Residential Supports may receive no more than 40 hours/week of any combination of Community Networking, Day Supports, and/or Supported Employment
  - Children receiving Residential Supports during school year may receive no more than 20 hours/week of any combination of Community Networking, Day Supports, and/or Supported Employment
  - Adults in private homes or children in private homes on non-school days may receive no more than 84 hours/week of any combination of In-Home Intensive, In-Home Skill Building, Personal Care, Community Networking, Day Supports and/or Supported Employment
  - Children in private homes on school days may not receive more than 54 hours/week of any combination of In-Home Intensive, In-Home Skill Building, Personal Care, Community Networking, Day Supports and/or Supported Employment
  - Participants in private homes with intensive support needs may receive up to additional 12 hours/day of intensive night supports with approval of Medical Director for up to 6 months.

- **Restrictions on Relatives or Legal Guardians Providing Services**
  - Relative or legal guardians living in household of the adult Participant may provide Community Networking; Day Supports; In-Home Skill Building, In-Home Intensive Support, Personal Care and/or Residential Supports
  - Relative/legal guardian must request approval from the MCO
    - Each MCO may use different criteria, but they generally involve documenting efforts of failure to find alternative, reliable providers
  - Typically relatives or legal guardians may only provide 40 hours/week or 7 daily units among all relatives/guardians providing services in the household
    - Many MCOs will develop a process that would allow guardians to exceed that limit, but that exception may have limitations and will require documentation of why the exception is needed
Provider Agencies and Employers are required to monitor services monthly

- **SIS Score / Support Needs Matrix**
  - Every individual participating in the Innovations waiver will undergo an annual Supports Intensity Scale (SIS) evaluation, which will guide the treatment team in identifying an appropriate amount of services in the annual plan. The SIS is replacing the NC Support Needs Assessment Profile (NC-SNAP) as an assessment tool.
  - Currently, PBH uses a system called the Support Needs Matrix (SNM) that uses the SIS score to determine a base budget for certain services, such as Personal Care, Respite, In-Home Skill Building, and Day Supports. As more individuals undergo SIS evaluations, the State is gathering information to begin implementing a system very similar to the SNM called “Innovations Plus”.
    - Under the SNM and planned Innovations Plus system, an individual is assigned to a particular budget based on the SIS evaluation and other factors that include the individual’s age, residence (group home, family home, etc.), and significant medical or behavioral supports needed and other factors.
    - An individual may request certain additional, or “add-on” services; the MCO will have the discretion to approve or deny add-on services.

- The State plans to have gathered a sufficient sample size of SIS scores (5200+) by April 2013 and it will take some time after that for the Human Services Research Institute (HSRI) to develop a resource allocation model. Therefore, while individuals will undergo the SIS, which may help guide the person’s budget much like their NC SNAP score did in the past, Innovations Plus will not be implemented yet.
- Resources: the Developmental Disabilities Training Institute website has information about the SIS in NC, [http://ddti.unc.edu/SIS.asp](http://ddti.unc.edu/SIS.asp), and AAIDD, which created the SIS, also has useful information on its website at [http://siswebsite.org](http://siswebsite.org)

In addition to these changes, each MCO may develop policies that could affect services or change the yearly planning process compared to what it had been under CAP. For example, some MCOs may request more assessments or information than was required previously. Such assessments or information usually will often help support a request for hours/services. If new assessments are required, the MCO should provide sufficient notice that the assessment is needed and allow a reasonable period of time to get the assessment. Another common trend is toward group instead of individual services. If a person is requesting individual services, the request should be supported by clinical documentation of why individual services are necessary and group services are inappropriate. The length of service authorizations for some services may become shorter, and may require Temporary Authorization Requests (TARs), particularly for intensive services, that may initially be limited to ninety (90) days.

**Do I have a right to appeal the new Innovations waiver restrictions/policies?**

Unfortunately, there is not a simple answer to this question at this time. Because many of the services under the Innovations program are “optional” services, meaning that a State may choose not to provide them under its Medicaid state plan, their elimination does not always clearly require a right to appeal. When this happens as a result of legislative changes to state laws, a State may not be
required to afford appeal rights to changes in “optional” services. Here, however, because individuals are being transitioned from services under one waiver to services under a new, similar waiver, the question is less clear, and appeal rights may be required. If a person requires services beyond the limitations outlined in the new waiver, they should discuss this with their case manager/care coordinator and submit a Plan requesting adequate services that will meet their needs. If a notice of appeal rights is not given, there may be other avenues available to pursue an appeal at OAH or OCR.

**Do children have legal protections to new restrictions/policies under the Innovations waiver?**

Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, states must provide early and comprehensive preventive care and broad treatment services for children and youth under age 21. EPSDT services include any medical or remedial care that is medically necessary to “correct or ameliorate” a defect, physical or mental illness, or condition (health problem), or to maintain a child’s health or prevent the condition from worsening. For EPSDT listed services offered under the Innovations waiver that are subject to a particular restriction or limitation, states are still required to provide those services if they are found to be medically necessary to “correct or ameliorate” a defect, physical or mental illness, or condition, or to maintain or prevent it from worsening.

EPSDT only applies to services that specifically appear in the federal Medicaid statute; services that provide only skills education (or “habilitative” services) do not appear in the statute. As a result, states are not required to overrule restrictions under the Innovations waiver for strictly habilitative services, such as in-home skill building, that are not EPSDT listed services.

**Can I request a reasonable accommodation/modification of the Innovations waiver’s restrictions?**

In very limited circumstances a person may be able to request a reasonable modification of (or exception to) the Innovations program rules. The law governing reasonable modification of state policy or program rules is usually based on an individual’s right to live in the most integrated setting/least restrictive environment, and it is very specific to the circumstances of a particular individual’s risk of institutionalization. These rights stem from the Americans with Disabilities Act (ADA) and the *Olmstead* cases, which require cost neutrality, *i.e.*, the community services cannot cost more than care in an institutional setting. Another possible basis for a reasonable modification or accommodation does not necessarily require risk of institutionalization but could be based in changes necessary, because of specific aspects of his or her disability, to allow an individual equal access to the waiver program. Please keep in mind, legal representation is likely to be needed to succeed in an appeal in most of these cases. The waiver programs are designed to keep people with disabilities out of institutions, so exceptions are quite rare and very fact-specific.

Families who submit a plan that is denied and want to appeal, may contact:

- Disability Rights NC (statewide) 1-877-235-4210
- Legal Aid of NC (statewide) 1-866-369-6923
- Legal Services of Southern Piedmont (if recipient lives in the Mecklenburg county area) 1-704-376-1600
• Council for Children’s Rights (if recipient is a child and lives in Mecklenburg county)  
  1-704-372-7961  
• Pisgah Legal Services (if recipient lives in Buncombe, Henderson, Madison, Polk, Rutherford or Transylvania counties) 1-800-489-6144

However, please be aware that these nonprofit agencies have limited resources and cannot represent many of the families that contact them. Families with the means to do so may wish to contact a private attorney.

How is Disability Rights NC helping individuals and families transition?

Disability Rights NC is closely monitoring the individual LMEs as they transition to MCOs and responding to address problems where possible and working at the policy level to ensure rights are protected during the transition. Much of our work may not be readily apparent to individuals as we communicate with individual LMEs, DHHS, and CMS. We are also advocating public policies that would mandate additional terms for behavioral health MCO contracts between the State and LMEs to ensure compliance with State and Federal law. At the more individual level, Disability Rights NC is conducting trainings in some areas of the State as they transition to MCOs. We also continue to provide technical assistance to some individual requests for assistance, and we represent people in individual Medicaid Appeals at OAH where we have the capacity to do so. Disability Rights NC also continues our work ensuring rights of people with disabilities in MCOs through the two federal lawsuits we have against PBH, one on behalf of six individuals and the appropriate level of services and the other on behalf of a class of recipients who, we allege, were not provided appropriate due process when PBH began using the Supports Need Matrix.

The transition to managed care for mental health, developmental disabilities, and substance abuse services has and will continue to affect thousands of individuals, and many families/guardians have questions or concerns about the transition. Disability Rights NC employs approximately one attorney for every 158,000 individuals with disabilities in North Carolina and the work of these few attorneys is spread among our various targets. Based simply on capacity, we cannot offer individual representation to everyone affected by the transition to managed care. Instead, we provide information and guidance to help you understand the changes and self-advocate for a resolution to your concerns. However, we use your concerns and information to help inform us about problems and issue areas as LMEs transition to MCOs. We hope you understand that even though we may only take limited individual cases for representation, these cases are selected strategically, and we continue to advocate for changes that will be positive for as many people as possible through our efforts.

This document, created in April 2012 and modified November 2012, contains general information for educational purposes and should not be construed as legal advice. It is not intended to be a statement of the law and may not reflect recent legal developments. If you have specific questions concerning any matter contained in this document or need legal advice, we encourage you to consult with an attorney.