Disability Rights North Carolina

October 30, 2020

Dr. Mandy Cohen, Secretary
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

Via email only to: mandy.cohen@dhhs.nc.gov

Re: Union and Cabarrus Counties Catchment

Dear Secretary Cohen:

We write regarding the proposed change in catchment area requested by Union and Cabarrus Counties. As you know, Disability Rights North Carolina (DRNC) is our state's protection and advocacy organization, charged with advancing the rights of people with disabilities. Until now, we have never weighed in on the decision by a county or by the Department regarding the assignment of a county to the catchment area of an LME/MCO. We are doing so now because how you respond to this situation will be watched carefully by the other LME/MCOs. We are urging you to take this opportunity to re-set expectations about how LME/MCOs must serve their constituents.

As we understand it through media reports, Union and Cabarrus commissioners have expressed concerns about the failures of Cardinal Innovations regarding, among other things, providing for appropriate services. Similar concerns were raised in correspondence from Forsyth and Mecklenburg County officials to Cardinal. The provision of appropriate services is, of course, a fundamental duty of an LME/MCO. *See* N.C. Gen. Stat. § 122C-115.4 (requiring LMEs to "assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results"); *see also O.B. v. Norwood*, 838 F.3d 837, 843 (7th Cir. 2016) ("'where the Medicaid Act refers to the provision of services, a participating State is required to provide (or ensure the provision of) services, not merely to pay for them'") (quoting *A.H.R. v. Washington State Health Care Authority*, 2016 U.S. Dist. LEXIS 2587, 2016 WL 98513, at *12 (W.D. Wash. Jan. 7, 2016)).

Comments recounted by North Carolina Health News indicated a frustration with county efforts to collaborate with Cardinal. This concern echoes what we hear from beneficiaries and families,

who feel their efforts to engage Cardinal's assistance are ineffective. Frequently, beneficiaries are given a generic list of providers rather than assistance locating a suitable provider. This is often a fruitless process because of insufficient provider availability. Of course, establishing a sufficient network of providers is a key duty of an LME/MCO. *See* N.C. Gen. Stat. § 122C-115.4 and 42 C.F.R. § 438.206(b)(1) (2020) (requiring a single state agency to "ensure, through its contracts, that each MCO. . . consistent with the scope of its contracted services . . . [m]aintains and monitors a network of appropriate providers . . . sufficient to provide adequate access to all services covered under the contract for all enrollees."). Cardinal's failure to fulfill its contractual and statutory obligations has dire consequences for beneficiaries. The families of many enrollees, unable to get assistance from Cardinal, must also live with the relentless stress – not to mention job loss, economic hardship, and personal consequences – created by the long-standing failure of their LME/MCO to meet its obligations.

We are primarily concerned with what, in our opinion, is the failure of Cardinal Innovations to understand itself to be a public health agency charged with ensuring the delivery of behavioral health services. Over the years, Cardinal has taken a narrow view of its obligations, contending, as North Carolina Health News pointed out, that it was not bound by state rules. It took this position in litigation over a finding of contempt. *See In Re A.C.G.*, No. 10-1552 (N.C. App. Sept. 6, 2011) ("PBH argues the Medicaid waivers under which it operates supersede Chapter 122C of our General Statutes.") In that case, Cardinal (then PBH) also likened itself to an insurance company. *In Re A.C.G.*, No. 10-1552 (N.C. App. Sept. 6, 2011). Cardinal continues to assert that its administration of waivers overrides its obligations under state and even federal law – arguing in recent cases that it is not bound by the *Olmstead* decision where it conflicts with Cardinal's administration of the Innovations Waiver. Are these simply historical artifacts of a prior incarnation? Echoes of these early warnings have continued to reverberate in the reasons underlying the concerns raised by all four counties: 1) Cardinal's failure to ensure that services are provided and 2) its resistance to oversight.

It is long past time the Department took a clear and public stand regarding LME/MCOs not fulfilling their obligations. LME/MCOs have not been held accountable for failing to have adequate provider networks, and for failing to appreciate the need to serve people in the community – including the children sent out of state for ineffective, costly, institutional care due to their failure to secure community-based services at home. These counties are telling you that Cardinal has failed of its essential purpose in their communities. *See* N.C. Gen. Stat. § 122C-124.1(b) (providing for the Secretary to act where an LME "is not providing minimally adequate services to persons in need in a timely manner.")

If you send the signal that Cardinal will be allowed to continue to neglect children and adults in need of services, and to utterly fail to appreciate the nature of its role as a public health agency, every LME/MCO will hear that loud and clear and will feel free to apply that approach to their exclusive Tailored Plan contracts. By the same token, if you approve these counties going to another LME/MCO, it is critical that you extract from the destination LME/MCO clear commitments to establish robust networks and produce positive outcomes, and to not follow the Cardinal model that has long hindered our behavioral health system.

This letter is not an endorsement of any LME/MCO that these counties may seek to join. It is a request that you set clear expectations for all LME/MCOs that Cardinal is not a model to be emulated; it is a cautionary tale to be studied. The core lessons, in our opinion, are these:

- LME/MCOs – which are public health agencies – cannot be allowed to subordinate their duties as *local* management entities. An LME/MCO should view itself as primarily concerned with ensuring the provision of needed supports and services. Cardinal's unabashed reference to itself as akin to an insurance company speaks volumes and has echoed through the years in its actions. While there have been high level management changes at Cardinal, nothing has changed the underlying culture in this regard.
- The Department cannot allow LME/MCOs to dictate the terms of contracts, including how success is measured, and how oversight is conducted. LME/MCOs exist at the pleasure of the Secretary, who awards contracts worth billions of dollars. Yet, it appears that the Department has historically been unwilling or unable to assert its leverage to negotiate and enforce strong contracts with meaningful measurables and consequences for failure.

You are uniquely positioned to make a fundamental shift in how behavioral health services are delivered in North Carolina. And it will not be through tweaks and adjustments; it can happen – and will *only* happen – with real accountability and clear messaging about how you expect LME/MCOs to serve the public interest, and how you expect your department to enforce that vision.

Sincerely,

Virginia Knowlton Marcus
Chief Executive Officer