

## 1915 b/c WAIVER QUESTIONS

Statewide implementation of the 1915 b/c waiver raises a number of questions for licensed professionals who have been working in the public sector to serve both Medicaid and state-funded clients. It is imperative that North Carolina maintain a well-trained, clinically sophisticated workforce who have the skill and knowledge to treat these complex cases.

The Professional Association Council submits the following questions that need answers prior to implementation of the waiver. PAC is concerned about the erosion of licensed professionals who will be willing and able to treat Medicaid patients in the waiver environment. We are also concerned about ensuring that there is access to quality, appropriate care – and access to the lesser cost services that keep patients out of the more costly services. We want to ensure against quality care being compromised in an effort to curb costs.

### POLICY

1. *What will DHHS do to assure the continued ability of licensed professionals to be able to treat Medicaid patients, particularly in the outpatient setting.*

Under CMS managed care regulations, Medicaid managed care organizations (LMEs) are required to ensure access and availability of all needed services to recipients in their catchment areas. To that end, LME-MCOs will be required to show adequate availability of and access to outpatient services. LME-MCOs can use tools like incentivized rates in order to build outpatient practices in underserved areas.

2. *What happens to any savings that are generated by an LME in the waiver? Where do the proposed savings come from and what is being “saved”? Do savings come from limiting care to clients? The state’s budget language contains a provision to save \$10M from the waiver project so how will there be any savings and what will happen to any dollars over the \$10M in savings?*

Proposed savings comes from several major areas. MCOs are required to provide care management of high cost/high risk consumers—usually those who use costly inpatient and ED services—and ensure access to community services which often results in reduced service costs. MCOs also provide administrative efficiencies since DMA will no longer subcontract functions of the Medicaid program to HP, CSC, PCG, etc. but will pay a flat administrative percentage to the MCO for performing all Medicaid functions including provider enrollment/monitoring and payment of claims. If DMA realizes more than \$10 million in savings (these savings are for DMA, not the MCO) it will influence future budget decisions.

3. *What is the timeframe for deciding the composition of the LMEs who will be operating in the waiver environment?*

Announcement of the successful applicants will be August 1<sup>st</sup>, 2011, with the “go live” date being no later than January 1, 2013. However, if LME-MCOs are not successful with the implementation, the configurations of the LME relationships may change. The State has the authority to assign Medicaid and LME catchment areas by January 1, 2013 if necessary.

4. *What happens to patients during the transition from the current system to the waiver system? How will the transition be handled? If a provider is seeing a patient but will not be a provider under the waiver system how will the patient be notified? Will the provider be given time to transition that patient?*

The LME-MCOs are required to offer contracts to any providers who currently serve a Medicaid client in their catchment areas for the first year of the waiver. If a provider declines the contract, or if a provider does not meet contractual requirements in subsequent years, the LME-MCO is required to assist that consumer with finding and transitioning to another provider.

5. *Has there been any thought to exempt outpatient therapy from the waiver?*

No. The LME-MCO needs to manage all levels of care. Professional outpatient services are the most fundamental and basic of services in the mh/sa system. LME-MCOs need to be able to support consumers through the recovery process and utilization of outpatient care is a key service component for service recipients as they transition through levels of care in the system.

6. *How will we insure when wavier goes through that we haven't inadvertently created another layer of LME infrastructure – as has been the experience in the private insurance market, just adding another layer of complexity that increased cost and lowered provider rates?*

The LME-MCOs are required to follow a specific Medicaid contract that mirrors all federal requirements for managed care—no more, no less. Keeping the Medicaid contracts at the local level and in the public sector incentivizes responsiveness to local need. The bottom line becomes quality client care—not saving money, as could be the case in a for-profit system.

7. *The capitated waiver system seems at odds with mental health parity. It limits benefits and makes it different from the system for treating physical health needs. Why is that so?*

Capitated funding should not affect parity. Whatever elements of MH parity can be accomplished at the State level can also be accomplished within the capitated system. Creating a capitated waiver for MH/DD/SA services protects the specialty care and funding for the unique needs of the populations served by the public system. Coordination with care for physical health needs is essential and required in the waiver.

8. *Has anyone considered the impact of this plan on integrated care and the cost-shifting that traditionally has taken place in managed care carveouts? This puts a disincentive for the LME to assume care for the complex psychiatric patients and shift care to primary care where the LME has no oversight.*

Through the collaboration of the LME-MCOs with the various CCNC networks and the use of the four-quadrant model for identifying the appropriate medical home for an individual based upon the need/intensity of need for that individual, the system is in place to assure an appropriate balance between primary care and behavioral care for all recipients. The DMA contract requires intense CCNC/ LME-MCO collaboration to effectively manage all recipient needs. Both are required to share data, develop integrated care practices, and meet very similar population performance outcomes.

## **STANDARDIZATION**

1. *Will claim forms and other documents be standardized across LMEs?*

LME-MCOs are required to use standard HIPAA transactions for electronic claims submissions. LME-MCOs are required to use standardized enrollment forms, treatment authorization forms, and provider contracts.

2. *Can claims be submitted electronically using one system regardless of the LME?*

The LME must accept electronic claims in traditional HIPPA-compliant transactions regardless of operating system.

3. *Will there be a standardized billing system?*  
The LME must accept electronic claims in traditional HIPPA-compliant transactions regardless of operating system.
4. *Will LMEs allow billing of insurance claims through intermediaries?*  
Yes
5. *If proprietary forms are required, will the waiver LMEs reimburse providers or work with EMR vendors to implement into existing EMRs?*  
Currently there is no standardized Electronic Medical Record template required of all providers, nor is an EMR required in order to be a network provider. If there is such a requirement in the future it will be done with the participation of and consideration of the providers in the networks.
6. *Will there be a standardized credentialing process that is provider friendly? For example, we understand that Western Highlands is requiring a 19-page form, graduate transcripts, letters of reference, etc. for licensed professionals who are licensed under the laws of North Carolina and have already been approved by their licensing board. This is not provider friendly.*  
PBH and WHN and any new managed care sites are required to use the NC CMS-approved, standardized enrollment and credentialing process. CMS does not allow NC to 'grandfather' current Medicaid providers into any LME-MCO network. Each MCO is required to credential and enroll their own specific provider network. We have required the LME-MCOs, as vendors of Medicaid, to use the same process across MCO sites. No interview is involved. The LME-MCO is also required to provide technical assistance to any potential provider applicant who may need assistance with completing enrollment forms.
7. *How will claims for dual eligible – Medicaid and Medicare – be handled under the waiver?*  
Professional claims must be submitted to Medicare as the primary payer. The EOB, along with the claim, must then be submitted to the MCO. We are exploring ways that in the future the claim can be crossed over automatically.
8. *Will there be a statewide contract for providers or will I have to contract with each different LME?*  
You must contract with each LME-MCO. Each MCO is a different network. This is not different than being paneled with multiple insurance companies such as BlueCross, First Health, or Magellan. Each LME-MCO will use a standard, standing contract.
9. *Will I as an outpatient provider have to contract with the same documents as a CABHA?*  
Outpatient providers will submit a standardized application and receive a standard contract. Agencies who seek to be certified as a CABHA must meet the requirements and go through the process outlined in rule (10A NCAC 22P)
10. *Will there be a standard authorization process across LMEs? What is being put in place to standardize the procedures for requesting authorizations?*  
All LME-MCOs will be required to use the same authorization request form. Each LME must offer all Medicaid State Plan services, but each will have the authorization to develop their own utilization criteria that best meets the needs of the recipients in their catchment areas.

## **PRIVATE PRACTICE/PROVIDERS**

1. *Why is there not a way to allow any willing outpatient provider to provide services in their community? Has there been a high cost to outpatient services that makes it a target? Does the person who only needs outpatient services have to be part of this waiver? What happened to freedom of choice of providers?*

Under a 1915b waiver, the Medicaid agency can waive choice of providers. The LME-MCO must meet access and availability standards and will contract with enough providers to meet network needs. In addition, the LME-MCO will base contracting on recipients' needs and performance of providers. While the cost of outpatient services has increased dramatically and fraud and abuse efforts have identified many problems in the current unmanaged system, this is not the reason for putting these services under the capitated waiver. Outpatient services are part of the waiver because they are an essential level of care that the LME-MCO must manage to meet the mh/sa needs of ALL recipients in their catchment areas. If a provider chooses in subsequent years not to contract or is not offered a contract, the LME-MCO will assist the service recipient with the transition to another provider.

2. *I am a directly enrolled outpatient provider who has been serving my community for years – what will happen to my practice and my clients if I am not selected as a provider?*

The LME-MCOs are required to offer a contract to any provider who currently provides services to a Medicaid recipient in their catchment area. In subsequent years, the LME-MCOs may define the network based on consumer needs and performance of providers. If a provider chooses in subsequent years not to contract or is not offered a contract, the LME-MCO will assist the service recipient with the transition to another provider.

3. *Who will set fees for service?*

In general, LME's will set fees based on DMA cost finding but may make changes to incentivize certain providers or services. For example, PBH enhanced psychiatry rates to incentivize psychiatric services in their rural service area.

4. *If I apply to be in an LME's network do they have to accept me, or can they deny my application?*

At the onset, the LME-managed care organization (MCO) is required to offer a contract to all current in network providers. But the managed care networks are closed and the LME-MCO has the authority to restrict entry into the behavioral health managed care system. If an individual requesting services chooses a provider not in the LME/MCO network, that provider may be asked to join the network for the purpose of providing services. That provider would be required to meet all requirements for admission to the provider network.

5. *How will initial and follow-up services be authorized? Will there be special provisions for urgent, non-scheduled appointments?*

As with the current statewide policy, there will be an identified number of non-managed visits allowed before prior authorization is required. Also, there are provisions for authorization of emergency visits and interventions, whereby the LME-MCO is notified and authorization is determined based upon the concurrence of an emergency situation.

6. *Do private practitioners who participate with Medicaid need to be capitated?*

The LME-MCO receives a capitated payment—not the provider. As mentioned above, outpatient services and outpatient providers constitute an integral level of care for mh/sa recipients under the 1915 b waiver.

## AGENCY/PROVIDER

1. *What do waivers do to the H code issue and ability of provisionally licensed professionals to be employed?*

At this time, the Department has granted an extension of the provisionally licensed billing through the LME for 1 additional year. Provisionally licensed providers may still bill 'incident to' MDs under managed care.

*The CAP-MR/DD waiver currently allows for behavioral consultation services, not traditional behavioral therapy, to address the unique needs of people with DD and severe behavior problems. Will all LMEs offer this service when they start administering the 1915 b/c waiver?*  
The LME-MCOs will operate under the NC Innovations waiver, not the CAP MR/DD waiver. The Innovations waiver includes the service, "Specialized Consultation" which encompasses behavioral consultation services.

3. *What will be left of the actual LME structure when that LME contracts with PBH? What will the new LME infrastructure be? What will be the chain of command – who will interact with the providers that have contracted with area programs for years?*  
In areas where LMEs have chosen to merge with PBH there will be agreed upon and approved merger agreements. There is a statutory requirement to maintain a local presence in the existing communities. PBH has reported that there will be a Community Operations Center in the OPC catchment, similar to the current Area Office. There will be a Director of the Community Operations Center and provider relations staff located at the OPC Community Operations Center. As mergers occur there will be opportunities for public forums. PBH also will contact and have educational sessions directly with providers.
4. *Who will be deciding what providers will be working in the waiver site – Will OPC for example be part of the decision-making process once it contracts with PBH?*  
PBH will offer a contract to current Medicaid providers serving recipients in the OPC counties. Provider Relations Staff and the Director of the Community Operations Center will be involved in the development and management of the local provider network
5. *Will there be clinical input into the decision making process regarding selection of providers?*  
During subsequent operational years, PBH and all other LME-MCOs will use performance and client outcomes as ways to measure inclusion in the provider network. Provider selection is also informed by an annual Capacity and GeoAccess study to ensure there are adequate numbers of providers to meet consumer needs. The clinical specialty is an important consideration as well as the results of the provider's performance. See Provider Search function on PBH website to see how consumers access providers.  
<http://www.pbhsolutions.org/search/>
6. *Often change has happened without thinking of the outcome. There are a lot of providers who have spent a lot of money developing systems and services based on past system structures. What happens to them if they aren't included in an LME waiver?*  
See above about first year contracting requirements.
7. *Agencies who have CASP funding would like some guidance in writing about how to position themselves and what happens with the CASP funding.*  
We are well aware of the importance of CASP services and are committed to ensuring that they continue and are successful. CASP funding will continue and we are assessing the most effective way for the funds to be managed within the waiver environment.

## **QUALITY ASSURANCE/CONSUMER ISSUES**

- 1. Will this in any way affect the patients who get their psychiatric care from primary care offices? Will the LME be managing their care?*

LME-MCOs will NOT manage care provided by MDs or DOs. Only psychiatric care is included. The LME-MCOs will have a very close working relationship with CCNC. If the primary care practice employs a MH therapist (ex. LCSW, LPC), that therapist will be required to enroll in the LME-MCO network for authorization and payment of claims.
- 2. Have any evaluations been done that show the impacts of the waiver system on consumers?*

Yes—for over 6 years, DHHS has overseen PBH. Each year, PBH has an independent consumer survey performed. The Innovations waiver also has a list of quality measure for I/DD consumers and DMA monitors contract performance for care of all consumers under the waiver. Reports of performance outcomes are gathered on a quarterly basis. In addition, 2 external vendors review PBH performance annually. This information is posted on the PBH web site <http://www.pbhsolutions.org/outcomes/>
- 3. How will this improve the quality of life for consumers? Is this only being done for financial reasons?*

The LME-MCO will be able to create a high quality provider network and assure access to services. They will use care management and care coordination to ensure that clients receive the correct level of care from qualified providers.
- 4. How will the waiver increase access to services, particularly for adults?*

Under managed care, CMS requires on-going reports of penetration and use of services across all levels of care. The LME-MCO is required to do outreach for all recipients, provide information and education seminars on ALL Medicaid services. The LME-MCO is required to do community-building and identify community barriers to treatment and well as collaboration with other community stakeholders are removing those barriers.

## **CABHA QUESTIONS**

- 1. If one of my patients goes to a CABHAs for services, the CABHA won't share a client with me as an individual provider. How do we fix this?*

The LME-MCO has the authority to monitor the provider referral process and to ensure clinical best practice. Concerns regarding referrals should be directed to the LME-MCO