

# Statewide Expansion of the 1915 B-C Medicaid Waiver

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**Public Policy:** In order to achieve administrative efficiencies, cost effective operations toward the ultimate goal of consistent access to high quality services, the NC Department of Health and Human Services (DHHS) will expand the 1915 B-C Medicaid Waiver for people with mental health, intellectual/developmental disabilities, and substance abuse conditions across all areas of the state. The expansion will be completed by July 1, 2013.

**Goal:** A Plan for the statewide restructuring of the management responsibilities for the delivery of services for people with mental illness, intellectual/developmental disabilities, and substance use conditions. This Plan will establish a system that is capable of managing all public resources including Medicaid, state funds, federal block grants; HealthChoice and any other public funding that may become available for mental health, intellectual/developmental disabilities and substance abuse services. This plan is guided by a set of principles and includes objectives, timeframes for completion, accountability and cost impact.

## **Principles:**

1. Establishment of a statewide framework for the public management of privately delivered services.
2. The framework will establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of medically necessary services and supports, and continuity of care for consumers with mental health, intellectual and developmental disabilities and substance abuse conditions.
3. The management framework will ensure the development and maintenance of community systems that consistently offer high quality services.
4. As the 1915 B-C Medicaid waivers expand statewide, the current CAP-MR/DD waiver will be phased out. The utilization management functions currently carried out by the state's Utilization Review contractors (including LMEs) will also be phased out.
5. The expansion of the 1915 b/c waiver will replicate the PBH demonstration model, a proven system for the operation of all public resources for MH-DD and SA. (see attached)
6. In order to attain financial and management efficiencies as well as statewide consistency in operations the number of Local Management Entities (LMEs) will be reduced by establishing a minimum population threshold of 300,000 by July 1 of 2012 and 500,000 by July 1 of 2013.
7. Reduction in the trend of escalating costs in the Medicaid Program while ensuring medically necessary care through the 1915 B-C Medicaid Waiver by use of managed care strategies such

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as care coordination and utilization management, as well as the deployment of a system for allocation of resources based on reliable and valid assessment of intensity of need. These strategies will efficiently direct people to the right service, and ensure that consumers receive the amount of services needed at the appropriate funding level, no more, and no less.

8. LMEs operating Medicaid waivers will maintain a local presence in order to respond to the unique needs and priorities of localities.
9. LMEs selected to manage Medicaid waivers will implement a process for feedback, exchange of information and ideas across multiple media venues and tools to ensure communication with consumers, families, providers and stakeholders regarding disability specific and general waiver operations.
10. LMEs will be responsible for establishing and maintaining systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual/developmental disability or substance abuse conditions with other organized systems such as the local Department of Social Services, Community Care of North Carolina, hospitals, school systems, the Department of Juvenile Justice and other community agencies.

#### **Objectives:**

1. Increase minimum population thresholds for each Local Management Entity as follows:
  - a. As of July 1, 2012, the minimum population of a Local Management Entity must be 300,000.
  - b. As of July 1, 2013 the minimum population of a Local Management Entity must be 500,000.
  - c. For Local Management Entities that do not meet minimum population threshold criteria By July, 1, 2012, LME systems management payments will be reduced to the amount paid to LMEs of 300,000.
  - d. For any LME that does not meet minimum population thresholds of 500,000 by July 1, 2013, the Department will assign management of Medicaid waiver and State funding to a fully compliant B-C waiver LME.
2. By April 1, 2011, the Department will publish a Request for Applications (RFA) for operation of a 1915b/c Medicaid Waiver, limited to Local Management Entity applicants. This RFA will specify contract requirements. The RFA will include but not be limited to the following:
  - a. The importance of disability-specific infra-structure and competency to address the

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- clinical, treatment, rehabilitative, facilitative and support needs of all disabilities covered by the 1915b/c waivers.
- b. Administrative and clinical functions including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.
  - c. The required competency of the LME to manage *all* aspects of waiver operations. The Department may not require the LME to sub-contract any management functions to other entities. Sub-contracts for management functions will be limited to the following functions:
    - i. Information Systems
    - ii. Customer Service operations (including call center)
    - iii. Claims processing
    - iv. Provider enrollment, credentialing and monitoring
    - v. Professional services
3. There must be *a single entity* responsible for all aspects of waiver management. The following operational models are acceptable options for LME RFA applicants :
    - a. Merger model: a single larger Local Management Entity is formed from the merger of two or more LMEs.
    - b. Inter-local agreement among LMEs: a single LME is identified as lead for all waiver operations, financial management and accountability for performance measures.
  4. Providers of case management services for consumers with intellectual/developmental disabilities will have the opportunity to be enrolled by LMEs operating b/c Medicaid waivers to provide Community Guide Services for at least the initial year of waiver operations.
  5. By August 1, 2011 the Department will select those Local Management Entities that have been assessed to meet minimum criteria for waiver operation according to the requirements of the Request for Applications. The selected LMEs are eligible for onsite evaluation of readiness.
  6. By December 31, 2011 the DHHS will evaluate the feasibility of adding habilitation services to the state Medicaid Plan through the "I Option" as a strategy to address the needs of Medicaid enrollees with intellectual/developmental disabilities that are not enrolled in the Innovations waiver and not enrolled in an Intermediate Care Facility for the Mentally Retarded (ICF-MR). The DHHS will report the findings and recommendations to the appropriate General Assembly Committee in February 2012.

7. The General Assembly will enact legislation that supports the key components of this Plan and protects counties from financial responsibility for cost over-runs experienced by LMEs operating Medicaid waivers.
8. The DHHS will fully operationalize the Local Management Entity-Community Care of North Carolina protocols for cross system coordination. The DHHS will align Medicaid policy to reflect the respective roles and responsibilities of Local Management Entities and Community Care of North Carolina.
9. Statewide implementation of the 1915 b/c waivers will be completed by July 1, 2013. First expansion is planned for January 1, 2012 with the expectation that all LMEs will have been selected for waiver management by January 1, 2013. At that time, LMEs that have not aligned with an operational B-C waiver site will have Medicaid funds assigned to a fully operational B-C waiver site.
10. Status reports to the appropriate General Assembly Oversight Committee will be provided according to the following schedule:

October 1, 2011

April 1, 2012

October 2012

February 2013

October 2013

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# Expansion of the 1915(b)(c) Medicaid Waiver for MH/DD/SAS

Joint House & Senate Appropriations  
Subcommittee on Health and Human Services

Lanier Cansler  
Secretary DHHS  
4/5/2011

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## Proposed Plan

- Expand 1915 (b)(c) Medicaid Waivers statewide for individuals with MH/DD/SA service needs by 7/1/13
- Increase the minimum population threshold for LMEs to 300,000 by 7/1/12 and to 500,000 by 7/1/13 to attain financial and management efficiencies and statewide consistency. Reduce number of LMEs to 8-10.
- Maintain a local presence in order to respond to unique needs and priorities of local communities

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## What is a 1915(b)(c) Medicaid Waiver?

- Combines services for all Medicaid funded MH/DD/SA service recipients into a single capitated funding model
- Eliminates “any willing and qualified provider” provision. Waiver site can limit provider network
- Waiver entity assumes risk in managing services within the Medicaid capitation rate
- Combines authorization management of Medicaid/State Funds at the community level
- Expansion of successful PBH pilot waiver covering Cabarrus, Davidson, Rowan, Stanly, and Union counties

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## Goals of the 1915(b)(c) Medicaid Waiver

- Improved Access to Services
- Improved Quality of Care
- Ensure services are managed and delivered within a quality management framework
- Increased Cost Efficiencies
- Predictable Medicaid Costs

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## Goals of the 1915(b)(c) Medicaid Waiver (cont'd)

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- Empower consumers and families to shape the system through their choices of services and providers
- Empower LMEs to build partnerships with consumers, providers and community stakeholders to create a more responsive system of community care

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## Managed Care Tools

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- *Capitation* provides local flexibility and control of resources
- *Payor of claims* ensures that funds are spent in accordance with authorizations
- *Rate setting authority* allows adjustment of rates according to local conditions
- *Closed network* allows for competition and choice while rightsizing the marketplace which ensures the fiscal viability of providers
- *Utilization management* ensures consumers receive the appropriate service in the right amount to meet their needs
- *Care Coordination* directly intervenes to ensure consumers receive the care needed when it is needed in order to prevent higher cost services

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## Benefits of a Publically Managed 1915(b)(c) Medicaid Waiver

- Predictable Medicaid expenditures for MH/DD/SA services
- Maintains public infrastructure to manage MH/DD/SA services
- High quality standards/consumer outcomes
- Improved access to services
- Public accountability at state and local level
- Coordination with Primary Care/CCNC
- Savings remain in North Carolina and may be reinvested

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## Cost Impact of Statewide Medicaid Waiver Implementation and Reduction in LMEs

### Projected State Savings:

- Year 1/SFY 2012: \$10,537,931
- Year 2/SFY 2013: \$52,551,082
- Year 3/SFY 2014: \$132,214,213
- Year 4/SFY 2015: \$235,799,286
- Year 5/SFY 2016: \$253,285,205

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## Next Steps

- Legislation to allow expansion of the current waiver site -- PBH (15 Counties) and additional sites (S316/H424)
- Proceed to implement waiver into previously identified waiver sites ECBH (19 Counties), Sandhills (8 Counties), Western Highlands Network (8 Counties)
- Amend General Statutes to increase minimum population for an LME and allow DHHS to assign management of Medicaid/State funds if LMEs fail to realign
- Protect counties from financial responsibility for cost over-runs

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## Next Steps (cont'd)

- Released RFA April 1st to identify new waiver sites including:
  - Administrative and Management competencies
  - Disability specific infrastructure
  - Administrative and clinical functions
  - Functions that may be subcontracted
  - Local presence and stakeholder involvement
- Identify new waiver sites by August 2011
- Readiness reviews and implementation of new waiver sites
- Statewide implementation of waiver by July 1, 2013

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