DHHS 1915 b/c WAIVER ENTITY PROJECT

Joint Legislative Oversight Committee
On Mental Health, Developmental Disabilities and Substance Abuse Services
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N.C. 1915 b/c WAIVER: WHAT IS IT?

- Waiver - Request to CMS that provisions of the Social Security Act (SSA) be "waived"
  - State wideness
  - Fee-for-Service payment requirements
  - "Any willing and qualified provider"
- 1915(b) waivers are commonly known as a "freedom of choice" or managed care waiver
- 1915(c) waivers are Home and Community Based Services waivers in lieu of institutional care, such as our CAP-MR/DD waivers
- b/c Waiver combines services for all Medicaid funded MH/DD/SA consumers into a single capitated funding model
- Waiver Allows: The operations of a capitated manage care system as vehicle for service provision to Medicaid recipients

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- Waiver Goal - Implementing improvements in the Medicaid Program designed to increase cost-effectiveness, efficiency, consumer access, choice and provider quality. Providing uniform management approach to Medicaid and state funded services.
- 1915 (b) - B-3 Services allows for additional consumer services to be funded from "savings" in the Waiver
- 1915 (c) - Focuses on services to I/DD consumers and allows the management of State/Community ICF-MR services in addition to current CAP-MR/DD Waiver services and other Medicaid funded I/DD consumer services

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- 1915 b/c - Waivers have different authorization lengths and renewal periods (2 - 5 years)
- Provides opportunity to create fiscal incentives that can generate improved consumer outcomes
- Waiver eliminates "any willing and qualified provider" provision - LME MUST ADDRESS ACCESS AND CHOICE CONCERNS - can limit provider network

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- Waiver LME can negotiate rates - generally follow current Medicaid rates
- Waiver management entity (LME) assumes risk in managing the delivery of MH/DD/SA Services within the financial framework of the Medicaid capitation rate
- Services must be managed in a cost/neutral manner (Actual waiver costs must be less than or comparable to actual fee-for-services (FFS) program costs

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- Combines authorization management of Medicaid/State Funds at the community level
- Provides for **Stable** and **Predictable** Medicaid Expenditures for MH/DD/SA Services

1915 b/c WAIVER POLICY TOOLS

- **Capitation-** provides local flexibility and control of Medicaid/State funding
- **Claims Payment-** ensures that funds are spent in keeping with service authorizations
- **Rate Setting Authority-** allows waiver entity to adjust service rates to meet local needs

1915 b/c WAIVER POLICY TOOLS CONT'D

- **Closed Network-** allow competition/choice with right sizing the provider network/provider stability
- **Utilization Management-** provides a tool to ensure that consumers receive the right service at the right level
- **Care Management-** provides direct support to high cost/high risk consumers

WAIVER GOALS

- Improved Access to Services
- Improved Quality of Care
- Increased Cost Benefit
- Predictable Medicaid Costs
- Combine the management of State/Medicaid Service Funds at the Community Level

WAIVER GOALS CONT'D

- Support the purchase and delivery of best practice services
- Ensure that services are managed and delivered within a quality management framework
- Empower consumers and families to set their own priorities, take reasonable risks, participate in system management to shape the system through their choices of services and providers

WAIVER GOALS CONT'D

- Empower the LME to build partnerships with consumers, providers and community stakeholders with the goal of creating a more responsive system of community care.
- Increased consistency and economies of scale in the management of community services
- Create financial incentives for LMEs and providers to achieve state goals that improve consumer outcomes

1915 b/c WAIVER HISTORY IN NORTH CAROLINA

- April 2005: DHHS began operating under two new waivers in the PBH (formerly know as Piedmont Behavioral Healthcare) LME Area. These Waivers included:
  - The Piedmont Cardinal Health Plan—a pilot 1915 (b) Freedom of Choice Waiver Project, and
  - The Innovations Home and Community Based Services (HCBS) 1915 (c) Waiver

1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- Waivers managed by PBH LME

- Pilot Project: Medicaid funded services for MH/DD/SA on a capitated basis in the five county (Cabarrus, Davidson, Rowan, Stanley & Union) area.

1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- The capitated funding is paid to PBH in a per member per month (pmpm) payment that is based on the historical service costs associated with six different Medicaid eligibility groups
- PBH Waiver has received annual outside reviews and significant monitoring on the part of DMH/DD/SAS and DMA

1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- PBH is nationally accredited under NCQA and has developed an aggressive internal quality management and provider monitoring program.
- Based on the performance of PBH Waiver and the guidance from the LOC and the NC General Assembly, DHHS has elected to expand this pilot project beyond the PBH area.
- Expansion will initially be limited (1 - 2 LMEs) with the eventual goal of statewide implementation

1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- December 2009: DHHS submitted waiver amendment to CMS designed to expand the pilot project through a modification of the existing PBH Waivers.

Note: This Waiver Amendment has since been approved by CMS.

1915 b/c WAIVER EXPANSION SCHEDULE

- February 18, 2010: Posting of Request for Applications (RFA)
- March 4, 2010: Bidder's Conference
- April 14, 2010: RFA Application Due Date
- July, 2010: Selection of LME(s)
- January, 2011: Planned Expansion Waiver Start-Up Date

1915 b/c WAIVER EXPANSION SCHEDULE CONT'D

- **Note #1**: 1-2 LMEs to be selected as expansion Waiver sites
- **Note #2**: Consumer participation in the RFA selection process
- **Note #3**: Requires Technical Amendment to current Waivers to add new LMEs

WAIVER LME SCOPE OF WORK

- Recruiting & Credentialing providers
- Developing and overseeing a comprehensive MH/DD/SAS Provider Network

WAIVER LME SCOPE OF WORK CONT'D

- Authorizing Payment for Service
- Processing and Paying Claims
- Conducting Care Management, Utilization Management and Quality Management Functions
- Compliance with DMA and DMH/DD/SAS Contract requirements

WAIVER LME SCOPE OF WORK CONT'D

NOTE: These critical functions are required of all LMEs in their management of State funded services. However, successful operation in a capitated environment requires very sophisticated management, technical and IT capacity

WAIVER EXPANSION SELECTION CRITERIA

Organizational Arrangements for Application:

- **Single LME**
- **A merger of two or more LMEs (Per G.S. 122C-115.3(a) a full merger can only become effective at the start of a new State fiscal year)**
- **Various subcontracting arrangements among two or more LMEs**
- **A management agreement among two or more LMEs**

WAIVER EXPANSION SELECTION CRITERIA CONT'D

- **Note #1: DHHS may contract with a single LME, a merged LME or a lead LME—DHHS will contract with and make all State/Medicaid capitated funding payments to a single LME.**
- **Note #2: LMEs may propose to contract out one or more of the functions required under the DMA or DMH/DD/SAS contracts. LME responsible for all contractor performance.**

WAIVER EXPANSION SELECTION CRITERIA CONT'D

Minimum Requirements:

- **Medicaid eligible population (3 years or older) = 70,000+ (6 LMEs currently meet this standard)**
- **Fully divested of all State funded or Medicaid reimbursable services**
- **Fully accredited for a minimum of three (3) years**
  Note: If not accredited by URAC or NCQA must become so by 3rd year of waiver operations

WAIVER EXPANSION SELECTION CRITERIA CONT'D

- Meet all Single Stream funding requirements
- Financial Status and Viability--Sufficient financial resources and strong financial management
- Letter of support from full LME Board assuming financial responsibility in submitting application
- Can not serve as legal guardian for a recipient of Medicaid funded MH/DD/SA Services

WAIVER EXPANSION SELECTION CRITERIA CONT'D

- No LME Staff or Board Member conflict of interest
- Strong IT Capacity
- Letter of Support from the LME Consumer and Family Advisory Committee (CFAC)
- Letter of Support from full LME Board

NOTE: MINIMUM REQUIREMENTS ARE REVIEWED ON A PASS/FAIL BASIS

WAIVER EXPANSION SELECTION CRITERIA CONT'D

Additional Requirements:

- Clinical Operations (35% of Score)
  - Customer Services
  - Care Management/Utilization Management
  - Quality Assurance and Quality Management
  - Consumer grievances and Appeals
  - Provider Network Management

WAIVER EXPANSION SELECTION CRITERIA CONT'D

- **Administrative Operations (35% of Score)**
  - Administrative Staff Qualifications
  - Health Information System
  - Records Management
  - Encounter Data and Claims
  - Financial Reporting Requirements
  - Clinical Reporting Requirements
  - Fraud and Abuse
  - Subcontracts
  - Timeliness of Provider Payments
  - Financial Management/Monitoring
  - Review of Proposed Organizational Structures

WAIVER EXPANSION SELECTION CRITERIA CONT'D

- Implementation Plan (30% of Score)
  - Tasks
  - Timelines
  - Expected Results
  - Transition of implementation of subcontracted functions

BASIC APPLICATION EVALUATION CRITERIA

- Track Record of Success as LME
- Demonstrated Capacity to Operate a Managed Care Program
- Strong Care Management/Utilization Management Function
- High Quality Provider Network Management Program
- Solvent and Financially Viable Organization

BASIC APPLICATION EVALUATION CRITERIA CONT'D

- Automated Management Information System
- Demonstrated Capacity to Manage Systems of Care
- Ability to Facilitate the Development and Utilization of Natural Supports

Note: Applicant scoring based on Site and Desk Reviews

WAIVER ISSUES/CONCERNS

- Capitation Rates:
  - Paid PMPM
  - Payment in Full for services
  - PMPM based on historical utilization + program changes
  - Total dollars increase/decrease with number of eligibles
  - Independent actuarial support

WAIVER ISSUES/CONCERNS CONT'D

- Rate set for six (6) Medicaid eligibility groups (e.g. TANF-adult/child 3+, Foster Children 3+, Blind/Disabled 3-20, Blind/Aged/Disabled 21+, DD HCBS Innovations Waiver All Ages)
- Fair Rate = Fair Risk
- What services are in/out? (e.g. ER costs, pharmacy)

RISK MANAGEMENT

- Waiver Model: Transfers Risk to LMEs
- Need Risk Reserve - Mercer recommends 16%
- DHHS will add 2% per year to capitation to develop restricted risk reserve

RISK MANAGEMENT CONT'D

- Contract requires LMEs to "refresh" Risk Reserve if it falls below required level
- "Savings" can be placed in Risk Reserve
- Purchase of Stop Loss Insurance
- G.S. 122C-115.3.(g) place counties at risk for financial failure of LME

PERFORMANCE MONITORING

- Consumer Satisfaction
- Consumer Involvement
- Consumer Access/Choice
- Complaints/Appeals
- Service Utilization Rates
- Cost Performance (Waiver vs. FFS)
- Prompt Pay – Providers
- Integration with primary care
- DHHS Monthly Monitoring

ADMINISTRATIVE COSTS

- LMEs participating on the waiver will no longer receive a separate LME Systems Management Cost payment
- Will be negotiated as a percentage of overall funding
- PBH currently at 9.5% for both State & Medicaid funds

IMPACT ON LME MANAGEMENT SYSTEM

- Waiver Model will reshape community management structure
- Increased consistency & economies of scale
- Reduce # of LMEs as a result of minimum covered lives requirement
- Economies of Scale vs. Local Management
- Generate Mergers & Alliances
- Demand technical competence
- Risk Management Concerns

PROVIDER CONCERNS

- Limited Provider Network
- LME rate negotiation capacity (Note: higher rates can be paid to address access concerns)
- Expanded service authorization function
- Loss of direct enrollment in State Medicaid Program (contract with LME)
- Loss of State level cost reporting/cost finding
- Inclusion in larger system of care (e.g. community ICF-MR facilities)

Note: Some concerns can be addressed in DHHS/LME contracts

STATE FUNDING MANAGEMENT ISSUES

- Waiver LME controls bed day funding at: State Hospitals, ADATCs & Developmental Centers
- Must purchase all bed day use
- Creates financial incentive to fund alternative community services

STATE FUNDING MANAGEMENT ISSUES CONT'D

- Funding can follow the consumer if beds reduced
- Support Olmstead Goals
- Need to monitor impact on State Facility budgets (e.g. facility cost reductions may not equal lost LME receipts)

CONCLUSION

- Waiver expansion provides long-term vision for our community system
- Serves to create financial incentives that generate effective outcomes for our consumers
- Create economies of scale in LME management system
- Provides consistency in management and generates economies of scale in both management and service delivery

CONCLUSION CONT'D

- Provides predictable annual Medicaid costs
- Requires careful implementation and monitoring
- Expansion of one LME - 12-15% of N.C. Medicaid Eligible