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OPERATIONS/READINESS REVIEW OF MECKLINK BEHAVIORAL HEALTHCARE

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

OCTOBER 5, 2012

MARSH & McLENNAN COMPANIES

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Introduction

Purpose, Background and Methodology

This report summarizes the findings of the August 28, 2012 readiness review of MeckLINK Behavioral Healthcare (MeckLINK), a local management entity (LME) in North Carolina, implementing a prepaid inpatient health plan (PIHP) targeted for January 1, 2013. MeckLINK was selected by the State of North Carolina (State), Department of Health and Human Services (DHHS), as a successful applicant for the Centers for Medicare and Medicaid Services (CMS) Section 1915(b)(c) waiver expansion.

Background

LMEs bidding on the PIHP must fully prepare their systems, staff and processes to implement the program consistent with CMS requirements and the State criteria listed in Appendix A. DHHS also requires the implementing LMEs to adopt a set of policies and procedures (P&Ps) developed by PBH, the first PIHP in North Carolina. PBH has designed effective P&Ps during the past several years in collaboration with the intra-departmental monitoring team (IMT). Thus, DHHS wants to ensure statewide consistency of P&Ps while also addressing local needs.

The DHHS Division of Medical Assistance (DMA) contracts with Mercer Government Human Services Consulting (Mercer) to assist the IMT in its oversight of the PIHP implementation process. The IMT includes representatives from DMA and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS). As part of its oversight, the IMT conducts readiness reviews. Mercer provides technical assistance to the IMT on readiness milestones and prepares the readiness review reports.

Methodology

The review includes a desk review of documentation submitted by the LME in response to a data request prepared by the IMT and Mercer. Results from the desk review are incorporated into an interview questionnaire that lists implementation milestones. The questionnaire and resulting onsite review are organized into the following categories:

- PIHP organizational management tasks
- Contracting and capitation
- Facilities management
- Member services
- Clinical care management/utilization review (CM/UR)
- Network operations/provider relations
- Quality assurance (QA) and quality improvement (QI)

- Financial management/monitoring
- Claims and information technology (IT) staffing
- Claims administration system development
- Reporting

The IMT and Mercer would like to express appreciation to MeckLINK for preparation of materials and its active participation during the onsite review.

Organization of the Report

Section 2 of the report discusses findings, including strengths, challenges and opportunities for improvement. If there are no particular findings related to the review categories listed above, the category is not addressed in the report. Section 3 discusses the Plan of Development requirements.

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Highlights of Findings

This section of the report highlights the strengths and areas identified for continued improvement.

Due to the number of significant challenges and limited progress over the last few years (see Appendix B), it is recommended that DHHS have discussions with MeckLINK within the next month to either determine the length of delay or to determine whether MeckLINK can proceed to become a PIHP and whether alternative management needs to be identified. Implementation readiness should be determined based upon consistent progress and satisfactory compliance with the plan of development outlined in this report. Mercer also recommends that the IMT conduct weekly reviews to monitor completion of recommended tasks outlined in this report.

Strengths

- The AlphaCM information system selected by MeckLINK is operational in other LMEs/managed care organizations (MCOs). The plan to use AlphaMCS should provide claims management and other capabilities necessary to operate as a MCO.
- The available clinical P&Ps for Innovations Waiver care coordination are clear and well written. MeckLINK has a consultant assisting them with development of the remaining behavioral health clinical P&Ps.
- The engagement of a credentialling verification organization is a positive step to help credential nearly 1,000 providers.
- A Provider Council actively participates in planning network activities and provided input on the network application.
- A new telephone system (Cisco Agent) was successfully implemented on August 22, 2012 that allows improvements in call answering, as well as tracking and trending data.

Challenges

- The executive leadership is newly hired. At the time of the 120-day review, the chief executive officer was on the job for about two weeks. The chief financial officer will begin work in October 2012. The medical director was also recently identified.
- Currently, MeckLINK has about 80 staff members. The goal is to hire approximately 220 additional staff for the January 1, 2013 start date. This is a significant number of vacant positions to hire, orient and fully train. While it is reasonable to phase in staffing, there are entire departments that have little to no staff. These staffing issues, coupled with a very new executive team, are likely to present significant challenges in meeting the go-live date.

- AlphaCM was not operational at the time of the review. Although training is scheduled, existing staff members are not familiar with the system's capabilities. Due to the number of vacancies and the newness of the IT system, staff may not be trained in time for the January 1, 2013 target start date.
- Job descriptions have not been developed for all positions. This may delay hiring processes, as MeckLINK job descriptions and titles must fit into the standards of Mecklenburg County Human Resources prior to posting job openings.
- The organizational chart does not currently reflect functional job titles in all areas, which leads to confusion about actual responsibilities of the divisions.
- The review team was unable to assess the cross-departmental integration capabilities (Customer Services, Utilization Management, Care Coordination, Member Services, Network Management) necessary to operate a managed care program due to the staff vacancies and because the AlphaCM system is not operational.
- MeckLINK has not participated fully in events sponsored by DMA and/or DMH/MH/SAS on managed care implementation and, as a result, has not benefited to the extent possible from the "lessons learned" by other LMEs/MCOs.
- P&Ps specific to Medicaid managed care operations have not been developed. These should be the driving aspects of setting up the IT systems and processes.

Findings

Contracting and Capitation

MeckLINK indicated that it will contract with providers at fee-for-service rates. The initial contract period will utilize existing Medicaid fee schedules. This will enable MeckLINK to review utilization and cost data using historical information for comparative purposes and in conjunction with authorizations for monitoring actual costs and anticipating future expenditures. Processes for monitoring actual and projected utilization and expenditures have not been developed.

In addition, necessary steps for reconciling capitation membership and income have not been taken. While MeckLINK understands the high-level requirements for reconciling membership and payment data, they have not documented the report requirements, nor have they created detailed desk procedures necessary for performing the monthly reconciliation. P&Ps for the reconciliation of membership and income at the member-level need to be documented. P&Ps need to include all aspects of reconciliation, including retroactivity and exception reporting. Staff needed to perform the detailed reconciliation have not been hired. Staff will need to be hired and adequately trained prior to go-live.

Strengths – Contracting and Capitation	Opportunities for Improvement
• MeckLINK will contract with providers at fee-for-service rates, facilitating the review of utilization and cost data against budget utilization and expenditures.	• Hire staff. • Finalize P&Ps and train staff related to capitation reconciliation. • Ensure that the revenue/capitation reconciliation process is performed at the member level. • Develop processes for financial monitoring and early warning indicators.

Member Services/Access

The Customer Services Division is supervised by the division director for service management, who also supervises utilization management. There are currently five licensed staff members that answer calls and two case coordinators. One staff person is bilingual, and additional bilingual employees are being recruited, as well as staff with strong customer service experience. The organizational chart has 17 vacant positions under Customer Services, either intake specialists or UR specialists. These titles reflect Mecklenburg County positions and not the actual functional titles for managed care operations. A new organizational chart with functional titles would be helpful in clarifying the positions that perform distinct customer services functions and utilization management functions.

The use of licensed staff to answer the telephone line is an expensive use of clinician time, especially due to the expected increase in call volume projected by staff to double or triple post waiver implementation. MeckLINK reported they use licensed clinicians due to a Utilization Review Accreditation Committee (URAC) policy requirement; however, DMA and URAC have clarified this policy for North Carolina Medicaid programs. The use of non-licensed staff to answer the member services line is allowable and would increase the availability of licensed clinicians for crisis calls, care coordination and utilization management.

MeckLINK plans to answer calls directly after hours and on weekends by utilizing one licensed and one unlicensed person. This staffing complement may not be adequate to handle the increased call volume. MeckLINK will need to develop a contingency plan to address high call volume during afterhours and weekends.

Staff reported that when licensed clinicians are busy with calls, the case coordinators answer the line. In emergencies, they will obtain key information and inform the member that a licensed clinician will call back within thirty minutes. It is not an acceptable practice to call back individuals who are in need of urgent care, and this practice should be discontinued.

Staff also noted that if the member in crisis does not want to disengage from the call, the case coordinator will instant message the clinicians or will ring a desk bell to alert them to the emergency call. A clinician will then assist the caller in crisis.

The Emergency Call Disposition flowchart provided for the desk review emphasizes warm line transfer to a clinician during emergent calls. However this protocol was not reported as practice by the review participants.

MeckLINK successfully migrated to the Cisco Agent call system, which has improved call center documentation, includes live call monitoring capabilities and tracks key telephone metrics, such as average speed of answer and dropped calls.

General information can be taken on complaints by the call center staff, either case coordinators or clinicians answering the phones. They attempt to resolve the issue on the initial call if possible, and if not, transfer the call to a QI advocate, who will manage the complaint. Future plans include training all call center staff on how to identify, attempt to resolve and document complaints, as well as provide information on the complaint process.

There does not appear to be a clear distinction between the customer services function and CM/utilization management (UM) functions at MeckLINK. Typically, in MCOs, the customer services unit provides call answering by non-licensed trained specialists that: 1) obtain the reason for the call, 2) collect basic demographic/eligibility information and 3) provide information on accessing services, filing grievances and appeals, and other general information. These specialists utilize tested scripts and receive training on identifying urgent and emergent situations. In an emergent or urgent situation, they transfer calls to licensed clinicians via a "warm line," always maintaining voice contact with the member while the call is being transferred. The member services unit is also typically responsible for member materials and managing the preparation and distribution of information, such as the Member Handbook.

Call center clinicians also have the responsibility to contact consumers for follow-up appointments after discharge from inpatient levels of care in order to ensure they see a provider within seven days of discharge. Clinicians will follow up with consumers for up to 15 days and then send a letter with the provider's contact information, asking them to call the provider directly for an appointment or call the LME. Typically, this function is a care coordination function, not a customer services task. If this task is transferred to care coordination, the need for clinicians in the customer services unit may decrease.

Strengths – Member Services	Opportunities for Improvement
• Cisco Agent successfully implemented. • Clearly documented emergency call disposition flowchart. • P&Ps in place to support the day-to day oversight of the customer services team, including quarterly inter-rater reliability testing, live call monitoring, periodic reviews of call center documentation and 1:1 supervision.	• With DMA, review the URAC-North Carolina agreement for use of qualified bachelor's level staff/customer services representatives (CSRs). • Assess the feasibility of utilizing CSRs instead of licensed clinicians to answer the customer services line and develop a plan to phase in CSR use. • Assess the feasibility of transferring the responsibility to contact consumers following

Strengths – Member Services	Opportunities for Improvement
	discharge from inpatient levels of care from the customer services function to the care coordination function. • Discontinue the practice of calling back members in crisis, and institute the practice of warm line transfers of urgent calls to licensed clinicians. Train staff on urgent call response and crisis management practices. • Develop a contingency plan for handling after hours and weekend call volume increases.

Clinical Care Management/Utilization Review

The Care Coordination Division and the Utilization Management Division are supervised by two separate division directors, reporting to the deputy department director. The Care Coordination Division includes an Innovations senior manager and a senior manager for mental health/substance abuse (MH/SA) care coordination.

MeckLINK hired an experienced I/DD program manager from PBH and a previous county employee for the MH/SA program manager position. One full team has been hired for intellectual disability and developmental disabilities (I/DD), and a second team will be hired by the end of September. The goal is to hire all MH/SA care coordination positions by November 1. Caseloads will range between 30 to 33 consumers. Team leads will have a caseload of about five. The Care Coordination Division is in the process of hiring the following positions by November 1:

- Twenty-three I/DD care coordinators, in addition to the 14 positions currently filled
- Five Supports Intensity Scale (SIS) specialists, in addition to the filled SIS clinical supervisor
- Twenty-three MH/SA care coordinators in addition to the 10 current positions

In addition to the medical director, a part-time psychiatrist will be available to consult on complex cases. Prest & Associates, Inc. provides physician peer reviewers for review of appeals and complex cases. Review of initial denials will be addressed through the UM Department. Appeals will be handled though the Quality Management and Training Department.

The UM program description, the Innovations' program description and related P&Ps are clearly written. MeckLINK engaged a consultant to work on these documents in collaboration with staff. The same consultant is developing the program description and P&Ps for the MH/SA care coordination program.

MeckLINK met with the current targeted case management (TCM) agencies and discussed the transition plan from TCM to care coordination. Corrective action plans for the I/DD cases have

been assigned to care coordinators, who are collecting service plans in preparation for the transition from TCM.

Initially, individuals will be identified for care coordination through the AlphaCM system based upon their diagnosis. In the future, service utilization data, crisis events and hospitalizations will also be used to identify candidates.

Currently, providers use eCura to submit treatment authorization requests electronically. They are in the process of moving to AlphaCM. Provider training is planned to coincide with the conversion to the new system. The review team was not able to assess the system coordination of CM/UM with quality management (QM) and network operations because the AlphaCM system was not operational.

Strengths – CM/UR	Opportunities for Improvement
• Clear description of the UM program. • Clear policies and procedures for Innovations. • Consultant working on behavioral health policies and procedures.	• Timing challenges to recruit and train staff on P&Ps and new IT system; may not be feasible to meet January 1, 2013 target start date. • Identification of CM/UR reports needed to manage care and comparison on desired reports with AlphaCM capabilities.

Network Operations/Provider Relations

The network operations and provider relations functions are well defined. However, there are five vacancies in this unit that need to be filled as soon as possible. MeckLINK reviewed and analyzed Medicaid paid claims data for the past 60 days and identified over 1,000 providers. About 940 unduplicated providers are actively serving Medicaid eligible individuals.

The provider network director reported receiving about 92 agency applications as of the date of the review. Hospital and licensed independent practitioner applications will be distributed during the first week of September through Medversant, a credentialing verification organization (CVO). All remaining provider applications are due by September 30, 2012.

MeckLINK has a credentialing committee, chaired by the medical director. This committee will credential providers based upon the reviews completed by the CVO. The credentialing committee also functions as the practitioner advisory committee and has 50% provider representation.

MeckLINK is making preparations for provider outreach to ensure that all interested providers currently serving members remain in the network. They are also planning for member transitions in the event that the providers currently serving MeckLINK members elect not to become a contracted network provider. Network specialists (once hired) will continue outreach activities in October following the September 30, 2012 due date for submission of all provider applications.

The Provider Relations and Network Department has a variety of ways to communicate with its providers. There is a comprehensive provider website, quarterly provider meetings and Hot Sheets, which are weekly (or more often than weekly) newsletters which are transmitted electronically to every network provider and also available on the website. Hot Sheets update providers on new or revised processes, trainings, regulatory changes and other LME business updates. In addition, there is an external provider council that consists of county contracted providers and other behavioral health providers operating in the county area.

The provider network director has identified a set of network management reports and is working with AlphaCM on the provider portal.

Challenges include completing network contracts and transitioning members when current providers elect not to contract with MeckLINK. The five vacancies in the provider network operations department is a significant challenge that may delay executing provider contracts.

Strengths – Network Operations/Provider Relations	Opportunities for Improvement
• Well defined functions of the Network Operations and Provider Relations Department. • Identification through paid claims data of 940 unduplicated providers actively serving Medicaid eligible individuals. • The Medversant contract (CVO) is in final stages of negotiations to verify the credentials of licensed independent practitioners and hospitals. • A credentialing committee, chaired by the medical director, with 50% provider representation. • Reports necessary to monitor provider network operations identified. • Effective provider communications strategies established.	• Recruit and train five provider relations specialists to fill vacancies (posted on 7/31/2012). • Refine the provider network development plan by identifying the specific services reflected in Medicaid claims data to ensure the appropriate array of services will be available. • Investigate if paid claims data for past 60 days identified all providers serving Medicaid members. • Continue outreach to the provider network and finalize the network transition plan. • Timing challenges of negotiating nearly 1,000 contracts by start date may not be remediable.

Quality Assurance and Quality Improvement

The Quality Management and Training Department reports to the division director for administrative services, a position that also supervises informatics and analytics and administrative services. This department should report to the medical director or clinical director of the organization to enhance clinical quality. While the quality improvement plan indicates the medical director oversees quality management for MeckLINK, it is highly unusual to have the administrative services director supervise quality management. This is inconsistent with best practice.

The medical director chairs the quality improvement committee, which is a best practice. The QI committee has a well-designed committee structure and has active participation by consumer and family advisory committee (CFAC) members.

In addition to performing quality assurance, improvement and training activities, the QM department also handles complaints and appeals. There is one quality improvement project for each URAC accreditation module: call center/customer services, CM/UM and provider network operations.

The review team was not able to assess the system coordination of QM with other clinical and network operations because the AlphaCM system was not operational.

Strengths – QA and QI	Opportunities for Improvement
• Clearly written quality improvement plan • Medical director chairs QI committee, and representatives from Prest & Associates, Inc. also participate. • Effective QM committee structure (credentialing, communications, data integrity, clinical risk, training subcommittees and a time-limited outreach and education subcommittee) with active CFAC involvement.	• Realign the reporting relationship of the QI manager to the medical director or senior clinical position in the agency. • Identify QI reports needed and compare with those available on AlphaCM system.

Financial Management/Monitoring

MeckLINK demonstrated knowledge regarding the financial requirements for the PIHP program. This includes knowledge about hiring and training of staff, development of P&Ps related to required financial processes and the need for accurate and timely reporting. Project plans reviewed during the onsite included all necessary components related to financial processes, reporting and ongoing monitoring. However, project plans were not current and lacked sufficient detail necessary to perform accurate project management.

MeckLINK is in the process of developing P&Ps that are needed for financial processes. MeckLINK needs to complete the development of the detailed procedures related to critical financial processes, including reporting, eligibility reconciliation, capitation payment reconciliation and month-end processing. Additional P&Ps that need to be documented in detail include those related to the application of coordination of benefits, fraud and abuse detection and incurred but not reported (IBNR) methodology.

Financial reporting is a critical development area for any LME implementing the PIHP program. For MeckLINK, the requirements for report development have not been identified. Report

requirements need to be documented and steps added to the project plan that define a path for creating necessary reporting related to early warning indicators which compare budgeted income, expenses, membership, utilization of services and costs of services, with the end goal of ensuring financial viability of MeckLINK's PIHP program. Reporting is also essential in order to report and monitor risk reserve and IBNR.

The use of prior authorization data to predict IBNR medical claims liability for services is highly recommended. Using this data requires collaboration with the clinical departments to ensure authorizations for services, such as inpatient stays, Innovations services, intermediate care facilities for I/DD and residential services, are accurate and updated as utilization/concurrent review is conducted. Discharge dates, approved number of days, etc. must be updated and accurate when running reports for the prior month. In practice and as an example, at month-end, finance would run an inpatient activity report for the prior month. This report should be shared with utilization review staff to establish agreement that the data is correct, known authorized days are accurate and the admit/discharge dates are up to date. Using a spreadsheet with estimated per day rates for contracted providers would then be used to produce a reliable estimate of outstanding liability for a given period. Claims associated with authorizations must also be considered and removed from the liability estimate as they are paid. This method will require that accurate inpatient census reports are available from the new AlphaMCS system.

Project work plans lack sufficient detail and are not updated with recent data. The plan that Mercer reviewed during the 120-day onsite was dated May 2012, and more recent updated project plans were not presented for review. MeckLINK needs to ensure that all business requirements related to financial processing have been collected and that detailed information is included in the project plan. During the 120-day review, the review team noted that some business requirements are missing. It is critical that MeckLINK establish a process to ensure that all requirements have been collected and that implementation criteria are established, including those related to the AlphaMCS system implementation and those related to financial processes and reporting. Mercer recommends that specific testing and verification steps be established to confirm the data conversion for the AlphaMCS implementation. This is necessary in order to verify that the conversion of historical data is correct, that the new and modified software performs as expected and that all report development conveys accurate and timely data.

During the onsite, the review team noted that there was not a single project manager responsible for maintaining the project plan. It is recommended that MeckLINK establish a dedicated and knowledgeable project manager responsible for overall project management, including project plan maintenance and accurate project status communication throughout the organization.

Strengths – Financial Management/Monitoring	Opportunities for Improvement
• Chief financial officer in process of being hired and expected to begin duties in October 2012. • Performed review of historical Medicaid data received from the State.	• Perform thorough testing of new AlphaMCS software. This should be done using predetermined test plans that incorporate user acceptance testing by all business areas that use AlphaMCS or the data created by it. • Perform rigorous testing to confirm the accuracy and completeness of the data conversion related to the AlphaMCS implementation. The accuracy of those areas must be ensured in order to provide accurate data for financial reporting. • Complete interface development and testing between AlphaMCS claims system and Advantage accounting software. • Advantage accounting software needs to be able to send checks to non-network providers (i.e., hospitals for emergency room services) instead of electronic fund transfers, as is the current requirement under the county payment process through Advantage. Payments must be made within 30 days of receipt of the medical claim. • Develop processes in Advantage so that Medicaid providers can be paid without delay, instead of through the encumbrance process currently required. • Complete all financial P&Ps necessary for the PIHP program to operate successfully, including those related to financial tracking, month-end reporting, IBNR and risk reserve monitoring, capitation payment reconciliation, coordination of benefits/third party liability and fraud and abuse. Develop reports that support those processes. • Review Attachment W requirements to ensure data reports support State reporting requirements. • Develop high-dollar member and high utilization of services reporting. • Develop a program integrity committee or department to establish fraud and abuse detection mechanisms. • Develop third party resource identification P&Ps utilizing calls with members, State reporting and claims submissions.

Strengths – Financial Management/Monitoring	Opportunities for Improvement
	• Financial monitoring, trending and executive dashboard reporting should be developed in preparation of the PIHP contract. • Document all reporting requirements and compare to AlphaMCS reports to establish development requirements. • Establish a project manager responsible for executing all necessary steps for collecting all PIHP program requirements, maintaining the detailed project plan and communicating status.

Claims and IT Staffing

MeckLINK's current status with the PIHP implementation is not consistent with expectations for the 120-day review. Requirements for Claims and IT have not been clearly and completely determined, new staff hiring has not occurred, project planning lacks sufficient detail and reporting requirements have not been documented. The AlphaMCS implementation is under development; however, user acceptance test plans related to data conversion and system implementation have not been developed.

Train-the-trainer planned by Alpha CM for MeckLINK will be with current LME (State funded) claims staff; however, current claims staff working on the LME business are county employees and must apply for the positions within MeckLINK. This may result in a new department without seasoned staff or subject matter experts available.

P&Ps that were presented for review were mostly based on existing county procedures and staffing. In many cases, P&Ps need to be rewritten to reflect changes related to the MCO's business processes.

Strengths – Claims and IT Staffing	Opportunities for Improvement
• Implementing AlphaMCS software for claims processing. • Using external consultants to assist in defining internal process flows.	• Expedite the creation of job descriptions. • Hire and train staff on new processes related to PIHP, in addition to the system functionality, including check payments from the accounting software. • Train-the-trainer staff are county staff that may not be future MeckLINK employees. As a result, there may be a gap in trained staff to provide on-going assistance.

Claims Administration System Development

AlphaMCS, built by AlphaCM, Inc., will be MeckLINK's new claims management system. The planned implementation date is currently October 29, 2012 for State funded services and Medicaid services on January 1, 2013. MeckLINK's current status with the PIHP implementation is not consistent with expectations for the 120-day review. Requirements for Claims and IT have not been clearly and completely documented, and staff hiring in those areas has not occurred. The AlphaMCS implementation is under development; however, user acceptance test plans related to data conversion and system implementation have not been developed. The project plan that we reviewed during the onsite meeting contained missed milestones and lacked sufficient detail necessary for proper project management. Reporting requirements have not been assessed and analysis to determine system development specifications has not been performed.

In order to go live with the PIHP program, MeckLINK must implement the new AlphaMCS software, hire and train staff on the new system, convert historical data, develop and implement interfaces to other business applications, develop a new data warehouse/server, create a myriad of reports and develop P&Ps. While there are activities underway for the AlphaMCS implementation, such as data conversion, the project components related to the collection of requirements, data validation, user acceptance testing and detailed project planning are missing or incomplete. MeckLINK has not completed a gap analysis for reporting to document the difference between what AlphaMCS provides for reporting and what MeckLINK will need to develop.

System documentation presented to the review team at the onsite was outdated (November 2011). For a new system implementation, it is important to have current system documentation. A system demonstration was not available during the onsite because the data system is not expected to be implemented until October 29, 2012. A test environment was not available at this time either with any data specific to MeckLINK.

P&Ps that were presented for review were mostly based on existing county procedures. In many cases, P&Ps need to be rewritten to reflect changes related to the MCO's business processes.

Strengths – Claims Administration System Development	Opportunities for Improvement
• Implementation of AlphaMCS, owned by AlphaCM, Inc., to support the PIHP. MeckLINK has joined the AlphaMCS user group with five other MCOs actively participating in North Carolina to ensure consistent or additional system operations. • Integration with county's processes ensures robust disaster and recovery processes are in place.	• Obtain current system documentation from AlphaCM. • Perform detailed analysis to ensure all requirements for implementing the PIHP program have been documented. • Develop detailed P&Ps specific to claims operations, including, but not limited to: — internal claims audit

Strengths – Claims Administration System Development	Opportunities for Improvement
• Added Cisco telephone system to handle PIHP calls, routing and reporting processes within MeckLINK. • AlphaCM tests their claim system every six months for disaster recovery processes. .	— high dollar claims review — Authorizations — Claim adjustments and voids — Third party liability and coordination of benefits — Provider data loads and maintenance — Claim denials — Out-of-network provider payments • Develop detailed P&Ps specific to IT operations to support the PIHP data security. • Confirm business requirements related to AlphaMCS implementation have been fully documented, and establish testing methodologies to verify data conversion for State funded operations and system accuracy. • Review claim system edits to understand what data validations occur and what edits may result in a claim denial. • Document reporting requirements and determine development requirements. Reports must be in place prior to implementation. • Add necessary detail-level tasks to the project plan. • Recommend hiring a dedicated project manager. • Develop detailed test plans on PIHP-specific types of processes on AlphaMCS, especially those related to inpatient and emergency room claims. • Develop and implement ANSI 270/271 eligibility inquiry and response capabilities for verification of covered members, with the State to reconcile the eligibility information on the system. • Train staff on Medicaid processes, in addition to system processes on AlphaMCS. • Train providers on the provider portal of AlphaMCS.

Reporting

MeckLINK will perform reporting through AlphaMCS or the data warehouse maintained by the county. This will include internal and external reporting. AlphaCM, Inc. is developing the system reporting that will be utilized by all of the PIHPs and includes approximately 47 operational reports and 22 state reports. MeckLINK plans to implement a server to specifically handle ad-hoc reports and analysis. The data warehouse will be updated nightly with data from AlphaMCS and will handle additional scheduled and ad-hoc reports.

Strengths – Reporting	Opportunities for Improvement
• Generic operations reports for managed care organizations provided by AlphaMCS.	• Ensure reports provide MeckLINK the ability to operate as a PIHP. This includes identification of key clinical and financial reports to identify areas of concern. Key management should discuss the reports to direct change and ensure continued fiscal solvency of the PIHP. • Complete assessment of business reporting requirements, including a comparison of the reports available in AlphaMCS. • Document reporting specifications for development required to be production-ready prior to go-live. • Develop reports as determined by the collection of requirements and specifications. • Test all reports delivered by AlphaMCS, including how the reports will be utilized to monitor operations.

3

Plan of Development

The tasks below are considered vital for MeckLINK to address to successfully implement the waivers. Each task must be accomplished before the go-live date in order to help assure a smooth transition as a PIHP.

MeckLINK Plan of Development—must be completed before implementation
Contracting and capitation • Hire staff. • Finalize P&Ps and train staff related to capitation reconciliation. • Develop processes for financial monitoring and early warning indicators.
Member services • Discontinue the practice of calling back members in crisis, and institute the practice of warm line transfers of urgent calls to licensed clinicians. Train staff on urgent call response and crisis management practices. • Develop a contingency plan for handling after hours and weekend call volume increases.
Clinical CM/UR • Timing challenges to recruit and train staff on P&Ps and new IT system; may not be feasible to meet January 1, 2013 target start date. • Identification of CM/UR reports needed to manage care and comparison on desired reports with AlphaCM capabilities.
Network operations/provider relations • Recruit and train five provider relations specialists to fill vacancies (posted on 7/31/2012). • Refine the provider network development plan by identifying the specific services reflected in Medicaid claims data to ensure the appropriate array of services will be available. • Investigate if paid claims data for past 60 days identified all providers serving Medicaid members. • Continue outreach to the provider network and finalize the network transition plan. • Timing challenges of negotiating nearly 1,000 contracts by start date may not be remediable.
QA and QI • Identify QI reports needed and compare with those available on AlphaCM system.

MeckLINK Plan of Development—must be completed before implementation
Financial management/monitoring • Perform thorough testing of new AlphaMCS software. This should be done using predetermined test plans that incorporate user acceptance testing by all business areas that use AlphaMCS or the data created by it. • Perform rigorous testing to confirm the accuracy and completeness of the data conversion related to the AlphaMCS implementation. The accuracy of those areas must be ensured in order to provide accurate data for financial reporting. • Complete interface development and testing between AlphaMCS claims system and Advantage accounting software. • Advantage accounting software needs to be able to send checks to non-network providers (i.e., hospitals for emergency room services) instead of electronic fund transfers, as is the current requirement under the county payment process through Advantage. Payments must be made within 30 days of receipt of the medical claim. • Develop processes in Advantage so that Medicaid providers can be paid without delay, instead of through the encumbrance process currently required. • Complete all financial P&Ps necessary for the PIHP program to operate successfully, including those related to financial tracking, month-end reporting, IBNR and risk reserve monitoring, capitation payment reconciliation, coordination of benefits/third party liability and fraud and abuse. Develop reports that support those processes. • Develop high-dollar member and high utilization of services reporting. • Develop third party resource identification P&Ps utilizing calls with members, State reporting and claims submissions. • Financial monitoring, trending and executive dashboard reporting should be developed in preparation of the PIHP contract.
Claims and IT staffing • Expedite the creation of job descriptions. • Hire and train staff on new processes related to PIHP, in addition to the system functionality, including check payments from the accounting software. • Train-the-trainer staff are county staff that may not be future MeckLINK employees. As a result, there may be a gap in trained staff to provide on-going assistance.

MeckLINK Plan of Development—must be completed before implementation
Claims administration system development • Obtain current system documentation from AlphaCM. • Perform detailed analysis to ensure all requirements for implementing the PIHP program have been documented. • Develop detailed P&Ps specific to claims operations, including, but not limited to: — internal claims audit — high dollar claims review — Authorizations — Claim adjustments and voids — Third party liability and coordination of benefits — Provider data loads and maintenance — Claim denials — Out-of-network provider payments • Confirm business requirements related to AlphaMCS implementation have been fully documented, and establish testing methodologies to verify data conversion for State funded operations and system accuracy. • Review claim system edits to understand what data validations occur and what edits may result in a claim denial. • Document reporting requirements and determine development requirements. Reports must be in place prior to implementation. • Add necessary detail-level tasks to the project plan. • Recommend hiring a dedicated project manager. • Develop detailed test plans on PIHP-specific types of processes on AlphaMCS, especially those related to inpatient and emergency room claims. • Develop and implement ANSI 270/271 eligibility inquiry and response capabilities for verification of covered members, with the State to reconcile the eligibility information on the system. • Train staff on Medicaid processes, in addition to system processes on AlphaMCS. • Train providers on the provider portal of AlphaMCS.
Reporting • Ensure reports provide MeckLINK the ability to operate as a PIHP. This includes identification of key clinical and financial reports to identify areas of concern. Key management should discuss the reports to direct change and ensure continued fiscal solvency of the PIHP. • Complete assessment of business reporting requirements, including a comparison of the reports available in AlphaMCS. • Document reporting specifications for development required to be production-ready prior to go-live. • Develop reports as determined by the collection of requirements and specifications. • Test all reports delivered by AlphaMCS, including how the reports will be utilized to monitor operations.

The tasks below are important operational issues, but not considered as essential and critical for successful implementation of the waivers. The tasks below should be completed as soon as practical following the implementation of the waivers.

MeckLINK Plan of Development—can be completed after implementation
Contracting and capitation • Ensure that the revenue/capitation reconciliation process is performed at the member level.
Member services • With DMA, review the URAC-North Carolina agreement for use of qualified bachelor's level staff/CSRs. • Assess the feasibility of utilizing CSRs instead of licensed clinicians to answer the customer services line and develop a plan to phase in CSR use. • Assess the feasibility of transferring the responsibility to contact consumers following discharge from inpatient levels of care from the customer services function to the care coordination function.
QA and QI • Realign the reporting relationship of the QI manager to the medical director or senior clinical position in the agency.
Financial management/monitoring • Review Attachment W requirements to ensure data reports support State reporting requirements. • Develop a program integrity committee or department to establish fraud and abuse detection mechanisms. • Document all reporting requirements and compare to AlphaMCS reports to establish development requirements. • Establish a project manager responsible for executing all necessary steps for collecting all PIHP program requirements, maintaining the detailed project plan and communicating status.
Claims administration system development • Develop detailed P&Ps specific to IT operations to support the PIHP data security.

APPENDIX A

Local Management Entity PIHP Criteria

1. A proven track record with demonstrated success in operating as a LME, as defined in North Carolina General Statues §122C-116.

2. Demonstrated capacity to operate a managed care program, as exemplified by:

   – Financial and risk management resources to ensure that liquidity and solvency requirements are met.

   – Flexible financial analysis and monitoring tools to identify service utilization and costs in a timely manner.

   – The ability to grow equity and capital resources, while providing extended behavioral health benefits to State and county populations.

   – The ability to identify third party resources to ensure that Medicaid is the payer of last resort.

   – Effective fraud and abuse policies and detection mechanisms.

   – A cohesive management structure that meets the requirements to contract with the State.

   – A flexible, responsive customer services approach that is highly ingrained in the organization and promotes 24-hour access to services.

   – Access to industry standard tools, technology and expertise in MH, DD and SAS.

   – A CM/UM program that is person-centered, emphasizes the principles of recovery, resilience and self-determination and relies on state-of-the-art UM protocols and clinical practice guidelines.

   – A well-developed QM program that has sufficient clinical and technical leadership and data management capabilities to monitor and improve access, quality and efficiency of care.

- A provider network management program that facilitates the development, support and monitoring of network providers for the delivery of MH, DD and SAS provided to children, youth, families and adults.

- Experience and demonstrated success in implementing program innovations that result in improved administrative and clinical outcomes, such as increased access to care by traditionally underserved populations of all ages, improved community tenure, MH/DD/SAS-physical health integration and integrated assessment and service delivery for both co-occurring mental illness and substance use disorders and co-occurring mental illness and DD.

- Human resource and management support necessary to effectively recruit and retain clinical and administrative qualified professional staff.

- A solvent and financially viable organization that has sufficient financial and administrative resources to implement and operate managed care functions specified in the Request for Application (RFA).

- An automated management information system that is capable of performing all the activity, interfacing and reporting requirements (utilizing electronic data interchange) using HIPAA transactions.

3. Demonstrated capacity and a proven approach to managing systems of care that:

   - Rely on innovative approaches to address the diversity and cultures of the population served, including, at a minimum, contracts with culturally-competent providers.

   - Identify and implement the preferences of individuals and families in the design of services and supports through development and utilization of person-centered planning.

   - Facilitate the development of consumer-operated programs and use of peer support, including consumer/family team approaches.

   - Facilitate the development and utilization of natural supports.

   - Facilitate the use of self-management and relapse prevention skills, support stable housing and address the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities.

4. Demonstrated capacity to implement the requirements specified in this RFA through a well-designed and detailed implementation plan that clearly articulates tasks, timeframes and expected results.

APPENDIX B

MeckLINK Progress from LME to Potential PIHP

MeckLINK was reviewed by Mercer as part of an independent evaluation of each of the 25 LMEs between January and March 2008. The review focused on overall LME performance, which LMEs could be consolidated with other LMEs and the readiness of the LMEs to take on utilization review. MeckLINK's review was noteworthy; it was the only LME to receive Tier One designation in the areas of clinical, governance, information technology/claims, and financial and business operations. MeckLINK was also rated as Tier One in overall performance. It must be noted, though, that this review did not focus on the ability of the LME to operate as a PIHP, nor was it evaluated in that manner.

MeckLINK responded to the State's Request for Application in February 2010. As a result of the Request for Proposal submission, MeckLINK was selected in June 2010 as one of four LMEs to transition into a PIHP. DMA, DMHDDSAS and Mercer performed a desk review and conducted an onsite review of MeckLINK, and the positive results led to MeckLINK being chosen to implement as a PIHP on January 1, 2011.[1] The planned implementation was later granted an extension to July 1, 2011.[2] Prior to implementation, an onsite review was scheduled to take place. The review was scheduled for September 2010. This review was rescheduled to December 2010, but then was cancelled after a desk review turned up claims and IT deficiencies. A two-hour conference call was held on October 15, 2010 with MeckLINK, and a list of items that needed remediation was presented to MeckLINK. (A majority of the items have not been rectified as of August 2012.*)

No formal reviews were held, but the IMT reportedly did internal monitoring of MeckLINK's progress. DMA and/or DMHDDSAS have hosted periodic technical assistance meetings, but MeckLINK has not consistently participated in the events.

The next IMT and Mercer readiness review was held August 28, 2012 to prepare for a January 1, 2013 go-live date. The readiness review findings indicate that MeckLINK is not on schedule to

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[1] Special Implementation Update #74, June 7, 2010.

[2] Division of Medical Assistance letter from Michael Watson, Deputy Secretary for Health Services, September 2, 2010 to Michelle Lancaster-Sandlin, General Manager, Mecklenburg County.

implement as a PIHP on January 1, 2013. Mercer recommends that DHHS have discussions with MeckLINK within the next month to either determine the length of delay or to determine whether MeckLINK can proceed to become a PIHP and whether alternative management needs to be identified. Implementation readiness should be determined based upon consistent progress and satisfactory compliance with the plan of development outlined in this report. It is important to note that MeckLINK had been preparing to become a PIHP since sometime before 2010 when the initial RFA was submitted. MeckLINK has demonstrated limited progress in preparing to become a PIHP since 2008.

If it is determined that MeckLINK proceed with plans to implement as a PIHP, MeckLINK will most likely need focused technical assistance in order to fully resolve outstanding identified issues. A follow-up onsite review is recommended for early January 2013, at which time MeckLINK must demonstrate that they have made substantial progress with the plan of development items.

*Recommendations to MeckLINK in 2008	Status as of August 2012
1. Segregation of duties between County and behavioral health-managed care organization (BH-MCO) operations and functions	Not yet done
2. Tracking of revenue and expenses and account set up that allow for BH-MCO operations to be kept separate from County operations	In process
3. Financial reporting and financial statement presentation for BH-MCO operations, separately	In process
4. Risk reserve funds and accounts to ensure they are only accessible for this contract	In process
5. Tracking of the payment process from the claims system (eCura) to the accounting system (Advantage): A. Manual processes are currently in place for transferring payment information from eCura to Advantage B. Reporting and check research on claims paid could be an issue when payment information is not recorded in eCura C. Releasing payments in a timely manner to providers	Switched systems to AlphaMCS; still need to do these tasks and test
6. Lack of standard reports in the eCura system for live data for operational management, especially for clinical daily operations	N/A
7. Test process and verification of system upgrades is insufficient in production to ensure data integrity and that all processes are working accurately	Not yet done
8. Staffing plan, especially in areas such as provider network, to complete contracting prior to BH-MCO implementation	Have a staffing plan but still need a tremendous number of staff

*Recommendations to MeckLINK in 2008	Status as of August 2012
9. Policies and procedures have slow development: A. Policies should be documenting decisions B. Procedures should be documenting processes	Still an issue
10. Process flows were not available to the Mercer team for review	Not yet done
11. Front-end requirements for providers	Done, but don't yet know who all the providers are
12. Network contract in place to receive claims data	Unknown
13. Authorization number requirement and automatic denials	N/A
14. Claim processing: A. Understanding of applying the lesser of logic between billed and contracted rates B. Coordination of benefits and paying the member's primary insurance co-pay	Not yet done
15. Readiness for HIPAA formats: A. Completion of testing and implementation prior to July 1, 2011 for: i. 820 capitation payment ii. 834 eligibility and enrollment iii. 837I institutional claims format	Not yet done
16. Competing resources for staff that are responsible for the work on the separate projects	Not yet done

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