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North Carolina 1915(b)(c) Waiver Expansion Request for Application Evaluations

North Carolina Division of Medical Assistance

MERCER

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Executive summary

Introduction

The North Carolina (State), Department of Health and Human Services (DHHS) including representatives from Consumer Family Advisory Committees (CFACs), Division of Medical Assistance (DMA), engaged Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to provide technical assistance in the evaluation and selection of one (or more) local management entities (LME) to operate Medicaid-funded services through capitated prepaid inpatient health plans (PIHPs). The objective of the request for application (RFA) was to select one or two LME(s) to operate a PIHP that brings:

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:

    - 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 care management/utilization management (UM) program that is person-centered, emphasizes the principles of recovery and resilience and self-determination, and relies on state-of-the-art UM protocols and clinical practice guidelines.
    - A well-developed quality management (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 (NM) 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 RFA.
- An automated management information system that is capable of performing all the activity, interfacing and reporting requirements (utilizing electronic data interchange) using Health Insurance Portability and Accountability Act 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, time frames and expected results.

The timeline for RFA development and the scoring of proposals is outlined below:

- RFA released – February 12, 2010
- Bidders conference – March 4, 2010
- Training on scoring tool – March 30, April 12, April 13, April 14
- Proposals due from bidders – April 14, 2010
- Review of proposals – week of April 19, 2010
- Onsite reviews for finalists – week of May 3, 2010

Review of proposals

The state received proposals from four LMEs:

- East Carolina Behavioral Health (ECBH)
- Mecklenburg County Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS)
- Sandhills Center for MH/DD/SAS
- Western Highlands Network (WHN)

During Phase I of the proposal review, the Waiver Evaluation Committee reviewed the minimum requirements checklist and associated documents to determine a pass/fail score. All four LME passed minimum requirements.

Phase II of the review focused on the three major areas of each proposal: clinical operations, administrative operations and implementation plan. During this phase, a score of 85% or higher of the total possible points in each of the three sections was required for a bidder to be considered a finalist. Each of the raw scores was weighted, based on the weights outlined in the RFA to determine the raw score. The clinical operations and administrative operations scores were each valued at 35% of the total score, while the implementation plan was 30% of the overall score. The desk review scores, as the percent of total points available in each section, are provided below.

North Carolina 1915(b)(c) waiver final ranking of LME applications

Measure	Mecklenburg County MH/DD/SAS	Western Highlands Network	East Carolina Behavioral Health	Sandhills Center for MH/DD/SAS
Overall ranking of RFA process	Top ranking	Second ranking	Third ranking	Review Process Terminated
Desk review – overall score	166.35	168.80	165.30	113.50
Desk review – minimum requirements	Pass	Pass	Pass	Pass
Desk review – clinical operations	86.8%	89.1%	85.3%	41.9%
Desk review – administrative operations	97.1%	97.8%	97.8%	71.5%
Desk review – implementation plan	100%	100%	100%	100%
Onsite review findings	Review verified proposal contents; capacity to implement program within 6 months to 1 year.	Information technology (IT) inadequate; have staff knowledge and infrastructure to make significant IT changes within 1 to 1.5 years. Requires a full time Medical director having oversight of UM and QM.	Information technology inadequate; requires extensive IT changes that will likely take longer than 1 to 1.5 years. Requires further definition of the Medical Director's role and formalized policies and procedures.	Due to the State specification that the LME pass each desk review section at 85% or more, Sandhills Center was not awarded an on-site review.

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Finalist onsite reviews

Three of the four bidders, East Carolina Behavioral Health, Mecklenburg County MH/DD/SAS and Western Highlands Network, were identified as finalists and asked to participate in Phase III of the evaluation, which was a one-day site visit by the Waiver Evaluation Committee. An interview guide, based on each bidder's responses to the RFA, was developed for each site visit. The Waiver Evaluation Committee evaluated the bidder's programs and processes and the results are summarized below. The following information is not intended to provide detail on all LME functions.

Findings

If selected as a waiver entity, all finalists have agreed to hold a provider forum open to all providers in their covered area, to which the state will be invited to discuss the LME plan for implementation and seek provider input and comment.

East Carolina Behavioral Health

Clinical operations

The staff of ECBH displayed a strong commitment to improving the consumer's quality of life through access to quality care. The LME was recently awarded full Utilization Review Accreditation Committee (URAC) accreditation and is in the process of expanding from their current 10 counties to a 19 county service area. Management, supervisory and line staff of ECBH were available for interviews throughout the day, although questions were usually answered by management or ECBH consultants. The role of the medical director in providing clinical leadership for the LME will require further definition should ECBH be selected as a waiver entity, including the recommendation that the medical director chair two new committees; a UM Committee and an internal Critical Incident Committee. QM reports to finance, a reporting structure that the LME described as working well. ECBH management stated that while not on the organizational chart, QM is accountable to the medical director. If selected as a waiver entity, the medical director should have direct oversight of QM.

ECBH's call center provides 24 hours a day, seven days a week, telephone access for consumers. The toll-free number is answered by non-clinicians, with access to clinicians via three-way call with the consumer. Management stated ECBH will not add staff to this department if selected as a waiver entity, as phones can be set to roll-over to other trained staff during periods of high volume; however, ECBH is open to further discussion of staffing with the State. The training and monitoring of customer services and care management/UM staff is not standardized beyond daily supervision and case review due to the tenure of staff in these departments. If selected, ECBH states these processes will be standardized, citing a number of monitoring tools already under development. Silent call monitoring, a telephonic capability already in place at ECBH, and inter-rater reliability (IRR) testing will be incorporated into the training and monitoring of customer services and clinical staff. Information technology to support care management/UM is not integrated; customer services and care coordination staff toggle to the ECBH website for provider referral information and to ProviderLink to access the consumer's person-centered plan and other consumer information. Provider information on the website is also accessible by consumers; however, the provider search engine is limited to searching for providers by county and includes limited specialty information.

QM provided examples of active quality improvement initiatives, including improving authorization turn-around-time, decreasing the number of outbound calls (resolving questions on the first call with the consumer) and improving access to urgent appointments. ECBH has a number of active committees that include consumers, stakeholders and providers. In addition, a Clinical Advisory Committee will be active in May 2010, and a UM Committee will be formed if the LME becomes a PIHP. All LME departments are represented on the Quality Improvment Committee (QIC). The QIC establishes priorities based on impact on the consumer and the organization overall. ECBH's gaps analysis and needs assessment were comprehensive and have been shared with stakeholders. Network operations described a crisis continuum that includes first responders, Mobile Crisis in all 19 counties, three facility-based crisis centers, DD start teams for support or respite and active planning for telemedicine.

ECBH is the only bidder with local empowerment groups at the county level that meet monthly with the Consumer and Family Advisory Committee (CFAC), a process viewed as best practice by two consumers on the evaluation team. ECBH's support of the CFAC through training was evident and the CFAC has an active role with the LME, sharing information and opinions. However, the impact of the CFAC on ECBH activities that impact consumers was unclear, as committee members were unable to identify an initiative of the LME that resulted from their input. The consumer website is accessible and communication materials are good.

Administrative operations

ECBH's claims software, CMHC, is a vendor-supplied solution provided by Netsmart. The system has been in place for several years and is maintained via quarterly software updates sent by the vendor. The software is adept at performing claims billing functions; however, processes related to health plan administration are lacking. The system does

not allow entry of all clinical data and cannot display standard service codes due to size limitations. The system appears to be HIPAA compliant; however, the manner in which the transactions and code sets are utilized contains minimal functionality.

ECBH does not have a formal project life cycle and does not have standard processes for managing large projects. Testing is done informally and does not always involve business areas prior to production implementation.

Financial and administrative reports are produced using a combination of standard CMHC reports, as well as customized and ad-hoc reports using Crystal Reports.

Membership and encounter data processes were found to be in line with the State's requirements. System backups are taken at regular intervals and recovery processes are in place and tested routinely.

Pros	Cons
▪ URAC accreditation ▪ Experienced staff with tenure ▪ 24/7 telephonic access provided by ECBH ▪ Three-way conferencing (customer services, consumer, clinician) eliminates need for transfer of urgent/emergent calls ▪ Telephonic call monitor capability to assess periods of high call volume ▪ Consumer involvement expanded through local empowerment groups ▪ Full system backups are taken routinely and can be used to restore in the event of a system failure or loss of data ▪ Provider payments are made within mandated timeframes	▪ No plan to expand customer service staff ▪ Informal process for training and monitoring of customer services and care management/UM staff ▪ QM reports to finance ▪ Medical director role and responsibility over clinical functions not represented in organizational chart or staff interviews ▪ Not all processes and procedures are formalized ▪ Impact of CFAC on LME initiatives unclear ▪ No formal project management processes ▪ Claims software is focused on claim billing, not health plan administration ▪ No policies and procedures for claims audit ▪ Lacking processes for collecting and processing coordination of benefits data ▪ Not all clinical data is captured from the rendering provider ▪ System does not allow entry of multiple services and date spans ▪ Claim adjustments are manual ▪ Internal home-grown service codes are used within the Netsmart claims system due to limitations within the software

Mecklenburg County MH/DD/SAS

Clinical operations

Management, supervisory and line staff was available for interviews and staff functioning at various levels in the organization responded to questions asked by the evaluation team. The organization is URAC accredited. Mecklenburg's medical director and their clinical director participated in all interviews and all questions were answered in sufficient detail. The LME's customer services department, MeckLINK, is staffed by licensed clinicians 24 hours a day, seven days a week. After hours calls are taken by Behavioral Health Centers CMC-Randolph (CMC-Randolph), a process the LME is willing to change, as needed, if selected as a waiver entity. Calls taken by CMC-Randolph are not currently monitored; this will change if the LME is a PIHP. With an expected increase in call volume and the potential for more grievances and appeals, Mecklenburg plans to increase staffing, monitor average speed of answer to identify peak periods and have identified back-up staff for high volume periods. The current crisis plan includes access to six additional staff and supervisors for back-up, starting day one of the waiver. The medical director, located in close proximity to MeckLINK staff, provides structured clinical supervision twice weekly, addresses quality of care concerns from ValueOptions and is available to staff as needed. Clinical staff is monitored through IRR testing, live call monitoring and the review of clinical documentation using a standardized template. QM was described as having an internal LME focus, as well as a focus on the clinical care provided to consumers. QM's role with providers is focused on performance reporting, while provider relations works directly with providers to address plans of correction. Mecklenburg's committee structure includes a QM Committee, chaired by the medical director, with consumer participation, a System of Care Committee with consumer, school, housing, provider and other stakeholder participation, and a Community Best Practice Committee, with provider, family and consumer participation. UM is not a stand-alone committee but is part of two committees: the QM Committee and the Contracts Committee.

Mecklenburg fully divested of providing direct service April 1, 2010. Network operations is currently responding to the decision by CMC-Randolph to no longer treat children, requiring the transition of 750 children to other providers in a 30-day period. The provider community has responded to this need and processes are under development to ensure follow-up with families as part of the transition of care protocol. CMC-Randolph also provides crisis stabilization services and after-hours telephone response for Mecklenburg. The operating relationship between the LME and CMC-Randolph should be further explored should Mecklenburg be selected as a waiver entity.

Management staff stated information system staff assist them with reports, and readmission data is currently provided by CMC-Randolph. eCura, the LME MIS, is currently being upgraded to pay claims and will support reporting needs if Mecklenburg is selected as a waiver entity. Mecklenburg uses data to track follow-up post-hospitalization, frequency of provider changes and match diagnosis to intensity of service. As a waiver entity, Mecklenburg plans to use data to manage outliers, such as over- and under-utilization at the provider level.

The CFAC's relationship with the LME is strong. The committee is active, understands their vision, their strengths and the need to not only communicate information out to consumers, but to get messages back in from the community. The consumer website was easy to navigate, the information presented was clear and presented in an engaging format and the website is American with Disabilities Act (ADA) compliant. Consumer communication materials were found to be of "gold standard" quality, with comprehensive information that addresses all populations, is clearly communicated, is available in multiple formats and is graphically appealing. All consumer materials are reviewed by focus groups before use.

Administrative operations

Mecklenburg uses InfoMC's eCura software for claims and membership administration. The software contains functionality consistent with those required for health plan operations. Claims software functionality includes system configuration and allows users to establish which edits result in claims payment, denials and those that are pended for further review. Providers submit claims via the 837 or using a web portal. Web portal functionality allows providers to submit authorizations, claims and set up and enroll members.

The ability to gather and utilize coordination of benefits data exists within the eCura software; however, the policies and procedures for tracking and enforcement need to be developed.

Mecklenburg has policies and procedures for project management. Processes for testing software changes prior to production implementation include business area testing and signoff. Test environments exist which allow software to be tested separately before moving to production.

Financial data processing and reporting is an area of strength at Mecklenburg. Incurred but not reported (IBNR) calculations incorporate the use of authorized units, actual units accumulated, units billed and seasonal adjustments. New levels of detail can be added easily via system configuration. Financial budgeting is tracked by funding source and compared to authorizations and IBNR.

Pros	Cons
▪ URAC accreditation ▪ Staff functioning at various levels within the LME were knowledgeable of LME functions ▪ Medical director actively engaged in clinical functions ▪ Strong CFAC ▪ Consumer communication materials of "gold standard" quality ▪ System tracks and reports revenue and expense at the detail level and new levels can be established easily ▪ Formal project management policies and procedures ▪ Detailed policies and procedures for system backup and recovery	▪ After hours calls managed outside of the LME by CMC-Randolph ▪ Relationship with CMC-Randolph warrants further discussion if LME is selected as a waiver entity as this CMC-Randolph currently provides key services ▪ eCura enhancements and upgrades underway for claims payment and to support clinical operations ▪ No policies and procedures for coordination of benefits ▪ Diagnosis code from rendering provider is collected but not submitted on encounters ▪ IT staff is part of the county's structure; LME work requests are queued with other county priorities

Western Highlands Network

Clinical operations

Western Highlands Network provides 24 hour, seven days a week access to customer services through a toll-free services line. The training and monitoring of customer services staff includes live call monitoring and daily supervision. WHN has trained 55 peer support specialists and hopes to have some of these consumers work in customer services with strong supervisory support. Customer services and UM staff use the same source documents and same information system (IS). The medical director, currently a half-time position, attends team meetings, consults with UM staff and provides peer-to-peer consultation as needed. Should the LME be selected as a waiver entity, management described the focus of care coordination and care management shifting to high risk/high cost cases to bring the needed resources to the consumer. A number of processes were described as being in place but not standardized, such as the tracking of requests to change providers and use of out-of-network and out-of- region providers. Management of the LME acknowledged the need to formalize a number of processes and move the LME to be more data driven, and if selected as a waiver entity, the funding will be available to support these changes. Non-clinical customer services staff collect clinical information and authorize admissions to the state hospital, a process that WHN understands must change if the LME is selected to be a waiver entity. WHN demonstrated success through their innovative approach to meeting the needs of consumers; for example, the LME has opened a discharge home for adult men, have trained over 55 peer support specialists and plans to have peer support specialists employed in customer services to do follow-up with consumers not keeping appointments.

The director of quality management reports to finance and the medical director has no direct reports, changes made when WHN downsized due to Medicaid utilization management functions moving to ValueOptions. The structure of QM was described as being non-standard with all departments responsible for quality assurance/quality improvement. The LME has a continuous quality improvement team that looks across the entire organization and has representation from each department, as well as the CFAC. Overall, staff interviews did not provide evidence that the role of QM in the organization is understood or actively present in the LME, as represented in the proposal. This appears to be related to past staff reductions and the need to focus resources on mandated reporting to the State.

The strength of the CFAC's relationship with WHN was evident throughout the interview process. CFAC goals are aligned with the goals of the WHN and the waiver is viewed as an opportunity for the LME to do more for consumers. The website provides good information for consumers and WHN seeks CFAC input on all communication material.

Administrative operations

WHN's claims software, CMHC, is a vendor-supplied solution provided by Netsmart. The software is designed for claims billing functions; however, processes related to health plan administration are lacking. The system does not allow entry of all clinical data.

WHN does not have a formal project life cycle and does not have standard processes for managing large projects. Testing is done informally and does not always involve business areas prior to production implementation.

Financial controls are in place for tracking budget; however, WHN does not currently have the ability to track based on revenue from multiple sources. WHN lacks business processes for performing claims audit and applying claims adjustments.

Membership and encounter data processes were found to be in line with the State's requirements. System backups are taken at regular intervals and recovery processes are in place and tested routinely.

Pros	Cons
▪ CARF accreditation ▪ 24/7 telephonic access provided by WHN ▪ Experienced staff with tenure and a strong commitment to improving quality of care ▪ 55 peer support specialists trained ▪ LME is innovative in their approach to meeting consumer needs ▪ Encounter submission processes result in high percent of reimbursement. Processes are well documented	▪ Key processes and procedures are not standardized ▪ Non-licensed customer services staff collect clinical information and authorize admissions to the state hospital ▪ Insufficient quality management report to finance unit/management ▪ Understanding of the role of QM in the organization was not evident ▪ No formal project management processes ▪ Claims software is focused on claim billing not health plan administration ▪ No policies and procedures for claims audit ▪ Not all clinical data is captured from the rendering provider ▪ System does not allow entry of multiple services and date spans ▪ Claim adjustment and claim release process are manual

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Recommendations

Mercer recommends that the State consider Mecklenburg County MH/DD/SAS for the waiver expansion. Mecklenburg's information system was found to be adequate in both size and functionality. They demonstrated appropriate business knowledge and have well documented policies and procedures. Mecklenburg was candid about the items within their systems and business processes that need modification in order to perform correctly and, in some instances, are already taking some corrective steps. They have an implementation plan, which identifies next steps and timeframes. Mecklenburg has sufficient staffing already in place, which enables them to make steady progress during the next few months should they be chosen for expansion under the waiver program.

Both Western Highlands Network and East Carolina Behavioral Health have a significant number of issues related to their systems and business processes related to claims administration that would prevent them from performing well under the waiver expansion. These problems can all be addressed but it is estimated that it would take a much longer time period, and potentially require additional software investment, in order to accomplish the required system functionality that is required under the waiver program.

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