Advocating in Medicaid Managed Care-Behavioral Health Services

What is Medicaid managed care? How does receiving services through managed care affect me or my family member? How do I complain if I disagree with a decision by the MCO?

Disability Rights NC created this document to provide general answers to the above questions and provide further information about the differences families may encounter as they learn to advocate in a managed care environment for mental health, developmental disability, and substance abuse services. Since January 2012, Local Management Entities (LMEs) across the state have been transitioning to Managed Care Organizations (MCOs) for behavioral health services. The last LME transitioned in April 2013. Because of the numerous changes, this has not been an easy process for individuals receiving services, providers, or the MCOs themselves. The transition to managed care has also created some differences across the state as each MCO has some flexibility in how they operate their 1915(b)/(c) waiver program. The information in this document is intended to be a generalization of changes and how a person may address some common issues. It may not reflect some of the differences in how any particular MCO may operate. Some of the inherent LME functions, such as the appeals process, should remain consistent, but others may reflect choices made by a particular MCO.

What are MCOs?

Managed Care Organizations (MCOs) in North Carolina perform the functions that the Local Management Entities (LMEs) have performed for the last decade, but now the LME/MCOs also manage the Medicaid-funded behavioral health services. Each MCO administers its own Medicaid 1915(b)/(c) waiver\(^1\) and continues to manage State-funded behavioral health services. As an MCO, each entity is responsible for enrolling a closed network of service providers, providing care coordination for service recipients (sometimes called “enrollees”), authorizing or denying requests for services, paying providers for services, and other duties. Each MCO also manages the Innovations waiver for individuals with intellectual and/or developmental disabilities (formerly known as CAP-MR/DD or CAP/ID, now NC Innovations).

The MCO only manages behavioral health services. Services such as medical services, non-waiver personal care, CAP-C, CAP-DA, PT/OT for non-waiver recipients, private duty nursing, and other Medicaid services are still managed by NC DHHS and its contractors. For more information about who provides prior authorization for what types of services, see [http://www.ncdhhs.gov/dma/provider/priorapproval.htm](http://www.ncdhhs.gov/dma/provider/priorapproval.htm).

\(^1\) 1915(b)/(c) refers to the type of waiver approved by CMS to allow this type of managed care program. The Innovations Waiver is the 1915(c) and the 1915(b) covers all other Medicaid funded behavioral health services. This 1915(b)/(c) is considered a combination waiver to reflect the managed care model for all behavioral health services, including the Innovations waiver. Under this waiver model, each MCO is paid a per member per month rate regardless of an individual’s needs and the MCO is responsible for managing that money so as to provide services for all of the enrolled members.
Why the Change to MCOs?

The transition to managed care is the result of a N.C. General Assembly decision made during the 2010 legislative session to replicate throughout the state what was previously a demonstration project by Cardinal Innovations (formerly known as Piedmont Behavioral Healthcare or PBH). This decision transfers the responsibility of managing certain services from the State to the LME/MCOs.

Some LMEs have become a part of Cardinal Innovations. These LMEs (Five County, Alamance-Caswell, and OPC) are under the direct supervision and control of Cardinal Innovations, and use service definitions and limitations found in that program. The remaining MCOs are not under the control of PBH, but based on direction from the General Assembly, the North Carolina Department of Health and Human Services (NC DHHS) requires the MCO to maintain “fidelity to the PBH model.” Each MCO will interpret this language differently, within the flexibility provided by the 1915(b)/(c) waiver as approved by the Centers Medicare and Medicaid Services (CMS).

The Cardinal Innovations and N.C. Innovations waiver are substantially similar and contain many of the same services, so we will refer to them together as the “Innovations” waiver. For a comparison of CAP-MR/DD to Innovations waiver services, please see our factsheet that addresses those differences. Please consult your MCO waiver handbook for specific information about services under your particular waiver program.

Who provides waiver services? Do I have my choice of service providers?

Unlike standard Medicaid or CAP, MCOs operate a closed provider network. This means that every agency who wants to provide services in that MCO’s geographic catchment area must undergo a separate enrollment and credentialing process. The MCO decides whether or not a particular agency will be authorized to provide services within the network. Although MCOs may limit the network, they must have sufficient capacity to allow individuals to access services. In our experience, many agencies that provided services previously have been enrolled, although some have opted not to go through the process, especially if they provide services other than Medicaid-funded services. If your provider is not allowed to provide services in your MCO’s network, your care coordinator or the MCO will direct you to other options or your provider may choose to go through the enrollment process or the appeals process, if its application has been denied.

Who will provide case management?

Before LMEs became MCOs, individuals generally received case management services from a private third-party case management agency. As LMEs became MCOs, the “case manager” was generally replaced by a “care coordinator” employed by the MCO. This is true for most Innovations waiver participants, as well as for other individuals receiving case management services. As opposed to “case managers,” the care coordinator is employed by the MCO, rather than an independent agency, and the care coordinators play a different role. Most of the MCOs have followed Cardinal Innovations’ example and are using internal care coordination, although Western Highlands Network maintained external case management initially. Western Highlands Network is becoming part of the Smoky Mountains Center, and it is unclear at the time of writing this document what changes may be coming as a result.
find that their care coordinators rely more on information about guidelines and limits on services in guiding a plan compared to with the advocacy role case managers once played. Care coordinators assist with gathering assessments, develop person centered plans, and link and refer to appropriate services, but they generally do not play as active a role in problem-solving or advocacy as compared to many case managers. As a result, individuals must often be pro-active and obtain documentation of the individual’s needs from his/her caregivers, physicians and/or therapists. Individuals or their guardians should keep their care coordinator or case manager well-informed of problems with the individual’s services and document any conversations you have with the care coordinator. If additional services are needed, individuals or the guardians should take care to articulate and document specific needs, behaviors, or problems that necessitate additional services.

Although it is the care coordinator’s job to help guide an individual or family in identifying services or creating a plan that will meet the individual’s needs, they may not refuse to request a service on that person’s behalf. The care coordinators are supposed to use their knowledge of policy and procedures to the benefit of the individual, but there is an inherent conflict because they are employed by the MCO. There is a fine line between helping guide a person regarding the policies that govern a service and discouraging someone from requesting a service that is medically necessary, but which may exceed the guidelines and service limits. If you find that a care coordinator is trying to redirect an individual to a different service, you may want to ask questions about why the other service may not be appropriate or what the right service to obtain the same goal may be. If the care coordinator refuses to request a service, you should ask to speak to their supervisor as such discouragement may be a violation of due process rights.

What if I have problems with my care coordinator?

Understanding the differences between case management as it has operated previously and care coordination is important to making the most out of your relationship with a care coordinator. A care coordinator is supposed to help an individual access necessary services by identifying and requesting appropriate services and providing referral for possible providers of those services. If an individual is having difficulty accessing services, a care coordinator should be able to troubleshoot such issues. However, a care coordinator is not going to be as “hands-on” or advocate like some case managers may have done. If an individual or family continues to have difficulties with their care coordinator, they may request a different care coordinator. Most MCOs also have customer service divisions that may become involved in addressing problems with care coordinators. This is especially true if the recipient or guardian files a grievance with the MCO (see the section below on filing formal grievances with the MCO).

Are there ways to get a case manager?

For individuals on the registry of unmet needs, the MCO may offer Community Guide services, maintain third-party case management, or provide care coordination. Individuals with mental illness may be able to access case management as part of accessing new services. There are a few other limited circumstances in which an individual, especially those with very complex needs, may receive case management services or more intensive care coordination.

Medicaid-eligible children under the age of 21 may have access to more traditional case management services if such case management is “…necessary health care… to correct or
ameliorate defects and physical and mental illnesses…” or to prevent a condition from worsening. Such targeted case management is generally used when a child’s condition or circumstances are such that care coordination is insufficient to ensure the child access to medically necessary services. This targeted case management service must be requested under EPSDT and meet the requirements of medical necessity.

Who will approve or deny a request for services?

Most MCOs have not contracted with an outside agency, such as ValueOptions, to review requests for services from individuals, including Innovations waiver participants. Instead, each MCO should have an internal approval process (also known as “utilization review,” “utilization management,” or “care management”) that will make the decision to approve, deny, reduce, or terminate a service. The MCO will also approve or deny requests for state-funded or (b)(3) services (explained below). Although the utilization review and care coordination functions are both done by the MCO, there is supposed to be a “wall” between the two functions.

What if the MCO denies my request for Medicaid services?

If the MCO makes the decision to reduce, deny, suspend, or terminate an individual’s services, the MCO must provide written notification of that decision and provide for an opportunity to appeal. Individuals or their guardians have thirty (30) days from the date of the notice to begin the appeals process by making a request for the MCO to reconsider its decision. For an initial request for a new service, there is no entitlement to receive the service pending the appeal. If you are currently receiving services, and they are terminated or reduced, those services should continue pending appeal, if the appeal is requested within ten (10) days.

Most of the MCOs have taken the position that services are authorized for a particular period, such as the plan year, and treat each request for services as a new request for services. Under this interpretation, the level of services for the previous authorization is not continued throughout the appeal if the end of the authorization period occurs before the reconsideration and appeal are completed. A preliminary injunction ordered by OAH could maintain the previous level of services. We do not agree with the interpretation that a request for services to continue is transformed into an initial request for new services. Because of this issue, it is very important to request services timely and also file for reconsideration, including expedited reconsideration if necessary, and to appeal as soon as possible.

The reconsideration phase of an appeal is strictly an internal review of documentation of an individual’s needs and appropriate services to meet those needs. If it is available, additional documentation should be submitted with any request for internal reconsideration, along with a

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3 42 U.S.C. 1396d(r)(5).
4 EPSDT (Early Periodic Screening Diagnosis and Treatment) is a part of the Medicaid Act that requires a state to provide all medically necessary health care services to Medicaid-eligible children. Even if a service is not covered under the Medicaid State Plan, it may be covered for Medicaid-eligible children if the service is listed at § 1905(a) and if EPSDT criteria are met. For more information about requesting services under EPSDT in NC, see http://www.ncdhhs.gov/dma/epsdt/. As mentioned in our factsheet regarding waiver services, EPSDT may not apply to certain waiver services.
detailed explanation of the basis for the request. The MCO has forty-five (45) days to make a decision from the date they receive the reconsideration request. If an individual’s health or safety requires urgent reconsideration of the MCO’s decision, s/he may request an expedited review; the MCO must act on these requests within three (3) business days. If the MCO does not reverse its decision, the individual/guardian may appeal to the state Office of Administrative Hearing (OAH), where similar, strict deadlines still apply.

An appeal of the reconsideration decision to OAH must be made within thirty (30) days, and within ten (10) days in order for services to be maintained (but see discussion of authorization periods above). A mediation teleconference will be held with an impartial Mediator, at which time the parties can attempt to come to an agreement to settle the appeal. There is no obligation to compromise or agree to services less than are necessary for the individual. If mediation is unsuccessful, the individual/guardian will have an opportunity to present their case at a hearing (either in person or by phone) before an impartial Administrative Law Judge (ALJ) at OAH. For more information on advocating in the Medicaid appeal process, please see our factsheet on Medicaid Appeals in an MCO.

**What do I do if I am on a wait list for waiver services or do not qualify for Medicaid?**

The MCO is also responsible for identifying behavioral health services for individuals who do not participate in the Innovations waiver, such as individuals who have been waiting for CAP-ID/DD services, and for other individuals who may not qualify for Medicaid. Each MCO may use different criteria for statewide non-Medicaid services, such as developmental therapy. Unfortunately, some MCOs have cut or nearly eliminated some of the traditional state-funded services, like developmental therapy, because of the significant budget cuts made by the General Assembly for state-funded services. Individuals may still request medical services under standard Medicaid and the NC Division of Medical Assistance (DMA) will continue to review and act upon these requests. Some MCOs may authorize a limited amount of external case management services for individuals who do not receive waiver services, while others may authorize care coordination services from their own employees. If an individual is denied a state-funded service, they do not follow the Medicaid appeals process as there is a specific process for state-funded service appeals. There is also no requirement for maintenance of service through a state-funded appeal and a denial of services may be upheld for state-funded of services on the basis of the MCO not having funds for the service. For more information, please see our fact sheet on the appeal process for state-funded services.

**Has the waitlist for Innovations services changed?**

There will continue to be a waitlist for Innovations waiver services from an MCO; many MCOs refer to this list as the “Registry of Unmet Needs.” Some waiver slots are reserved for specific populations of individuals, including:

- Individuals at “significant, imminent risk of serious harm;”

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5 “The MCO is obligated to provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution).” 42 C.F.R. § 438.40(b)(2).
• Individuals moving from another waiver program (e.g., CAP-C);
• Individuals eligible for Money Follows the Person funding;
• Children aged 0-17 who are moving from an institution;
• Individuals receiving waiver services in another state who were transferred to NC for military service.

Previously, LMEs used a prioritization tool, which evaluated level of need and time on the waitlist, to establish a person’s position on the CAP waitlist. With the transition to MCOs, the registry of unmet needs is generally based on time, with the exceptions listed above. How an MCO defines individuals at “significant, imminent risk of serious harm” will be determined by the MCO.

Under the old LME system, many individuals on the waitlist for CAP services received a limited amount of state-funded services, such as Developmental Therapy or Respite. Individuals who do not participate in the Innovations waiver may also ask about “state-funded services” and “(b)(3) services” from an MCO. Under section 1915(b)(3) of the Social Security Act, MCOs in North Carolina may allocate some of the savings from the managed care system into additional services, such as Respite or Community Guide, for non-waiver participants. It may take some time for new MCOs to offer (b)(3) services because the services are based on savings incurred over a period of time. There may also be differences among MCOs as to which (b)(3) services they offer because the system is intended to allow each MCO flexibility or innovation in this area. This means one MCO may use (b)(3) services to try a new service, while another may provide additional services of a service they already offer. The (b)(3) and state-funded services are only available when the MCO allocates funding to support them. As a result, individuals might find that an MCO authorizes these services in very limited amounts, especially in the initial years of an MCO’s operation.

**What if I have trouble with my MCO?**

The MCOs are defined by geography/county lines. This means an individual cannot switch MCOs unless they change their county of residence, which may have other adverse implications. Each MCO has a grievance process and individuals assigned to address customer service issues. It is important to recognize that although an MCO may have a generalized complaint process or customer service department, each MCO is required by regulations to have a formal grievance process that obligates the MCO to respond within time guidelines.

Under the regulations, an MCO must have a grievance process to accept complaints about any matter other than an “action”. An “action” generally is related to services, such as a denial or limited authorization of a requested service. An appeal of an action is generally the appeals process for an MCO managed Medicaid-funded service, which, as discussed above, consists of reconsideration and an opportunity to be heard at OAH (also known as the state fair hearing).

Possible subjects for a grievance could include the quality of care or services provided, problems associated with interpersonal relationships such as rudeness, etc. Filing a grievance is important

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\[6\] An “action” is defined as “(1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.” 42 C.F.R. §438.401(b).
because not only does it generate a formal response to an issue, the grievances are part of the records the MCO must keep and how they report on customer satisfaction.

**What is the process for filing a grievance?**

Every MCO Handbook should give information about the grievance process and a contact number, but calling the main number should also connect a person to the right department. It is important to make sure you are filing a formal grievance and not just a complaint. Individuals may file a grievance orally or in writing, but if they file the grievance orally, they must follow this with a written, signed appeal unless they have requested expedited resolution. An MCO must provide reasonable assistance in completing forms and other procedural steps in the grievance process. This assistance is related to the function of filing the appeal and does not require help with describing the issue or advocating for resolution of the issue. The MCO must acknowledge receipt of the grievance and ensure that individuals making decisions on grievances (and appeals) are individuals who were not involved in a previous level of review or decision-making and who, if reviewing a clinical issue, are professionals who have the appropriate clinical expertise, as determined by the State, in treating the individual’s condition or disease. A grievance must be resolved within 90 days from the day the MCO receives the grievance. This timeline may be extended by up to 14 calendar days if the individual requests the extension or the MCO shows there is need for additional information and the extension is in the individual’s interest. If the timeframe is extended, the MCO must notify the individual. In general, an MCO must dispose of each grievance, resolve each appeal, and provide notice as quickly as the individual’s health condition requires within the established timeframes. Depending on the subject matter of the grievance, an individual may be able to access OAH through a petition for a contested case hearing, if the decision in question and the individual otherwise meets the requirements for a contested case.

**How is Disability Rights NC helping individuals and families with MCO issues?**

Disability Rights NC closely monitored the individual LMEs as they transitioned to MCOs and continues to respond to address problems where possible. We are also working at the policy level to ensure rights are protected, particularly in the appeals process. Much of our work may not be readily apparent to individuals as we communicate with individual MCOs, DHHS, and CMS. At the individual level, Disability Rights NC conducted trainings across the State regarding the transition to MCOs and advocating in a managed care system. We also continue to provide technical assistance to some individual requests for assistance, and we represent people in individual Medicaid Appeals in mediations and fair hearings at OAH, where we have the capacity to do so. Disability Rights NC also continues our work ensuring the rights of people with disabilities in MCOs through the two federal lawsuits we have against PBH and the State, one on behalf of six individuals regarding the appropriate level of services and the other on behalf of a class of recipients who were not provided appropriate due process when PBH began using the Supports Need Matrix.

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7 42 C.F.R. § 438.402(b)(3).
8 An appropriate clinical/healthcare professional is part of the grievance or reconsideration if it is an (A) An appeal of a denial that is based on lack of medical necessity; (B) A grievance regarding denial of expedited resolution of an appeal; or (C) A grievance or appeal that involves clinical issues. 42 C.F.R. § 438.406(a)(3)(ii)(A)-(C).
9 42 C.F.R. §438.405(b)(3)
10 N.C. GEN. STAT. § 150B-23; N.C. GEN. STAT. § 108A-70.9A.
The transition to managed care for mental health, developmental disabilities, and substance abuse services has and will continue to affect thousands of individuals, and many families/guardians have questions or concerns about the transition. Disability Rights NC employs approximately one attorney for every 158,000 individuals with disabilities in North Carolina and the work of these few attorneys is spread among our various targets. Based simply on capacity, we cannot offer individual representation to everyone who requests our help. Instead, we provide information and guidance to help you understand the changes and self-advocate for a resolution to your concerns. However, we also use your concerns and information to help inform us about problems and issue areas that need addressing more systemically. We hope you understand that even though we may only take limited individual cases for representation, these cases are selected strategically, and we continue to advocate for changes that will be positive for as many people as possible through our efforts.

This document, created in April 2012 and updated May 2013, contains general information for educational purposes and should not be construed as legal advice. It is not intended to be a statement of the law and may not reflect recent legal developments. If you have specific questions concerning any matter contained in this document or need legal advice, we encourage you to consult with an attorney.

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