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Attention:
Local Management Entities (LMEs)
Providers of Mental Health, Substance Abuse, and Intellectual/Developmental Disability Services

1915 b/c Medicaid Waiver Expansion

1915 (b)/(c) Medicaid Waiver Expansion

Please note the following details about the 1915(b)/(c) Medicaid waiver expansion and the changes it will mean to Medicaid providers. During a transition process over the next year, Medicaid-funded mental health, substance abuse, and intellectual/developmental disability services (MH/SA/IDD) will be administered by one of eleven Local Management Entities (LMEs) operating Medicaid Managed Care Organizations (MCOs) as DMA vendors. Medicaid recipients will be mandatorily enrolled into each LME-MCO's benefit plan based upon county of Medicaid eligibility.

Providers should verify recipient county of eligibility using the Recipient Eligibility Verification Web Tool outlined on the DMA website at: http://www.ncdhhs.gov/dma/provider/RecipEligVerify.htm. In the future, the Medicaid card and the other methods of verifying recipient eligibility (listed on the website) will be updated to include information about each recipient's LME-MCO.

Covered Benefit Package

Each LME-MCO will be responsible for enrolling providers into the LME-MCO network, providing prior authorization, and processing claims for the following services found at http://www.ncdhhs.gov/dma/mp/index.htm:

- Enhanced Behavioral Health Services (*DMA Clinical Coverage Policy 8A*)
- Inpatient Behavioral Health Services (*DMA Clinical Coverage Policy 8B*)
- Inpatient services for the treatment of mental health and substance abuse disorders and developmental disabilities
- Outpatient Behavioral Health Services including all services provided by psychiatrists for recipients with a diagnosis in the 290-319 range (*DMA Clinical Coverage Policy 8C*)
- Psychiatric Residential Treatment Facilities (PRTFs) (*DMA Clinical Coverage Policy 8D1*)
- Therapeutic Foster Care (TFC) (*DMA Clinical Coverage Policy 8D2*)
- Residential Child Care Levels II group, III, IV (*DMA Clinical Coverage Policy 8D2*)
- I/DD Services under the NC Innovations (c) waiver
- Hospital Emergency Department (ED) services: Each LME-MCO will be responsible for all facility, professional, and ancillary charges for services delivered in the emergency department to individuals with a discharge diagnosis ranging from 290 to 319.

Authorization of Services

Any Medicaid recipient currently receiving mental health (MH) and substance abuse (SA) services and CAP I/DD waiver services will continue to be able to do so. CAP- I/DD waiver recipients' services will crosswalk to NC Innovations waiver services. Each LME will hold information sessions for recipients and providers on the transition to the NC Innovations waivers. The crosswalk of CAP I/DD to NC Innovations services can be found at: http://www.ncdhhs.gov/mhddsas/providers/1915bcWaiver/comparisiongrid12-11.pdf

Each LME-MCO will assume responsibility for all current MH, SA, and CAP I/DD authorizations from current DMA Utilization Review (UR) vendors (ValueOptions, Durham, Eastpointe, Crossroads, and Pathways LMEs) for their county catchment areas and on the schedule noted below. Providers will not need to take any action to transfer active authorizations; all current authorizations will remain in effect. The one exception to this is Targeted Case Management for adults (see below).

Providers will need to send all new and concurrent authorization requests to their LME-MCO once the LME-MCO begins Medicaid operations and once the current authorization ends.

Targeted Case Management (TCM) and Care Coordination

Targeted Case Management (MH/SA TCM and I/DD TCM) is not a service available under the 1915(b)/(c) waivers. All authorizations for MH/SA TCM and I/DD TCM for recipients under the age of 21 will be continued to the end of the current authorization period. Any new or concurrent requests for TCM for children under age 21 must follow the established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) procedures and requirements, which are available at http://www.dhhs.state.nc.us/dma/epsdt. All EPSDT requests for TCM should be sent to the appropriate LME-MCO for processing.

The LME-MCO will be working with recipients and providers to develop transition plans for any recipients who are receiving these services at the time of transition. Some recipients currently receiving TCM may receive care coordination from the LME-MCO (see "Care Coordination" below).

Under a 1915(b)/(c) waiver, a number of activities that are associated with TCM become the responsibility of the LME-MCO. The LME-MCO refers to these functions as "care coordination." This is consistent with the way case management is provided in other healthcare settings all across the country and is similar to the model used by Community Care of North Carolina (CCNC) for the management of care for high risk consumers served by Medicaid in primary care practices. LME-MCO care coordination specifically focuses on the unique needs of individuals with mental health, substance abuse, and intellectual and developmental disabilities.

Care Coordination in an LME-MCO provides the following supports to consumers:

- Education about all available MH/SA/DD services and supports, as well as education about all types of Medicaid and state-funded services
- Linkage to needed psychological, behavioral, educational, and physical evaluations
- Development of the Individual Support Plan (ISP) or Person Centered Plan (PCP) in conjunction with the recipient, family, and other all service and support providers
- Monitoring of the ISP, PCP, and health and safety of the consumer
- Coordination of Medicaid eligibility and benefits

Enrollment in LME-MCO Medicaid Provider Networks

Enrollment contracts will be offered to all current Medicaid behavioral health providers in good standing during the LME-MCO's initial provider enrollment period. After the LME-MCO becomes operational, it will no longer be required to offer contracts to every willing provider, but will enroll providers based on the needs of the local recipients and on provider network performance.

Providers are required to enroll in the LME-MCO provider network to ensure that Medicaid services are authorized and that corresponding Medicaid claims are processed by the LME-MCO. After the transitional dates listed below, providers will no longer be able to seek prior authorization from a UR vendor or bill Medicaid directly for behavioral health services.

Provider enrollments should occur within 60 days prior to the effective date of each start-date listed below. However, providers are encouraged to apply early to allow for necessary processing time. Provider should contact the LME-MCO for their catchment area for enrollment information. In some cases, a provider may see a recipient whose Medicaid eligibility is with a different LME-MCO. The provider will need to contact the LME-MCO from which the recipient's eligibility originates to contract with that LME-MCO to receive authorization and payment.

LME-MCOs will offer specific educational sessions for all providers, including hospitals, on obtaining prior approval and submitting claims for payment.

Hospital Emergency Department (ED) and Inpatient Services

LME-MCOs are responsible for reimbursing hospitals for all services (professional, ancillary, and facility) provided in the ED during an emergency admission when the recipient has a primary discharge diagnosis of 290 through 319. In accordance with Section 1932(b)(2) of the Social Security Act, as amended by the Balanced Budget Act (BBA) of 1997, LME-MCOs shall reimburse claims for Emergency Behavioral Health Services consistent with the "prudent layperson standard" as defined in 42CFR 438.114. These services will be reimbursed without regard to the ED's contractual relationship with the LME-MCO.

Emergency Behavioral Health Services provided in the ED do not require prior authorization. LME-MCOs are required to pay for ED Emergency Behavioral Health Services for recipients with Medicaid eligibility in their catchment areas even if the recipient is seen in an ED in another LME-MCO catchment area. The "out-of-network" EDs will need to contact the LME-MCO

based on the recipients' county of eligibility to obtain payment for these ED services. A stakeholder group is currently working on a streamlined approach to ED credentialing/ enrollment and payment. Further details will be published as they become available.

Psychiatric inpatient services do require prior approval from the LME-MCO. Hospitals must request prior authorization from the LME-MCO managing services for the recipient based upon Medicaid County of eligibility.

When a recipient is admitted to a medical floor and then transferred to a separate psychiatric unit within the same hospital, the recipient should be discharged from the medical unit and readmitted to the psychiatric unit in order for all aspects of the claim to adjudicate correctly. The medical claim should be billed to Medicaid/HP and the psychiatric claim should be billed to the appropriate LME-MCO.

If a claim for inpatient treatment of MH, SA, or I/DD spans the date of initial operation of the LME-MCO, then the entire facility claim should be billed to Medicaid/HP and the LME-MCO is not responsible for any portion of it. Physician-based claims would need to be split, with the portion of the claim prior to the initial date of LME-MCO operations being billed through HP and the portion of the claim after the initial date of operation going to the LME-MCO.

Payment for Services

Providers should continue to bill Medicaid (HP) for all dates of service prior to the effective start date of the LME-MCO operations. After the start-date of LME-MCO operations (listed below), all behavioral health claims for services listed above should be billed to the appropriate LME-MCO. In order to bill claims to the LME-MCO for the services listed above, providers must be enrolled in the LME-MCO network (the only exception is for emergency services provided in EDs as noted above).

The LME-MCOs will accept electronic HIPAA 5010 transactions and they will respond with 5010 transactions.

Transition Timeline

The **proposed** timeline for this transition is listed below. *Please continue to read the Medicaid Bulletin for updates on transition dates.*

The current LME-MCO, PBH, will be expanding on the following schedule:

- PBH was originally comprised of Union, Stanly, Cabarrus, Rowan, and Davidson Counties
- Alamance and Caswell Counties were added October, 1, 2011
- Five County LME, consisting of Franklin, Vance, Granville, Warren & Halifax Counties were added January 1, 2012
- OPC LME, consisting of Orange, Person, and Chatham Counties will be added April 1, 2012

The following LMEs will be expanding to become LME-MCOs on the following schedule:

- January 3, 2012
  - Western Highlands Network, consisting of Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties
- April 1, 2012
  - East Carolina Behavioral Health LME, consisting of Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties
- July 1, 2012
  - Sandhills LME, consisting of Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond, Counties
  - Smoky Mountain Center, consisting of Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga, and Wilkes Counties
- January 1, 2013
  - Pathways, consisting of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, and Yadkin Counties
  - Eastpointe, consisting of Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson Counties
  - Mecklenburg LME
  - The Durham Center, consisting of Durham, Cumberland, and Johnston Counties
  - CenterPoint, consisting of Davie, Forsyth, Rockingham, and Stokes Counties
  - Southeastern Center (ECCS), consisting of Brunswick, New Hanover, Pender, Onslow, and Carteret Counties

PBH (formerly Piedmont Behavioral Health)

PBH is currently accepting enrollment applications for providers who have provided services to Medicaid recipients in the counties listed below. The PBH Provider Applications are posted at: www.pbhsolutions.org/providers. Clicking on the "pop-up" window or application link on that web-page will take providers to the application web-page. Select the correct application link and complete the brief demographic information questionnaire. Upon completion/submission of the questionnaire, providers will be able to download the PBH Provider Application and supplemental documents. Providers will receive an email from PBH regarding the two week timeline to complete and submit the application. PBH will offer technical assistance to any providers who may need help in completing their applications.

PBH contract specialists may be reached as follows for technical assistance:

Provider Name (A - I)	**Provider Name (J - R)**	**Provider Name (S - Z)**
Jana Rollins (704) 939-7747 Jana.Rollins@pbhsolutions.org	Andrea Hogue (704) 939-7890 Andrea.Hogue@pbhsolutions.org	Nichole Bailey (704) 939-7889 Nichole.Bailey@pbhsolutions.org

PBH-enrolled providers in the following counties should direct behavioral health service claims according to the schedule below:

- Alamance and Caswell: All MH/SA/IDD claims for dates of service after October 1, 2011 should be billed to PBH.
- Franklin, Granville, Halifax, Vance, and Warren: All MH/SA/IDD claims for dates of service after January 1, 2012 should be billed to PBH.
- Orange, Person, and Chatham: All MH/SA/IDD claims for dates of service after April 1, 2013 should be billed to PBH.

Western Highlands Network (WHN)
Providers should direct questions about enrollment in the Western Highland Medicaid provider network to the WHN Enrollment Line at 1-800-671-6560 x2469 or 828-225-2785.

For more information on all Medicaid operations, including enrollment, authorizations, and billing, please visit the Western Highlands website at: www.westernhighlands.org. Providers and recipients are encouraged to contact Western Highlands Network directly at 1-800-671-6560. WHMedicaidWaiverEnrollmentQuestions@westernhighlands.org.

East Carolina Behavioral Health (ECBH)
Providers can find information about enrollment in the ECBH Network on their website at: http://www.ecbhlme.org/Page_Provider_Home.php. To email the Provider Network Division directly please email prvrelate@ecbhlme.org. The fax number is (252) 332-8457.

For information about other areas of ECBH operations, please visit their website at: http://www.ecbhlme.org/ or call the main number at (252) 695-6400 or 1(877) 685-2415. The ECBH main office is located at 1708 E. Arlington Blvd. Greenville, NC 27858

Sandhills Center
Providers should direct questions about enrollment in the Sandhills Center Medicaid Provider Network to the Sandhills Center Provider Help Desk at 1-855-777-4652 or email ProviderHelpDesk@sandhillscenter.org. Provider Help Desk Questions and Answers are available on the Sandhills Center Website at www.sandhillscenter.org.

Recipients are encouraged to contact Sandhills Center Customer Services at 1-800-256-2452.

For more information on all Medicaid operations, including enrollment, authorizations and billing, please visit the Sandhills Center Website at www.sandhillscenter.org.

Smoky Mountain Center
For provider information about the Medicaid waiver, including credentialing and provider enrollment, please visit the Smoky Mountain Center website at: www.smokymountaincenter.com.

Providers may direct questions to providerinfo@smokymountaincenter.com or call the SMC Provider Phone Line at 1-866-990-9712, and select Provider Relations.

Recipients are encouraged to contact the Smoky Mountain Center Access Line at 1-800-849-6127 or to visit the website at: www.smokymountaincenter.com and choose the Consumers and Families page.

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