Five County Mental Health Authority

NEW Medicaid 1915 b/c Waiver Information

NC Medicaid Waivers: What They Are & Their Benefits to Consumers

Five County Mental Health Authroity and other LME's in NC will be applying to manage Medicaid costs for their citizens. Medicaid costs are one of the most significant line items in the state's budget. One way to manage Medicaid costs is with a Freedom of Choice Waiver. This is called a 1915(b) Waiver because the rules are under 1915(b) in federal regulations.

• It creates a "Carve-out" delivery system , a Closed Provider Network, of carefully selected credentialed providers who meet numerous Quality measurements.
• It creates programs that are not state-wide because all areas of the state are not under the plan.
• It provides an enhanced service package.

The "c" Waiver is a Home and Community Based Services Waiver.

• The State may offer a variety of services to consumers under a 1915© Waiver.
• The number of services that can be provided is not limited. Medical (skilled nursing) and non-Medical (Respite, case management, environmental modifications) services can be covered.
• Family members and friends may be providers of waiver services if qualified, except for parents of minor children.
• States have the discretion to choose the number of consumers to serve in a Home and Community Based Services Waiver.

What is a 1915(b)(c) waiver?

A Waiver is an agreement between the state and Center for Medicaid Services in Washington to be exempted from certain Medicaid rules. A waiver is necessary for the state to enter into managed care contracts because of the transfer of risk (of losing money) from the state to a Managed Care Organization. It requires the MCO to have an adequate risk reserve. It requires the Managed Care Organization to provide organizational functions found in a typical health insurance plan such Management of the Provider Network, Quality Management, and Utilization Management.

What benefits should a Waiver provide to Consumers?

• Choice
• Voice
• Medically necessary needs being met
• A process for complaint/grievance solution
• Second opinions

What must Waiver LMEs/MCOs offer to consumers?

• Provide telephone contact7 days a week, 24 hours per day
• Provide emergency referrals 24/7 within one hour
• Provide emergency care within 2 hours
• Provide urgent care within 48 house, usually an assessment.
• Provide routine care within 10 working days.
• Appointment wait times:
  -Scheduled appointments: 60 minutes
  -Walk-in appointments: 2 hours
  -Emergencies: face to face within 2 hours; if life threatening, immediate attention.
• Must offer all medically necessary services in the benefit plan regardless of whether or not there is a provider in the network for that service. A client-specific contract might be needed or a search for a provider with specific expertise.
• Qualified staff to evaluate service requested by service providers
• A qualified provider network, with the consumer given a choice between at least two providers.
• A choice of providers within 30 miles or 30 minutes in an urban area
• Provide written material within 14 days of receiving the first service. This material will explain the benefit plan, how to access services and consumer rights.
• Better communication with access to local decision makers
• Better use of savings
• The Managed Care Organization can change reimbursement rates to incentivize best practices or to better serve a target group of consumers
• Keep funding in the public system
• Adjust existing services to meet changing needs
• Give Consumer and Family feedback in an annual Consumer Satisfaction Survey

---