NC Mental Health Services: Overview and Preview of Coming Attractions

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Community Mental Health, Developmental Disabilities, and Substance Abuse Services in NC

- Counties
- Local management entities
- Medicaid managed care organizations

Legislative Milestones

- 2001: Mental Health Reform

  Service providers ⟶ Service managers
  (area programs) (local management entities)

- 2011: Medicaid Managed Care

  Service managers⟶ Service and money managers
  (managed care organizations)

A County Responsibility

"A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program."

G.S. 122C-115

Additional Option

A county with at least 425,000 people that uses the county manager form of government may administer services through a "consolidated human services agency."

G.S. 122C-127; G.S. 153A-77(b)

Organizational Structure Five Options

- Area authority
  - ✓Single-county area authority
  - ✓Multicounty area authority (94 counties)
- County program
  - ✓Single-county program
  - ✓Multicounty program
- Consolidated human services program

LME

"Local management entity" or "LME" means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.

G.S. 122C-3(20b); 122C-115.4

Boards of County Comm'rs

- Appoint the governing body for the LME
- Appropriate funds to support the LME

2001 Reform: County Commissioners Must

1. Monitor fiscal health
   - quarterly financial reports
2. Monitor service capacity
   - quarterly service delivery reports
   - annual assessment and progress report
3. Approve appointment of LME director
4. Participate in annual performance review of LME director
5. Review and approve LME business plan

Functions of local management entities (LMEs)

Local management entities are responsible for the management and oversight of the public system of MH/DD/SA services at the community level. An LME shall plan, develop, implement, and monitor services . . . to ensure expected outcomes for consumers within available resources.

G.S. 122C-115.4

LME Functions

- Assess the community's service needs and plan for an array of services to meet those needs
- Ensure the availability of qualified providers to deliver services
- Implement a system that connects consumers to appropriate resources

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LME Functions

- Approve specific services to individual consumers, evaluate the clinical appropriateness of services, and monitor client care to ensure that it is appropriate and effective
- Collaborate with other local service systems to coordinate and ensure access to services
- monitor and evaluate the quality and availability of services

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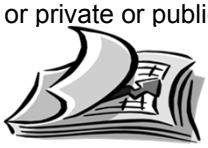
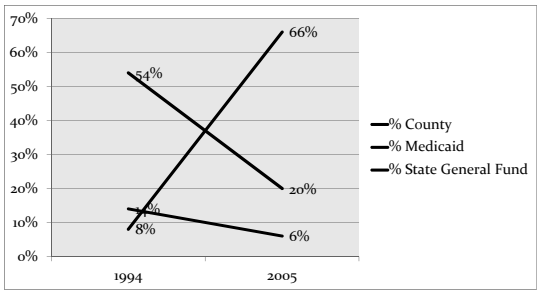
Medicaid and Mental Health Services in the United States

- 1986— Medicaid contributed less than three other payers: state and local governments, private health insurance, and consumers
- Now — Medicaid is the largest payer of mental health services in the United States, more than any other or private or public source of funding



NC Public Mental Health Authorities--Revenue by Source



The Need is Great

- 6% of adults have a serious mental illness (schizophrenia, major depression, bipolar disorder)
- 10% of children have a serious emotional disorder (chronic depression, major conduct disorders, substance abuse problems)
- 1/3 of people with MH/SA disorders are under the federal poverty level and are uninsured
- 1 in 4 uninsured adults have MI/SA

The Resources are Limited

Faced with limited budgets, states try to balance the amount and level of services provided to each individual with the need to cover the maximum possible number of Medicaid-eligible people.

Controlling Costs

- Medicaid beneficiaries are entitled to covered services that are medically necessary to meet the person's needs
- But state governments have discretion to
  - Define "medical necessity "
  - Determine what services are "covered services"
  - Place limits on services
  - Reduce provider reimbursement rates
  - Set cost-sharing for beneficiaries

Controlling Costs

Waiver of particular Medicaid rules would allow implementation of a "managed care" delivery system intended to contain costs while maintaining quality of services.

2009 DHHS Report

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Managed Care

- ❑ Managing the cost of care
- ❑ Managing the quality of care

More than 65% of the total U.S. Medicaid population is served through some type of managed care arrangement

Managed Care

- ❑ Managed Care Organization (MCO)
- ❑ Managed Behavioral Healthcare Organization (MBHO)

North Carolina Medicaid Managed Behavioral Healthcare

- ❑State contracts with LMEs--on a prepaid basis--to meet the behavioral health care needs of all Medicaid beneficiaries in their catchment areas
- ❑The LME/MCO authorizes and pays for services provided by LME-approved providers

Risk-Based Financial Model

- State pays the LME a monthly capitation rate (per member per month or PMPM rate)
- LME assumes financial risk for delivery of services (incurs loss if cost of furnishing services exceeds capitation funding)
- Mandatory enrollment of Medicaid beneficiaries

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Risk-Based Financial Model

- MCO has incentive to control costs by steering clients into the most appropriate, often less costly, services in a timely manner so problems do not escalate and require more acute, expensive services
- Savings from more cost efficient care can be used to provide additional services to recipients (reinvest savings to and expand the array of services)

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North Carolina Medicaid Managed Behavioral Healthcare

- fee for service → capitation
- freedom of choice → closed provider network
- defined services → service flexibility

Risk Management

- Size--The smaller the number of covered lives, the greater the risk that a small number of outliers on costs could result in overall financial losses for the MCO
- Functionality --Requires investment in managed care infrastructure and a level of management attention necessary to survive long-term under a risk contract with an administrative cap set by DMA

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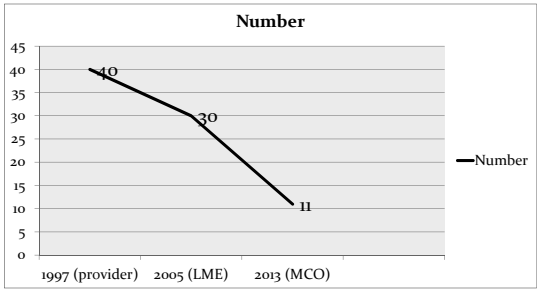
Medicaid Managed Care S.L. 2011-264 (H 916)

- Expand the Piedmont-LME 1915(b)/(c) Waiver to all LMEs by July 2013
- DHHS must select LMEs that have met minimum criteria according to RFA requirements
- Requires a minimum LME catchment area population of 500,000 by July 1, 2013

North Carolina Public Mental Health Authorities--Number



"Managed Care" Defined

Processes or techniques used by an entity that delivers, administers and/or assumes risk for health care services to control or influence the quality, accessibility, utilization , costs or outcomes of services provided to a defined enrollee population. Includes, but not limited to,

1. Payment mechanisms
2. Utilization management
3. Provider management

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Payment Mechanisms

- Between payer and MCO: Capitation creates incentive and need for MCOs to establish specific mechanisms by which to
  - control utilization (costs)
  - increase accountability (quality)
- Between MCO and providers: MCO can use performance-based contracting and incentive-based method of purchasing services

Utilization Management

- Premise —patients do not always access the appropriate type of services: controlling access can direct members to appropriate care, thereby reducing costs associated with inappropriate use or overuse
- Philosophy—quality care, measured by effective treatment outcomes, can reduce total cost

Utilization Management

- Medical necessity criteria to evaluate and determine the need for, and appropriate level of care
- Clinical practice guidelines to make decisions at specific nodal points in treatment
- Individual case management for high risk/high cost patients

Provider Management in a Closed Network

- Size of network can be managed to ensure needed capacity, sufficient providers for consumer choice, enrollment is limited to those who demonstrate quality performance, and sufficient market share to support provider infrastructure and a healthy business environment
- MCO can evaluate providers on consumer treatment patterns and outcomes, costs of care, timeliness of appointment scheduling, volume and type of consumer complaints, etc.

Managed Care Mechanisms

- Best case—mechanisms are creative, save money that can be used for more services, and lead to increased quality of care and better client outcomes
- Worst case—poor management leads to financial ruin for an MCO or its providers or MCO concerns over financial risk lead to underutilization of services (members may not receive the services they need)