Local Management Entity (LME) Funding Issue

In 2001, Legislation passed that implemented Mental Health Reform. As part of this reform, the Area Mental Health Programs began the process of transforming themselves from an administrative and service delivery organization into a Management Unit that among other functions coordinates and pays for non-Medicaid eligible services. Medicaid eligible services are paid directly to the provider who has billed the State's Medicaid program. Service provision is done by providers that are Medicaid qualified or are qualified with the LME to provide services to non-Medicaid eligible recipients.

A key requirement of Mental Health Reform was the separation of funding streams for services and administration. In the old organizational structure in which Area Programs were primarily service providers, payment was made for Area Program administrative functions through an "add-on" to the service rate. Under the new organizational structure, payments will be made to the LMEs for administrative costs separate from the service funding. Attachment A is a schedule prepared by Crossroads LME and presented by David Swann at the October, 2005 meeting of the Legislative Oversight Committee. This schedule presents the administrative elements required of each LME for which they are paid administrative funding to provide.

To separate funding for administration from services and to provide funding for administration, the DMHDDSAS contracted with a nationally recognized healthcare financing expert, Pareto Solutions, to develop a cost model to predict the cost of performing Local Management Entity functions. Pareto Solutions identified the functions that LMEs were expected to perform, in accordance with the reform legislation, and using NC and national epidemiology prevalence data along with information on the actual cost of performing those same types of functions in managed care organizations. This contractor also developed a cost model to predict the cost based upon the population base for which the LME is responsible. The cost model assumes several important facts - 1) that the state is served by no more than 20 LMEs in accordance with the goals of the legislation, 2) that the LMEs are maximizing the use of information technology to perform their functions and minimize the number of required staff and 3) that the LMEs are mature and are fully performing all functions. (It is important to note that LME functions include a number of cost elements which Area Programs as service providers did not incur, such as provider relations, tracking of outstanding authorizations to providers against actual billings received, customer services to process complaints against providers, etc.)

1. Why was the LME Administrative Budget short in SFY 2004-2005?

DMHDDSAS began preparing to implement the cost model in the winter of 2004. We developed various scenarios about the total cost of the model, including the impact of holding programs with less than 200,000 population and/or 6 counties to the "minimally efficient" cost per citizen per month of $2.03 in a hypothetical 200,000 population area. At that time there were 33 programs expected to exist in SFY 2005. Using the cost model and holding programs with less than 200,000 or 6 counties to the

$2.03 standard, we projected total LME administrative cost of $153,846,116. In contract, when we came up with a possible grouping of programs to reduce to no more than 20, the total projected cost decreased to $123,740,050 - a potential savings of $30,106,066.

When we actually implemented the model in July 2004 we increased some of the funding for particular LMEs over our initial projections. For instance, at that time Roanoke-Chowan and Tidelands were planning to merge and they both maintained that they could not perform with the limited funding of $2.03 per citizen per month. In order to keep the merger on track, we increased their allocation. Similarly, Edgecombe-Nash, Wilson-Greene, and RiverStone (Halifax) were planning a merger and requested additional funding on a transition basis to keep them going until they could complete their merger. In the end, the allocations for SFY 2005 totaled $159,670,807.

The fundamental problem, however, is the need to fund smaller, inefficiently sized programs than the cost model anticipated. Attachment B presents the LMEs as they existed in 2001 compared to how they are configured in 2005. It also presents the number of LMEs that are below 200,000 in population using the 2005 population estimates. These include single county programs: Johnston, Catawba, Pitt; and many multi-county area programs in the eastern part of the state with very small populations: Edgecombe-Nash, Neuse, Roanoke-Chowan, Tideland, Wilson-Greene. Given the fact that the two large urban counties of Mecklenburg and Wake would not be split, to reach the anticipated target of no more than 20 programs, the remaining programs would have an average population base of 398,699. We currently are funding 22 programs that are smaller than 398,999, including 11 that are under 200,000 population. Two of the 11 under 200,000 population do meet the six county or more criteria (Albermarle and Smoky Mountain LMEs).

2. When did the Division expect the shortfall?

The cost model and the proposed association cost allocation plan for LME functions were discussed within the Department when we realized that a shortfall was unavoidable in late winter of 2005 which is when DMHDDSAS began experiencing significant cash flow problems. After being told that other Department funding in the amount needed was most likely not to be identified, the Department was able to identify funding from DMA's budget since Medicaid claims payments did abate and the transfer of $25 M was able to be made in order to close SFY 2005.

3. How did the Division expect to handle the shortfall? Why wasn't there a budget request for the additional funds?

As soon as the problem was recognized, we added the need for funding to our critical needs request which is internal to DHHS. A budget request was not made for several reasons. The problem was recognized when the budget process for the 2005-2007 biennium was well underway but was not pursued for the following reasons:

1. The financial shortfall related to administrative costs not services funding. The Department wanted to examine the possibilities of resolving this issue prior to bring it to the Legislature's attention and then would only do so if we are unsuccessful.

2. The Governor had already submitted his budget and the Senate was nearing final deliberations on their spending plan.
3. The Department had come to the conclusion that we were not going to be able to achieve the goal of 20 LMEs and realized that there must be some other type of adjustments made to the cost model in order to achieve the efficiencies and economies of scale that the reduction to 20 LMEs would have produced.

4. What is the impact on the SFY 2005-2006 budget?

The number of LMEs is still greater than the cost model predicted could be funded at an efficient, effective level. In addition, as we have moved forward with system reform, we have come to recognize that if we are going to have more than 20 LMEs, they will not be able to perform all of the envisioned LMEs functions. This is due to the lack of availability of clinicians with the appropriate credentials to perform some of the highly technical clinical functions and the need to provide more consistency and standardization throughout the system. Thirty different LMEs performing utilization review for Medicaid funds cannot provide the statewide consistency as required by the Center for Medicare / Medicaid Services. It also is inefficient to require providers to interact with 30 different LMEs in order to receive service authorizations. Thirty LMEs performing access, screening, triage and referral cannot perform that service as cost-effectively as fewer programs serving a larger population base since the primary cost associated with the function is one of staff availability - trained clinicians must be present 24/day regardless of how many times the telephone actually rings.

5. What actions are planned to alleviate this funding issue?

There are three steps in our plan at this time. They are:

a) The Division is developing an RFP to be disseminated to the LMEs that is designed to identify 10 LMEs that will perform the intake and referral and do utilization review. These functions are ones that can and are being done electronically and will generate savings within the existing structure of the LME funding. As stated in the previous paragraph, thirty LMEs performing access, screening, triage and referral cannot perform that service as cost-effectively as fewer programs serving a larger population base since the primary cost associated with the function is one of staff availability - trained clinicians must be present 24/day regardless of how many times the telephone actually rings.

b) The DHHS will perform a thorough analysis of all cost model functions to identify additional opportunities for efficiency. The Council and County Commissioners Association have agreed to perform a functional analysis in collaboration with DHHS of all LME functions to identify any other functions that can be performed more efficiently and effectively at a statewide or grouped LME level by March 31, 2006. Any efficiencies identified by these analyses will be implemented July 1, 2006. Using the most current information available and as presented in Attachment C, there is a substantial ($20M net increase) in the fund balances of the LMEs.

c) If these two efforts do not entirely eliminate the funding gap, we will look at modifying the formula and the related payments to address funding issues in LMEs where we have identified continuing payments that are inconsistent with their pier LME of similar size.