Nothing Compares
NORTH CAROLINA

Joint Legislative Oversight Committee
on Health and Human Services
Feb. 9, 2016

Department of Health and Human Services
Contracting for Mental Health Services

HB916: Session Law 2011-264
Statewide Expansion of 1915(b)/(c) Waiver

DHHS shall:

- Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for consumers in need of mental health, intellectual and developmental disabilities, and substance abuse services
- Maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model
- Designate a single entity to assume responsibility for all aspects of Waiver management (merger model & interlocal agreements)
- Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs

HB916: Session Law 2011-264
Statewide Expansion of 1915(b)/(c) Waiver

DHHS shall require LMEs approved to operate a 1915 (b)/(c) Medicaid Waiver to:

- Maintain a local presence
- Establish and maintain systems for ongoing communication and coordination to support services
- Ensure communication with consumers, families, providers and stakeholders regarding disability-specific and general Waiver operations
- Disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative and support needs of all disabilities covered by the 1915(b)/(c) Medicaid waiver
- Perform administrative and clinical functions (customer service, quality management, due process, provider network development, information systems, financial reporting and staffing)
- Maintain full accountability for all aspects of Waiver operations and for meeting all contract requirements specified by the Department

What is a 1915 (b)/(c) Medicaid Waiver?

States can request and implement Medicaid Waivers to change from a fee-for-service system to one that uses a capitated payment system for greater flexibility in how services are configured, delivered and paid for:

- [1915(b)(1)] - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- [1915(b)(3)] - Use the savings that the state gets from a managed care delivery system to provide additional services
- C waiver - Provide long-term care services in home and community settings rather than institutional settings

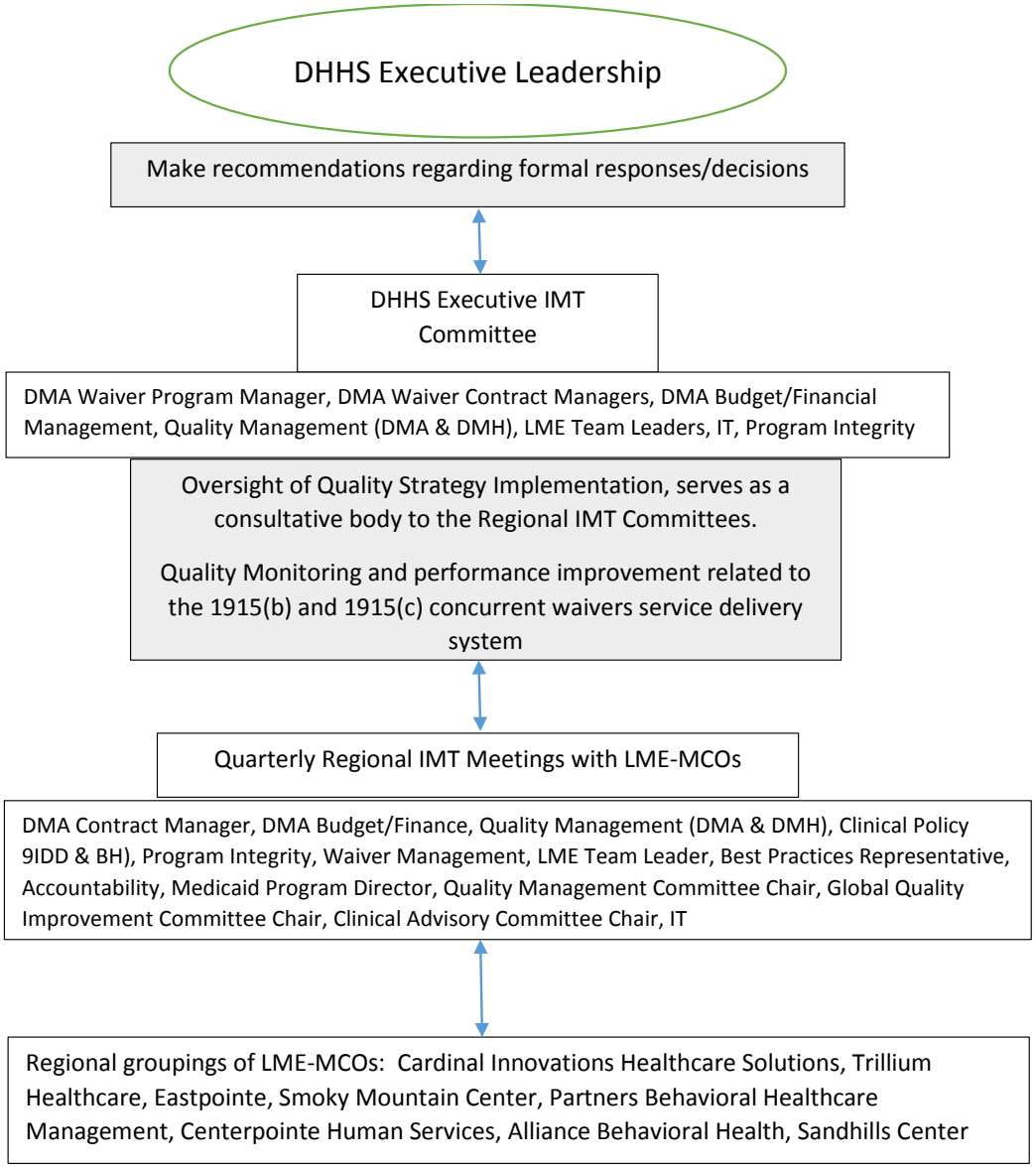
Unique Aspects of NC Waiver Management

Waiver Management by Local Management Entities ensures commitment to the needs of the community and collaboration with natural and related organizations and sources of support and participation in citizen/consumer care

Local LME-MCOs manage:

- All funding streams:
  - Federal Medicaid
  - Federal Block Grant funding (MH,SA and SS)
  - State Funds
  - Other Grants and Pilot Initiatives funding available
- Funding to provide services for all three disability groups in both age groups:
  - Mental Health
  - Substance Use Disorders
  - Intellectual and Developmental Disabilities

DHHS Oversight and Communication Structure



SB 208, Session Law 2013-85
Act to Ensure Effective Statewide Operation of the 1915 (b)/(c) Medicaid Waiver

The Secretary's certification shall be based upon an internal and external assessment made by an independent External Quality Review Organization

The LME-MCO is to ensure:

- Adequate provision against the risk of insolvency and submit all required financial records and reports to the Department under the Contract
- Timely provider payments
- Exchange of billing, payment and transaction information with the Department and providers

Items Monitored During Interdepartmental Monitoring Teams

- Organization Updates
- Finance
- DMA Quarterly Reports at a Glance
- DMH Quarterly Reports at a Glance
- Progress on Performance Measures
- Innovations Performance Measures
- Gaps Analysis & Needs
- Transition to Community Living
- Mercer / EQRO Review Follow-Up
- Projects and Policy
- Other DHHS Initiatives

DMA Medicaid
Services and Payment Monitoring

- Fiscal Monitoring: Monthly, Quarterly & Annually
- Medicaid Service Definition Monitoring
- Monthly, Quarterly and Annual Performance Monitoring
- Consumer and Provider Satisfaction Surveys
- Complaints and Grievances Monitoring
- Service System Gaps and Needs Analysis
- Quality Improvement Projects
- Program Integrity functions including fraud, waste and abuse

DMH/DD/SAS State Funded Services Monitoring Activities

- LME Sub-recipient Monitoring
- Fiscal Monitoring: Monthly, Quarterly & Annual Settlement
- Block Grant & State Funded Services Monitoring
- Monthly & Quarterly Performance Monitoring
- Service Outcomes
- Consumer & Family Surveys (Perception of Care & National Core Indicators)
- Complaints & Grievances Monitoring
- Service System Gaps & Needs Analysis
- Quality Improvement Projects

Current Monthly Monitoring

- Inpatient readmissions assigned to care coordination
- Timely service authorization and claims processing and payment
- Complaint/grievance processing and resolution
- Performance of call center
- Number of individuals waiting for service (I/DD)
- Number of incidents
- Transitions to Community Living (TLCI): In-reach, transitioning, housed
- Hospital stays and readmissions
- Emergency Department utilization
- Program integrity (fraud/waste/abuse)
- Number of persons served by disability area

Quarterly Performance Monitoring

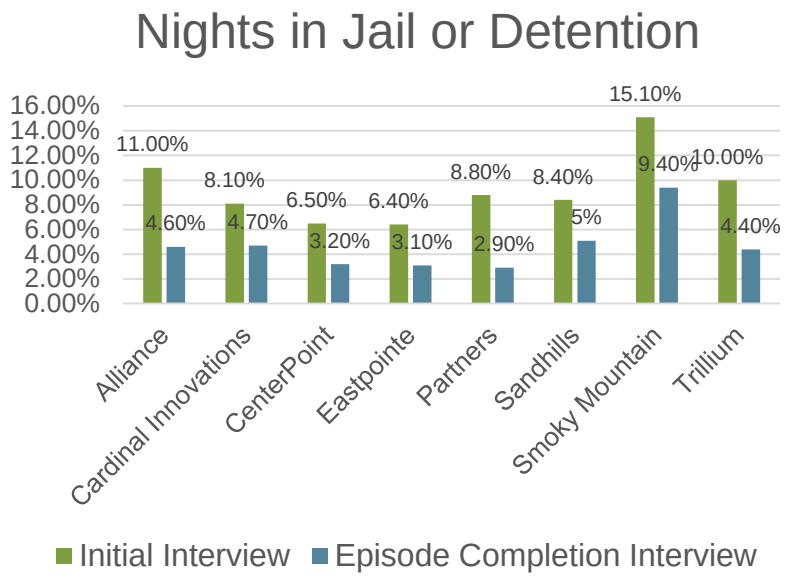
Measures have been developed and modified based on current nationally recognized performance indicators. The following measures are based on HEDIS standards:

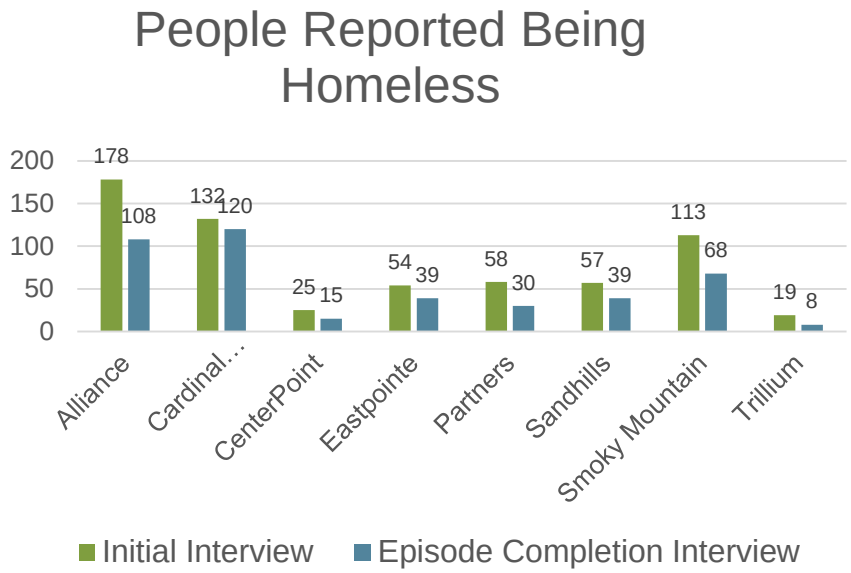
- Follow-up After Hospitalization for Mental Health
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Call Answer Timeliness
- Call Abandonment
- Mental Health Utilization
- Identification of Alcohol and Other Drug Services
- Integrated Care Measure – Adult
- Integrated Care Measure – Child and Adolescent

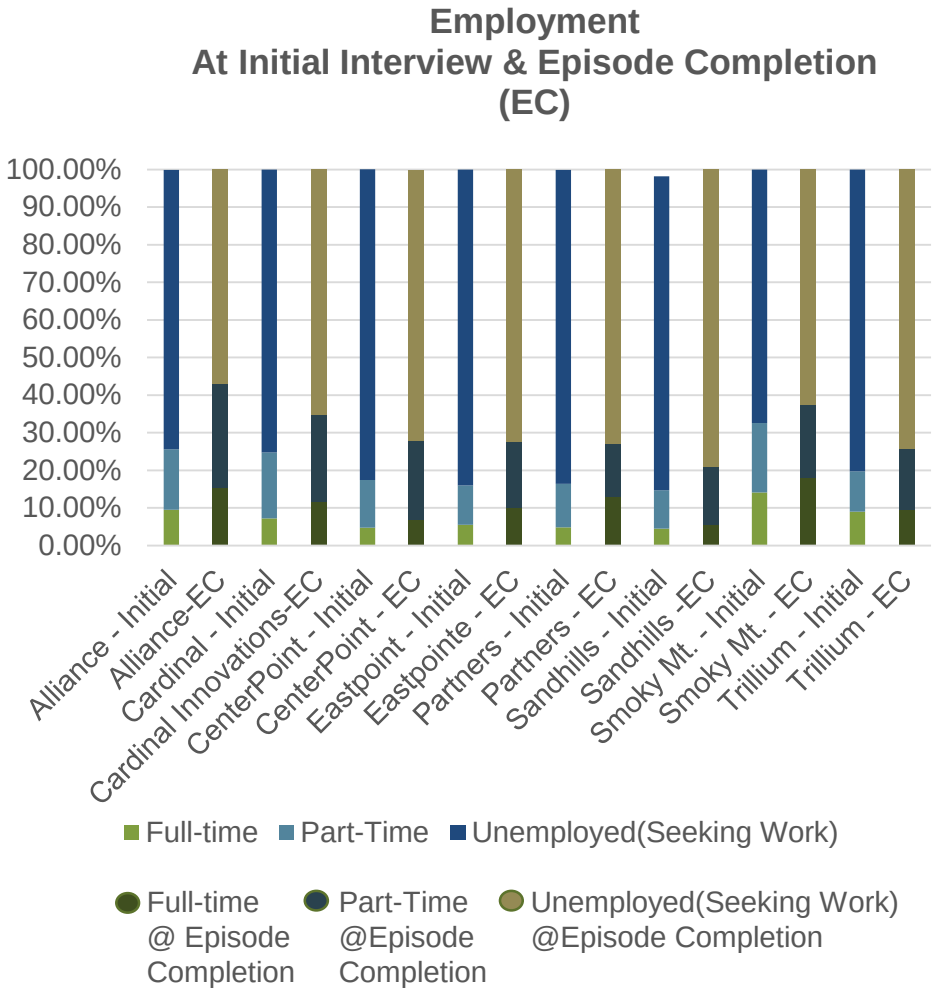
Additional Quarterly Performance Monitoring

- Substance Use Prevention
- Timely Access to Care
- Penetration Rates
- Initiation and Engagement in Svcs
- Crisis/Inpatient Services
- Continuity of Care/Follow-up
- Effectiveness of Care/Readmission
- Access/Availability
- Use of Services/Penetration
- Provider Network Capacity
- Patient/Provider Satisfaction
- Health/Safety (critical incidents)

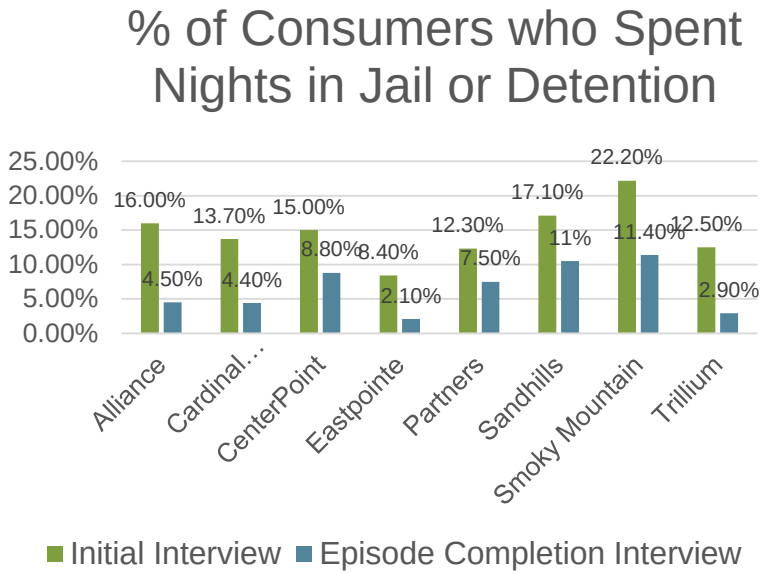
Service Outcomes: Adult Mental Health

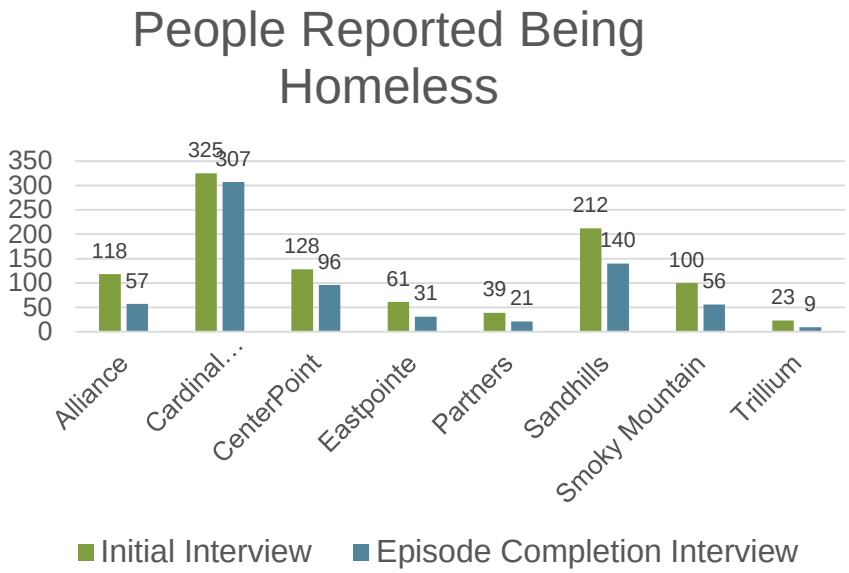


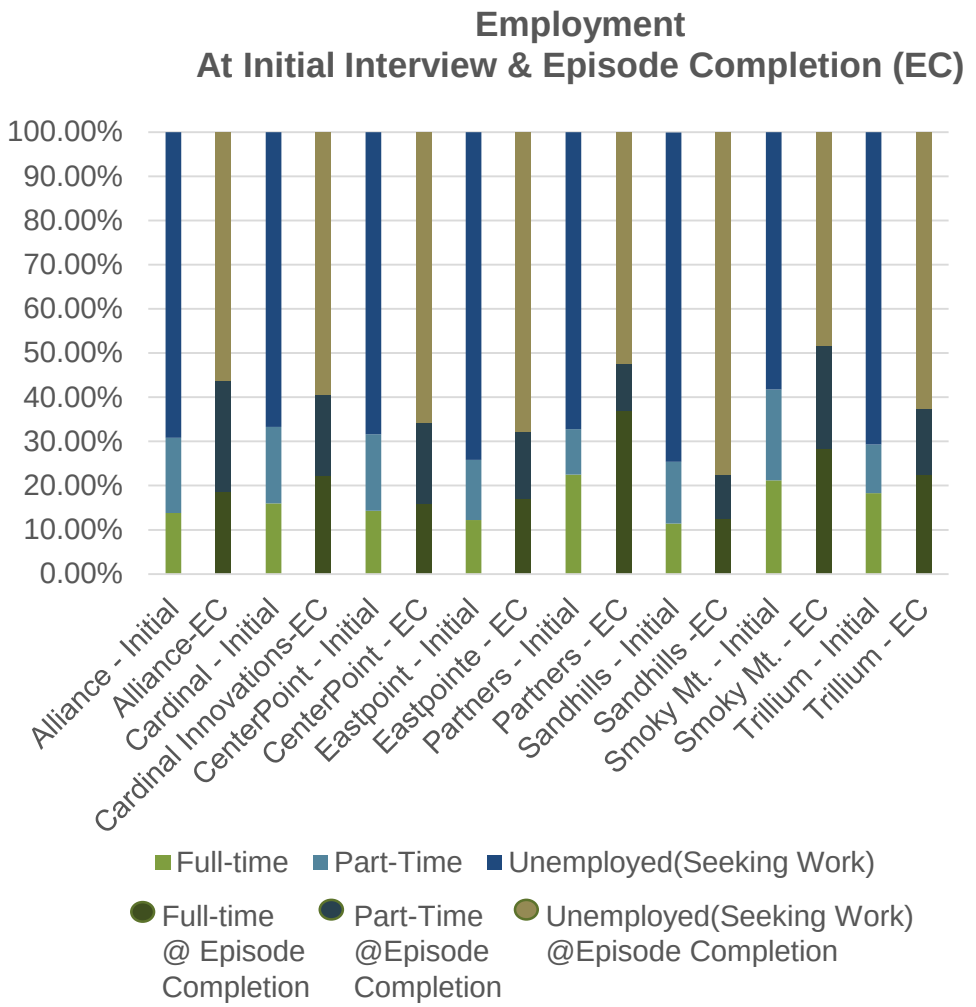




Service Outcomes: Adult Substance Use Disorder



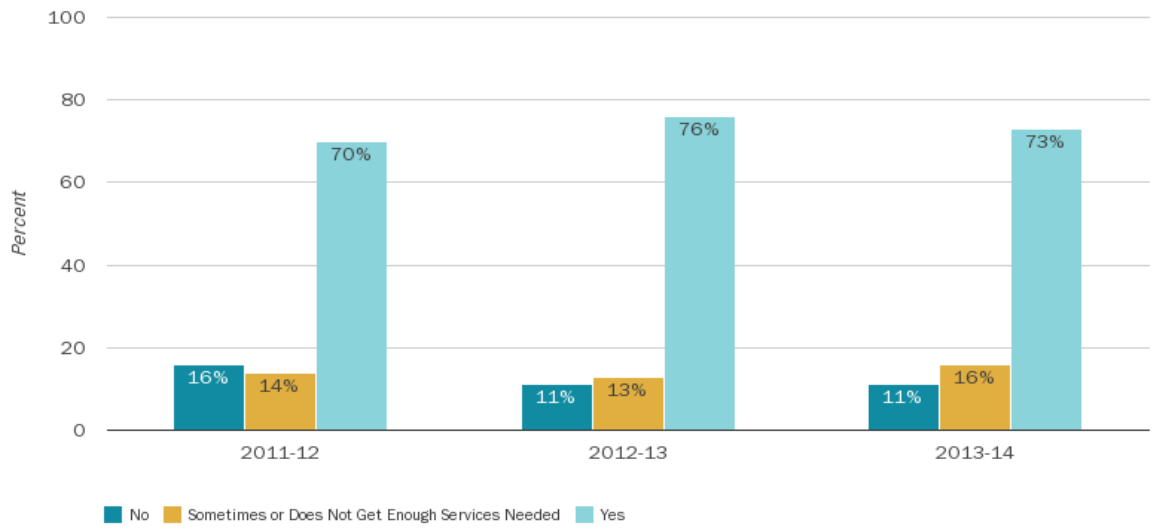




I/DD Service Quality: National Core Indicators

Gets Needed Services

The rate at which people report that they do not get the services they need.



Total Respondents: 2295 **State(s):** NC

Additional Info:

1) Total Number of Respondents = 2295
2) Proxy respondents (e.g., a family member) were allowed to answer this question

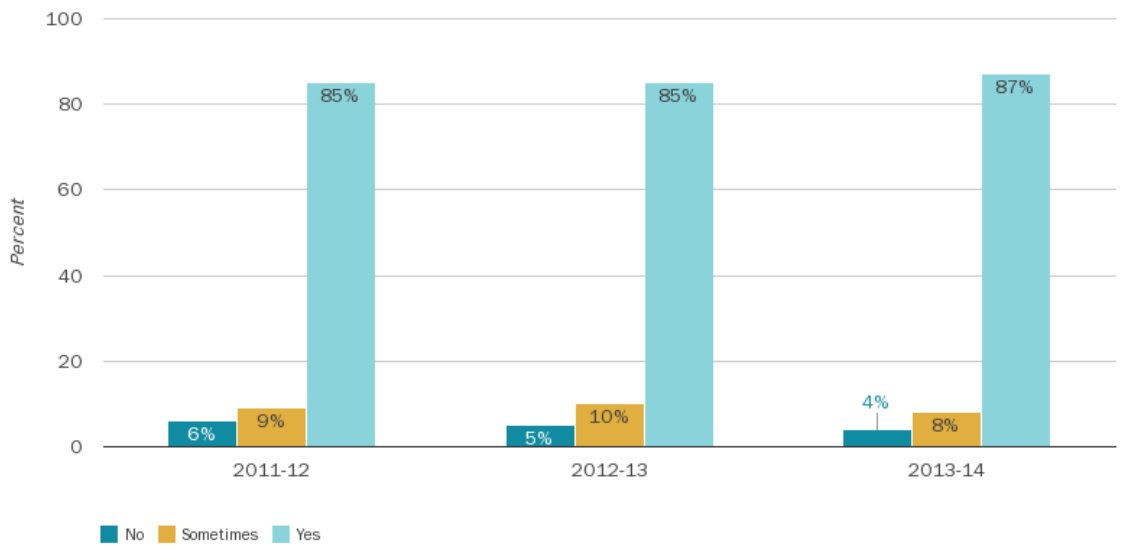
National Core Indicators. Chart Generator 2011-12, 2012-13, 2013-14. National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Retrieved on 12/14/2015 from the National Core Indicators Website: http://www.nationalcoreindicators.org/charts/.

Please Note: This item is used by some states to meet the following CMS Waiver Assurance/Sub-Assurance- Service Plan Service Plans address all participants assessed needs including health and safety risk factors and personal goals either by the provision of waiver services or through other means.

I/DD Service Quality: National Core Indicators

Case Manager/Service Coordinator Helps Get What They Need

The proportion of people reporting that service coordinators help them get what they need.



Total Respondents: 1032 **State(s):** NC

Additional Info:

1) Total Number of Respondents = 1032

National Core Indicators. Chart Generator 2011-12, 2012-13, 2013-14. National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Retrieved on 12/14/2015 from the National Core Indicators Website: http://www.nationalcoreindicators.org/charts/.

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SFY14 Gaps & Needs Analysis

The themes are an overview of the priorities and strategies that the LME-MCOs identified in their Gaps and Needs Analysis or Network Development Plan based on the LME/MCO Gaps and Needs Analysis.

This is not a comprehensive list of all LME-MCO initiatives; additional priorities and improvement initiatives can be found in LME-MCO Local Business Plans, Quality Management Plans and Annual Reports.

Priorities & Strategy Themes	Alliance	Cardinal Innovations	CenterPoint	Eastpointe	Partners	Sandhills	Smoky Mountain	Trillium
Assertive Community Treatment Stepdown Service	X	X						
B3 Services	X		X	X		X	X	X
Bilingual Staff	X						X	
Crisis Services	X		X	X	X		X	X
Co-Occurring MH/IDD Services	X	X					X	
Evidence Based Practices	X		X		X	X	X	X
Facility Based Crisis	X		X	X			X	
Increased Access to Substance Use Disorder Services	X		X				X	X
Increased Service Rates	X	X					X	
Integrated Health Care	X		X	X			X	X
Open Access/ Walk In Centers	X		X	X				X
Partial Hospitalization			X					X
Prevention Activities			X	X				X
Provider/Service Outcomes			X		X			X
Psychiatric Capacity Expanded			X	X			X	
Residential/Housing Options	X		X		X			X
Supported Employment	X		X			X	X	X
Technology Resources			X					X
Traumatic Brain Injury	X			X				

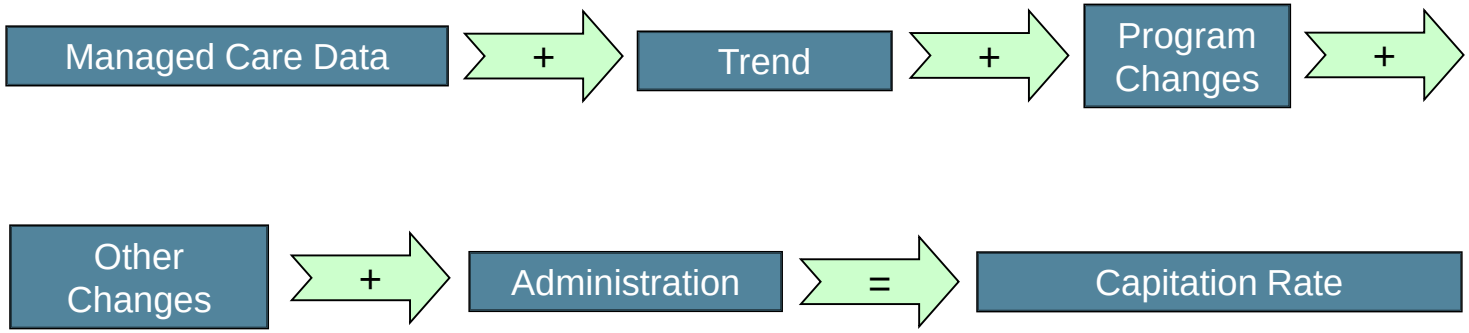
Fiscal Monitoring of MCOs

- Contractual Solvency Measures
- Comprehensive Financial Trend Analysis - Monitor key financial data and MCO performance
- Quarterly financial meetings with the MCOs
- Review audited financial statements
- Annual On-Site Review - MCO operations including finance, reporting and claims management
- Reinvestment Tracking – Identifies reinvestment expenditures
- Transition from Medical Expense Ratio to Medical Loss Ratio consistent with 45 CFR 158.150
- DMA/DMH Integration of Financial Monitoring - Consolidate reports for a single submission from the MCOs that will ensure accuracy and reduce redundancy
- MCO Comprehensive Financial Trend Analysis

Managed Care Rate Development

- CMS Requirements
  - “Rates must be actuarially sound” and developed by a credentialed actuary.
  - Actuarial certification reviewed against CMS Rate-Setting Checklist and CMS Consultation Guide
- Rate Development
  - Data Sources - Use of historical fee-for-service data and/or managed care data.
  - Trend – Projection of cost and utilization changes over a period of time.
  - Program Changes/Rate Issues - Adjustments applied to ensure rate range is consistent with program design for contract period.
  - Other Adjustments – These include, but not limited to financial experience, utilization and cost/user metrics.
  - MCO Administration – Administrative allowances including MH/SA Treatment Planning, Developmental Disability Treatment Planning and Risk Reserve requirement.

1915 (b)/(c) Waiver Rate Setting Process



PIHP Offer Rates

Example PIHP
Rate Summary
July 1, 2016 - June 30, 2017

Rating Group	Age Group	SFY 2015 Member Months	July 1, 2016 - June 30, 2017 Offer Rates		
			State Plan Services	1915(b)/(3) Services	Total Rate
AFDC	3+		$ -	$ -	$ -
Foster Children	3+		$ -	$ -	$ -
Aged	65+		$ -	$ -	$ -
Blind/Disabled	3-20		$ -	$ -	$ -
Blind/Disabled	21+		$ -	$ -	$ -
Innovations	All Ages		$ -	$ -	$ -
	Total Rate	-	$ -	$ -	$ -

Note: The PMPM includes the following considerations for administrative costs: 2% for the Risk Reserve, DD Treatment Planning, MH/SA Treatment Planning and % for general administrative costs.

What Determines Success?

- Cost Predictability
- Less Waste/Fraud/Abuse
- Reinvestment of Savings into the Local Community
- Improvements in Services
- Innovative Opportunities—the state invests in project, LME/MCOs extend those projects using savings and local manpower, and the state and LME/MCOs measure outcomes (Facility-Based Crisis)