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The Implementation of Local Management Entities in North Carolina

Produced for:

Division of Mental Health, Developmental Disabilities and
Substance Abuse Services, Department of Health and
Human Services

August 2007 (Final draft for discussion)

We must not, in trying to think about how we can make a big difference, ignore the small daily differences we can make which, over time, add up to big differences that we often cannot foresee.

Marian Wright Edelman

Love truth, but pardon error.

Voltaire

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Executive Summary

The establishment of Local Management Entities (LMEs) is an important linchpin in North Carolina's reform of mental health, developmental disabilities and substance abuse (MH/DD/SA) services system. It was designed to ensure that accountability for public-funded MH/DD/SA services stays with the public system—shared by the State Department of Health and Human Services (DHHS) and local counties and their sponsored LMEs—during the transformation to a unified community-based system. However, following the passage of the HB 381 Mental Health Reform Act in 2001, the transformation as envisioned has been rocky, full of hurdles that proved difficult to overcome.

Taking time to reflect on the implementation of LMEs and its effect on the system reform is timely and perhaps overdue. More importantly, although the review as requested by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDAS) shines a spotlight on the LMEs, it can provide a contextual analysis of the preceding six years so that there is a historic perspective in moving forward, with lessons learned by all the public partners, providers, and consumers. Its purpose is to answer the following questions:

- Has the implementation of LMEs been consistent with the statutory framework?
- How have other states implemented large-scale system reforms? What are the key lessons?
- What are the positive and negative aspects of the LME implementation experience?
- What should the public partners and their stakeholders do to improve the future course of action and realize the goals of the reform?

The review is comprised of two major tasks: (a) an environmental scan of how other states have implemented similar large-scale reform efforts, and (b) a review of LME

implementation in North Carolina, with findings of strengths and weaknesses, and recommendations for putting the reform on track.

Several states have been selected for an analysis of their experiences in attempting large-scale system reform. They include Georgia, Ohio, Pennsylvania, and Texas. Reform strategies from other states have also been included in the study, including New Mexico, Arizona, and Washington. The environmental scan included an analysis of level of authority and roles/functions between state and regional/local entities, the service delivery structure so that gaps in supply of services can be filled, management of fee-for-service Medicaid during the transformation, and major barriers to reform.

It was found that there is no ideal state model, but many effective strategies, as well as problems to avoid, that can be applied to North Carolina's current challenge. It was also found that:

- There is no perfect balance of power between state and local authorities for the state will always retain a higher control as a public funder; clarity, rather than a balance of power, is more important, and authority is practiced as a collaborative process and ownership of problems
- There is no ideal number of regional entities. The sampled states range from five to fifty-five; the critical issue is the value of local involvement and ownership.
- When Medicaid and non-Medicaid funds are managed together by a local or regional entity with strong clinical and fiscal competencies, the ability to influence the services delivered by providers, including services to non-Medicaid consumers, is enhanced.

North Carolina can learn a few key lessons from the sampled states as well:

- Most system reforms take time and effort, and the results may not be realized during the initial years. Many states are still making corrections to their initial reform decades later.

- Managing gaps in provider network requires state intervention, whether or not the local/regional authority is in place. Many states have preserved some role in issuing statewide RFPs to fill gaps in services.
- The involvement of counties, especially in sharing governance and in funding the administrative infrastructure and services, goes a long way to assure local ownership of the public disability system. This is true regardless of the size of contribution.
- Many state and local authorities have had to learn to navigate in a new environment where public/private partnership is the dominant mode of service delivery. The public sector needs to work effectively with their private partners; although services can be outsourced, public governance should not.
- As more private providers enter the public system, there should be serious attention paid to how ALL providers are being developed and monitored, so that Medicaid providers should not be treated differently from non-Medicaid providers, and consumers with similar needs should not be provided services that are widely apart in terms of levels and intensity.
- Past roles and functions, as well as the culture of practices, cast a long shadow on the public system; some old habits do not disappear. A large-scale system change needs to be accompanied by necessary cultural change.

In reviewing the LMEs, seven out of twenty-five LMEs have been selected to represent the common implementation experience, with focused areas of inquiry to guide data collection including:

- The vision for the system reform and LME's functions
- Planning for LME implementation
- Consumer access
- Consumer and Family Advisory Committee development
- Process of divestiture
- Provider development and oversight
- LME consolidations

Chief findings from the review of LME implementation indicate that there are some clear accomplishments, but also unresolved problems and lack of progress in essential areas.

Specifically, the accomplishments include:

- More funding support has come to the public MH/DD/SAS system
- The public partners have performed well in establishing a consumer voice through the Consumer and Family Advisory Committee and effective consolidation of LMEs from thirty-nine to twenty-five
- There have been small and incremental improvements to the delivery system; working relationships at the staff level between the DHHS and LMEs have been constructive
- LMEs have brought new local, innovative practices in taking System of Care to the next level, in preserving public psychiatry presence in areas with recruitment and retention challenges, and in collaboration with local hospitals; counties have played a pivotal role in the development of LMEs.

There are many weaknesses resulting from the implementation as well:

- In the rush to complete structural changes, the public partners have lost sight of the effect on consumers; there has been insufficient joint effort at resolving consumer access problems
- The pace and number of changes have been too fast and numerous, especially during the last two years, resulting in instability and insecurity about the future
- There are inconsistent practices across the LMEs in management of state funds, and insufficient tools for LMEs to improve consumer access, monitor the provider network, and develop expertise as a management entity.
- LMEs need to develop a common agenda so that meaningful dialogue with the public and private partners can take place

There is some urgency in addressing unresolved issues that have impeded the LME implementation, and the need to return to an open exchange and consultative process vertically and horizontally. These unresolved issues include:

- Common vision for LME

- Utilization review function for Medicaid
- Consumer access; screening, triage and referral (STR)

Some immediate steps should be taken:

- Open the dialogue about the status of the reform among the public partners and develop a forum for dealing with unresolved issues
- Consolidate LME functions, beginning with business functions
- Develop a problem solving agenda among the public partners, and if necessary, bring in the providers

Some short-term tasks have been identified to address the following:

- Improve consumer access to quality services
- Improve use of state hospitals/institutions as safety net providers and collaboration with LMEs
- Increase capacity for substance abuse providers and crisis services
- Review the status of LMEs with remaining divestiture of direct services
- Address urgent Developmental Disabilities issues
- Develop urban and rural workforce

Other critical issues should be scheduled for a mid-term action plan. They include:

- Develop rural delivery model
- Study the pros and cons of seeking additional Medicaid waivers
- Undertake regulatory reform and reduction in paper work

The complexity of the implementation was probably underestimated from the onset, thus the results have been mixed, with many problems remaining unresolved. Nevertheless, all public partners should take some comfort in having made the effort. They now need to set aside the errors of the past in order to restore trust and credibility. They can achieve this by having an open and honest dialogue to tackle the most urgent problems. Only when the public partners and their stakeholders emerge from the joint problem-solving

process with a win-win result can they move forward with a shared vision and strategies for an improved public MH/DD/SAS system. The opportunity is there; so is the necessity.

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I. Introduction

This review has been requested by DMHDDSAS to assess the LME implementation experience. Since the reform bill HB 381 that established the local governance structure went into effect in the fall of 2001, there have been questions raised about the benefit of the reform, the ability of LMEs to carry out their functions, and the State's own performance in achieving the reform objectives. In short, there is a general sense of disenchantment with promises unfulfilled. One need not go far to find a deep sense of frustration from all corners—from consumers and advocates; from providers; from community partners, including other service systems (social services, public health, school, juvenile justice, criminal justice, local hospital and medical institutions); from the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substances (LOC); from LMEs themselves, and last but not least, from the Department of Health and Human Services (DHHS) and its divisions responsible for executing the reform plan.

The irony is that some significant accomplishments have indeed taken place but have been overshadowed by the problems associated with the implementation, real and perceived. It is particularly difficult for the individual players to see beyond their immediate reality and problems. It is even more difficult for the general public to determine the extent to which the implementation of the public reform has fulfilled its intended purposes.

Although this review focuses on the LME implementation experience, it also touches on how all public and private partners have involved themselves in this challenging endeavor of turning former area programs as providers into local and area authorities with management and oversight functions. The journey has been challenging, and data from this review may shed light on the underlying reasons for the current frustration with the reform so that joint strategies to right the course can be developed.

A. Purpose

The purpose of the review is to answer the following questions:

- Has the implementation of LMEs been consistent with the statutory framework?
- How have other states implemented large scale system reforms? What are the key lessons?
- What are the positive and negative aspects of the LME implementation experience?
- What should the public partners and stakeholders do to improve the future course of actions and realize the goals of the reform?

These are challenging times for all involved in the implementation and monitoring of the public system reform. In order to be constructive, this review focuses less on pinpointing blames than on searching for shared solutions to the present and future challenges.

B. Scope of work

The review is comprised of two major tasks: (a) an environmental scan of how other states have implemented similar large-scale reform efforts, and (b) a review of LME implementation in North Carolina, with findings of strengths and weaknesses, and recommendations for putting the reform on track.

An environmental scan of other states aims to answer the following questions:

- Level of authority: What is the balance between the state and regional/local authorities? How have states achieved a proper balance? What processes have states employed to implement the state/regional/local governance? What functions are being assigned to different levels of the public system?
- Service delivery structure: How do other states ensure responsiveness to local needs and statewide consistency when a regional/local structure is employed? Is there an optimum number of regional/local entities? How do community services interact with hospital/institutional services?

- Managing Medicaid in the changing environment: Where fee-for-service Medicaid is the driving force, how do states manage to implement certain regional/local governance functions without losing statewide characteristics or compliance with “any willing and qualified providers?” How do public governance structures at the state/regional/local level ensure access of all consumers, not just consumers with Medicaid eligibility?
- Interplay between state and local counties: What role do counties play in the transformation? Should counties be required to fund certain services? What is the relationship between state and local governments in monitoring and oversight?
- Underserved and gaps in services: How do states address the gaps in services? How is the provider network for substance abuse developed overtime? How are the indigent consumers being served? How is the safety net being addressed?
- Major barriers to reform: What major obstacles have been encountered in the states’ transformation effort? What can be learned from them? How have other states managed the change process?

In reviewing the LMEs, the following areas of inquiry served as the framework for data collection and analysis:

- The vision of the reform: What is the vision? Is there shared understanding at all levels? How is the vision realized in the LME implementation? What unique local issues are being addressed?
- Planning for LME implementation: Local planning process, including assessment of consumer needs and scope of operation; involvement of county or counties, local partners; business plan development
- Process of divestiture: Whether the LME considered staying as providers; process of engaging consumers; development of Consumer and Family Advisory Committee (CFAC) and other infrastructure; issues surfaced during the initial planning process

- Interaction with State/local agencies: DHHS {DMHDDSAS, Division of Medical Assistance (DMA) etc. }, local counties and other public agencies: Patterns of interaction: communication, technical assistance; building blocks for LME; linkage to state hospitals and institutions; performance indicators
- Status of LME development: Timetable for LME development and merger; assumption of LME functions; provider development and oversight
- Services to consumers: Consumers' access to services; LME's efforts at promoting best practices; gaps in community services for all disabilities; core services development; safety net issues and strategies
- Retrospective review of LME implementation: Strengths and weaknesses; anticipated and unanticipated consequences; lessons learned.

This report represents one consultant's view of the LME implementation and results during the initial six years; this same consultant staffed the LOC from 2000 to 2001 that led to the passage of HB 381. DMHDDSAS should be credited for undertaking this review, and its purpose is served if the findings and recommendations generate an open and honest dialogue among the public partners, the consumers they serve, and the providers who deliver the services. In the life of a major system transformation, corrections at this stage are appropriate and necessary, and in keeping with the spirit of learning—with the courage to right the course.

II. Background

A. Rationale for the reform

It may be surprising that the public needs to be reminded of the rationale for the reform. After all, the pre-reform era had its share of problems that invited wide scrutiny from external and internal bodies for over ten years.¹ Yet the collective memory is often short, especially when the present is not trouble-free, and some of the problems identified as reasons for the reform have not been successfully dealt with. Another reason for reexamining the rationale is to put to rest misconceptions about the reform.

Many have considered the reform initiative an attempt to “privatize” the public system. This is an incomplete understanding of the intent of the reform. The entry of private providers in North Carolina had already occurred; in fact, there were increasing concerns that with both public and private sectors actively involved in delivering services, there was no neutral entity to manage consumer access, quality of services, or effective use of public resources. Added to the concern for public accountability was the national trend of outsourcing many of the public functions. North Carolina made a policy decision to never outsource governance or accountability for services delivered locally, but to preserve a public role through the development of LMEs. The LME is a local governance model, not a private managed care model.

In 2000, problems cited as symptoms of system failure were numerous:

- Loss of public credibility with the system, evidenced by the removal of the State’s Medicaid waiver program North Carolina Alternatives, issues with consumers falling into cracks, especially the indigent consumers and those with substance abuse problems
- Fragmentation and disconnection between hospital/institution-based and community-based services; area programs had no incentive to divert hospital

¹ In the 1990s major reports calling for system reform included the Government Performance report (1991) commissioned by the General Assembly, the DHHS’s Hospital Study Report (1997), and the state auditor’s report (1999).

admissions when there was no local financial penalty for using state hospitals or institutions, nor incentive for managing the utilization well

- Lack of articulation of a rational use of public resources; area programs were asked to be everything to everyone, resulting in underserving those with serious mental illnesses² and lack of services for individuals with substance abuse problem
- Weak linkage between area programs and counties and state, lack of accountability and consumer involvement at the local and State levels
- With the area programs functioning as providers, monitoring and oversight over the delivery system is weak
- Relationships were contentious and adversarial; lack of trust permeated stakeholders, including consumers, providers, area program, counties, and the state government

In all fairness, the early studies did acknowledge some exemplary area programs in the state and that despite unclear priorities or accountability for public resources, well-meaning people found ways to work together. Yet the governance of the system was broken; this became the focus of the reform.

B. Statutory framework

Reforming the public disability system became a policy mandate when the General Assembly during the 2000 session created the LOC with the explicit instructions to study and recommend improvements to the public system by the following legislative session.

It has been clear from the beginning that the current reform agenda came out of a legislative initiative. Although in the fall and winter of 2000 the LOC convened several study committees on governance, services, finance, DD, and hospitals, and invited public participation, the state's role was primarily resource support and technical assistance during the study committee and bill drafting process. Still, there were indications of

² Some of the Division's statistical reports showed the low percentage of severe and persistent mentally ill being served in the community system.

support for the reform, a willingness to march on the same course of change.

Notwithstanding the long history of distrust among public partners, including the rocky relationship between the DHHS and area programs, between area programs and other providers, and between the legislative and executive branches, there were also mutual confidence and respect that developed from working together on the reform agenda.

The statutory framework addressed several problems identified for the reform:

- Articulating how public resources should be prioritized by defining targeted populations in mental health, developmental disabilities and substance abuse services
- Stipulating that the DHHS develop a state plan, with strategies for implementing the framework of the reform; stipulating that counties be closely aligned with the area authorities including signing off on the appointment of the area director and a local business plan
- Separating management functions from provider functions for the area programs and creating local governance with strong county linkage and a business plan approved by the state; this is the rationale for creating LMEs at the local and regional levels
- Increasing consumer voice by establishing A State and Local Consumer structure; though this was not funded, DHHS created CFACs as part of the State Plan; these CFACs were codified in 2006.

The Mental Health Reform Act of HB 381 assigned the following functions to the local governance structure:

- Planning—including identification of service gaps and efficient and effective use of all funds for targeted services
- Provider network development—ensuring available, qualified providers to deliver services based on the business plan
- Service management—implementation of a uniform portal process, management of state hospital/facilities bed days, utilization management, case management , and quality management

- Financial management and accountability—carrying out business functions in an effective and efficient manner, managing resources dedicated to the public system
- Service monitoring and oversight—ensuring services provided to consumers and families meet state outcome standards
- Evaluation—self-evaluation based on statewide outcome standards
- Collaboration—with other local services systems in ensuring access and coordination of services at the local level.

In addition to these functions, the LMEs are also responsible for ensuring that core services to all consumers, within the state and local resources, be provided:

- Screening, assessment, and referral
- Emergency services
- Service coordination
- Consultation, prevention, and education

The term LME was not codified in this initial reform act, but defined in HB 2077 passed in 2006, in which LME is defined to mean “an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.”³ In HB 2077, the LME functions were further defined to include the following:

- Access for all citizens to the core services described in G.S. 122C-2. In particular, this shall include the implementation of a twenty-four-a-day, seven-day-a-week screening, triage, and referral process and a uniform portal of entry into care.
- Provide endorsement, monitoring, technical assistance, capacity development, and quality control. An LME may remove a provider’s endorsement if a provider fails to meet defined quality criteria or fails to provide required data to the LME
- Utilization management, utilization review, and determination of the appropriate level and intensity of services including the review and approval of the person-

³ HB 2077 Mental Health Reform Changes, General Assembly of North Carolina, Session Law 2006-142, 122 C-3 Definitions, (20b)

centered plans for consumers who receive state-funded services. Concurrent review of person centered plans for all consumers in the LME's catchment area who receive Medicaid funded services.

- Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.
- Care coordination and quality management. This function includes the direct monitoring of the effectiveness of person-centered plans. It also includes the initiation of and participation in the development of required modifications to the plans for high-risk and high-cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers, and review of consumer charts.
- Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee
- Financial management and accountability for the use of state and local funds and information management for the delivery of publicly funded services.

HB 381 and HB 2077 provide the statutory framework for the LME functions and responsibilities. However, it is important to note that the LME's functions are synchronized with the State authorities and functions in the following ways:

- DHHS's role as the state authority in statewide planning, standard development and financing strategies, and technical assistance to LMEs is assured.
- DMHDDSAS's role as a provider of state psychiatric hospitals and facilities is unchanged, although the reform legislation directs the state to develop strategies for LMEs to manage hospital/facilities bed days.
- DMA's role as the single Medicaid agency remains, however, DHHS is responsible for ensuring inter-divisional collaboration and development of Medicaid policies for the MH/DD/SA service system.

Another critical point about the statutory framework is that it provides a foundation, not a prescription, for the state plan to be developed, including how the framework is to be operationalized for implementation.

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III. Approach

A. Environmental Scan

Because no two states are alike in approaching their reform initiative and there is no ideal system in the nation, the purpose of the scan is not to locate a model state but a set of proven strategies tried elsewhere. Hence a targeted approach of comparing selected states, enhanced by additional information gleaned from other states, will be used. The advantages of using a mixed approach are many:

- The consultant may bring in—or not bring in—states for comparison on topical issues that are relevant to conditions in North Carolina.
- The best and the worst case examples can be referenced according to specific review questions.
- There are good exemplary practices found outside the targeted states. This approach allows the consultant to showcase exemplary practices to help address the larger question: do effective strategies exist in the nation?

The following criteria were used to make a selection of states to be reviewed, while bringing in examples from additional states to answer review questions:

- States that have had a system reform initiative for more than ten years, thus providing a track record
- States from different CMS Regions, including states that have implemented Medicaid Rehabilitation options
- States that represent geographic differences
- States that have a combination of state and local/regional authority structures
- States that have experienced difficulties in reform (almost all of them), and strategies used to overcome the difficulties

Using these selection criteria, four states have been chosen for the scan:

- Georgia
- Ohio
- Pennsylvania

- Texas

Other states with relevant experiences have also been added to the scan:

- New Mexico (The State Collaborative Initiative)
- Arizona (use of for-profit entities as regional authorities)
- Washington (regional authorities as nonprofit entities)

The focal point of inquiry throughout the environmental scan is an understanding of other states' management of large-scale system reform efforts, positive and negative lessons learned, and whether workable strategies tried elsewhere can apply to North Carolina. The following factors are used as the framework for analysis of data collected from the sampled states:

- *Clarity of accountability and authority*: Is there a clear accountability and authority structure in governance at the state and regional/local levels?
- *Balance of responsibilities*: Is there a healthy balance between the state and regional/local entities and a mutual understanding of the potential and limitations of shared governance?
- *The ability to manage change*: How has the change been managed? What are the mechanisms and results?
- *Impact on services for consumers*: Has the system reform improved services to consumers? How?

B. A Review of LME Implementation

To perform a comprehensive review of all existing LMEs would not be feasible within the short time frame given to this review, nor is it necessary for the purpose of this project. It is not designed as a review of individual performance of the LMEs, but a retrospective review of shared experiences that can help shed light on issues of the implementation.

As background to the LME review, the consultant scheduled numerous interviews and focus groups with key players at the state level, including staff from DHHS, LOC and staff, NC Council, provider associations, professional associations, consumers and

advocates. These interviews and focus groups, supplemented by background document research into the implementation experience since 2001, have provided necessary backdrops to the second part of LME review—on-site visits to selected LMEs.

The approach adopted for the LME on-site review is a targeted, qualitative field study approach, including specifically:

- Selection of LMEs with adequate representation of urban/rural characteristics, diversity in size, single vs. consolidated structure, and different stages of development; LMEs in the process of merging were excluded
- Develop a framework for the review to guide data collection
- Review background profile on each LME visited
- Use personal/group interviews to collect data regarding review questions
- Ensure transparency in the review process through exit conferences with LMEs under review
- Provide ongoing feedback to the Division on the progress of the review

Based on the sampling criteria, DMHDDSAS chose seven LMEs to be included in the review. Because the study approach underscores collective over individual LME experience, the LMEs participating in the review project have provided a valuable service to all—by sharing information critical to the LME implementation, and by participating in the discussions about necessary changes in the future. The seven LMEs chosen are:

- The Durham Center Area Authority
- OPC Area Program
- Crossroads Behavioral Healthcare
- Five-county Mental Health Authority
- Southeastern Center
- Sandhills Center
- Western Highlands Network LME

IV. Environmental Scan

A. The Scan

(1) Georgia

For more than ten years Georgia has launched a number of system transformation initiatives to improve the delivery system, while moving the state authority, Department of Human Resources (DHR) and Division of Mental Health, Developmental Disabilities, and Addictive Diseases (DMHDDADS) into the new roles of purchaser, regulator, and monitor. Georgia shares some similar characteristics with North Carolina: (a) it is in the same CMS region, (b) its division includes all three disabilities, (c) the division is part of an umbrella agency, DHR, and (d) North Carolina followed Georgia in seeking Medicaid Rehabilitation Option, using similar service definitions.

The House Bill 100 that propelled system reconfiguration in 1995 created nineteen regional entities, responsible for planning and provider development, as well as overseeing regional hospital/institutional and community services. The same legislation created thirty-six Community Services Boards (CSBs) from the former County Boards of Health as the public entity to provide mental health, developmental disabilities, and substance abuse services. Nineteen regions and thirty-six CSBs covered 159 counties in the State. CSBs also reported to a local governing board, with linkage to the counties, but the board and staff are considered public employees with the same benefit structure as state employees, and CSBs had the identity as “public entity providers.” In this original legislation, a member of the Regional Board may also sit on the CSB governing board whose membership is locally appointed. CSB took over community mental health center networks and assumes direct service function, whereas Regional Boards assume functions in planning, purchasing, and monitoring.

From 1995 to 2001 the CSB functions took off, creating large public providers to serve consumers, while private providers continued to grow. Meanwhile, the capacity of the regional board as the regional management entity was never fully implemented. In fact, the regional board was more of a “planning board” than a “governing board” for overseeing services in the region. There were concerns about consumers not being served by either CSBs or private providers, and concerns about an overreliance on clinic-based services provided by CSBs.

HB 498 was enacted in 2002 to redefine the authorities and responsibilities among the state, region, and CSBs. HB 498 attempted to improve consumer access by stipulating that:

- “A single point of accountability should exist for fiscal, service, and administrative issues to ensure better coordination of services among all programs and providers and to promote cost-effective, efficient service delivery and administration.” {37-1-2,(2)}
- “The functions of service planning, coordination, contracting, resource allocation, and consumer assessment should be separated from the actual treatment, habilitation, and prevention services provided by contractors.” {37-1-2,(8)}

HB 498, while articulating the need for a single point of accountability, never established a review mechanism to determine to what extent this was accomplished by the executive branch. It is left unimplemented to this date. The bill succeeded only in attempting to address the need to separate purchasing decisions from service provision functions. The regional directors were renamed in the bill as regional coordinators who reported to the central administration at DMHDDADS, essentially becoming part of the state authority. Most of the provisions in HB 498 remained unimplemented during leadership turnover. Meanwhile, from 1995 to 2007 the number of regional entities decreased from nineteen to five. The reduction in the number of regions has been driven by state budget cuts, rather than a deliberate consolidation effort. The regional capacity has drastically diminished over time.

For the last five years, the regional offices have been called on to address state hospital/facility problems, perform incident review, and investigate consumer complaints, while the central office has taken over the purchasing, provider development and contract management; the central office issues all RFPs for services with the exception of grant funding for CSBs, while the regions provide nominal endorsement and sign-off. Provider monitoring is considered insufficient, other than the limited ad hoc review of consumer complaints and serious incidents by the regions and contract management by the central office. The DMHDDADS has contracted with a private vendor, APS, to perform utilization management for all Medicaid and non-Medicaid services.

The state hospital/institutional services and community services remain separate, though the current regional offices still retain the oversight function of the state hospitals and institutions. Because the regions are seen as an extension of the state authority, and CSBs continued to enjoy certain amount of autonomy, the regions' ability to oversee CSBs and other providers is limited. The Supreme Court's Olmstead decision had its origin in Georgia's mental retardation institution, and currently the US Justice Department is investigating the quality of care in the State psychiatric hospitals, following a number of questionable patient deaths; during the spring and summer of 2007, *Atlanta Journal Constitutional* published a series of articles about the poor quality of care at Georgia's state hospitals.

Georgia is operating a Medicaid Rehab option, but the Medicaid plan has been subject to modifications by CMS. For example, although originally part of the Medicaid rehab option, the Community Support Team (a more intensive form of Community Support Individual) is no longer part of the state plan.

In April 2007 the DMHDDADS converted residential services for children into fee-for-service from bundled funding, i.e., billing a single rate for room/board and therapeutic services. The conversion has not worked well for providers; many have had difficulty complying with the billing requirements, resulting in program closures

in many parts of the state. The state's conversion to fee-for-services for adult services provided by CSBs has thus been temporarily deferred for another year until the problem with the children's conversion is resolved.

There are some practices in Georgia worth noting:

- It has developed a uniform consumer data base, the Multi-purpose Information Consumer Profile (MICP), that provides registration and utilization review applicable to all consumers receiving public-funded services, whether they are Medicaid eligible or not.
- The DMHDDADS has purchased a statewide crisis line and referral system (STR) through Behavioral Link, a vendor with a long history of providing crisis services in several regions of the State. Early indications show that the model is promising. The crisis screening/triage/referral system can effectively link consumers to appointments at the provider level, but it is not an access system and coexists with a "No Wrong Door" policy. Consumers continue to be admitted to services without having to go through the statewide system.
- With the purchasing function centralized at the Division level, the agency develops annual "purchasing plans" to examine the purchasing practices and fill service gaps.

(2) Ohio

Ohio is often cited as an exemplary case for state and local governance reform. For years, the Ohio Model has been studied as a case study for public sector reform⁴. The truth is more complicated, for Ohio has distinct flaws in its state and local governance in spite of its successful governance reform and subsequent system improvement efforts. Still, there is no doubt that the overall impact on consumer services has been positive in Ohio and the clarity of state/local governance is no longer a debatable issue.

⁴ The Ohio case was among one of the public sector reform cases used in the Kennedy School of Government at Harvard University and other national institutions, including US Department of Health and Human Services, see *Journey to Passage: the Ohio Mental Health Act*, by Gail K. Robinson, Mental Health Resource Center, February 18, 1991.

Ohio's major reform effort came when the Mental Health Act (amended substitute Senate Bill 156) was passed during the last month of the legislative session in 1988, providing local governance in the form of local boards in mental health services, alcohol and addiction services, and combined mental health and alcohol and drug addiction services. Today there are fifty-five such local MHB, ADAS, ADAMHS, and MRDD boards in eighty-eight counties, some boards are multi-county boards.

Although Ohio began its system transformation almost twenty years ago, the reform, similar to that carried out in North Carolina in 2001, was driven by a number of federal and state reports⁵ about the conditions of state hospitals and facilities, as well as the unbalanced expenditure⁶ when the number of consumers with mental health needs in the community was growing. Ohio was able to pass the sweeping reform bill owing to strong executive leadership support and fiscal analysis that showed that the system could become more efficient if the state hospitals utilization was managed by the local boards. However, Ohio's experience differed from North Carolina in that the transformation was less dramatic because the local boards had never assumed a direct service role; the learning curve for assuming new functions was thus less steep for local boards in Ohio. Moreover, the reform had strong support from the governor's office and stewardship from the Ohio Department of Mental Health.

The Mental Health Act's key cornerstone is the shift from hospital to community care by holding the local boards "responsible for mentally ill individuals, through commitment to the local boards rather than to the State. It would be up to the county to decide whether a person needed hospital care or could be treated in a community setting... The change in financing mental health care calls for a gradual shift of State funds currently used to operate State hospitals. These funds would be used by the local mental health boards to purchase inpatient services, in a manner similar to how boards currently contract for services provided by local agencies. Boards could purchase inpatient services from state

⁵ One such study that provided momentum for the reform was the *Mosaic Study* (David and Solomon), Cleveland Federation for Community Planning, 1983.

⁶ In 1988 Ohio spent over 50% of its State funds in State hospitals, 25% in community services, and 20% in research and support services.

hospitals, which would continue to operate under State control.”⁷ The local boards are charged with local planning, promoting local financing (participating in the county levy campaign), developing a local plan, purchasing public and private services, developing community-based services, auditing for compliance consistent with state rules, quality assurance for consumer access, and quality of services at the local level.

Significant features of the state/local governance in Ohio are:

- The local boards are considered political subdivisions and report to the governing board made up of local and state appointees (although the state authority can appoint a certain number of board members, the appointments are based on recommendations from the local boards and the state rarely rejects local nominees)
- Mental retardation and developmental disabilities have separate local boards, and structurally report to a different state agency. Both mental health and addiction services local boards also report to a separate state agencies (Ohio Department of Alcohol and Addiction Services became a separate state agency in 1989, breaking away from the Department of Mental Health). The separate state structures have made coordination and oversight difficult for local boards that are combined (MH/ADAS).
- Though the act further stipulated that the local mental health, alcohol, and drug addiction services boards “may provide for services directly to a severely mentally disabled person when life or safety is endangered and when no community mental health agency is available to provide the services,” in actuality none of the local boards have developed a direct service role.
- Ohio is the only state in the nation that has county levies—and attendant local levy campaigns—for health and human services including public welfare (children and family services), mental health, alcohol and addiction services, mental retardation and developmental disabilities services, and long term care services. The levy campaign conducted locally has directly involved local citizens in the public system, with the positive consequence of ownership and hence more oversight by local citizens in the direction and performance of the public health

⁷ Ohio Mental Health Act, 1988

and human services system. The local levies also allow a level of safety net during the lean fiscal years at the state level.

- Even though the local boards have clear functions in planning, purchasing and monitoring services, Ohio did not have a formal procurement process until HB 215 was passed in 1999. To date, some local boards have an RFP process to manage providers; some do not. The Department of Alcohol and Drug Addiction Services issues RFPs for certain Statewide services, such as prevention services.

Some exemplary practices in Ohio are:

- Due to shared interest in developing information system capacity, the Department of Mental Health and the Department of Alcohol and Drug Addiction Services have collaborated in purchasing a payer-based information system called Multi-agency Community Services Information System (MACSIS) that can capture data for Medicaid and non-Medicaid services. This is a payer-based information system that can register authorization and payment information, in addition to behavioral health profiles of consumers served, and the state and local boards have equal access. MACSIS went into effect in 1999 with extensive training and a long learning curve for some boards and providers. Today it is running smoothly today and has offered the local boards the ability to monitor all claims data and services to their local consumers in a system that remains Medicaid fee-for service.
- There have been improved business practices at the local level as a result of the board structure. Some boards use other boards to manage services, or perform certain functions. Many small rural boards have made alliances to purchase each other's functions. Local collaboration among all public systems is strong for both children's and adults' services (some have used pooled funding to fund services to children with multiple system needs).
- Ohio local boards have done well in managing hospital and institutional utilization; clear incentives and penalties are established for the board performance. Each board must pay for all hospital/institutional (public and private) utilization, and each board performs pre-hospital screening and coordinates with

- sheriffs and emergency room presentations. No one can be voluntarily admitted to a state hospital or institution without the board approval. Board staff also performs utilization review for all Medicaid services using a statewide protocol that is in compliance with Medicaid requirements. The Board Quality Assurance staff does on-site program monitoring as well.
- In 1999, the Department of Mental Health moved to establish a consumer outcomes project for children and adults in the mental health system. After a slow start, and a phase-in process to roll out the plan from board to board, the consumer outcomes project is now considered one of the best practices at the state level.

However, there have been significant events since the passage of Mental Health Act that demonstrate the need for the public partners to work effectively to realize statewide initiatives:

- In 1994 Ohio received approval from Health Care Financing Administration (HCFA, now CMS) to implement a 1115 Medicaid waiver for mental health, alcohol and drug addiction services, developmental disabilities, and children and families (in social services); however, the state legislature failed to pass an enabling legislation to allow for the waiver implementation. During the waiver design process, the state had considered combining all the local boards into eleven alliances and met with resistance. With the state's failure to implement 1115 Medicaid waiver, no further consolidation efforts took place until 2006 when two counties merged their mental health and alcohol and addiction services boards (Lucas and Hamilton Counties).
- In 1999 the Ohio Departments of Mental Health and Alcohol and Drug Addiction Services failed to use a vendor for the statewide management of Medicaid services, due to strong local opposition; in addition, a lawsuit was brought by an offeror who had not been awarded the contract, claiming unfair procurement process on the part of the state. To date, Ohio does not contract with any managed care organization to manage the Medicaid behavioral health utilization for Medicaid or non-Medicaid, both are managed by the local boards.

There were also problems in Ohio's Mental Health Act passed in 1988:

- Insufficient attention to the local board's role vis-à-vis provider network. While stipulating a clear planning and contracting role, the Mental Health Law did not give the local boards the ability to provide screening, triage and referral function nor utilization management, only retroactive utilization review. The subsequent HB 215⁸ did not go far enough in granting the boards this responsibility as a result of provider opposition. This ambiguity was tested a number of times by the strong provider council in litigation against the boards for making certain UR decisions.
- Because of the state structure with the three free-standing departments of mental health, alcohol addiction services, and mental retardation and developmental disabilities, local boards have faced challenges in coordinating state standards and rules. What Ohio has traded off is county control for lack of efficiency from economy of scale. The large number of local boards for different disability groups has made it difficult to expand local board capacity. Interestingly enough, this lack of board capacity has increased leverage of providers, especially providers with multi-county reach. Managing providers has continued to be a challenge in the current fee-for-service Medicaid system, despite the fact that the boards continue to provide UR for both Medicaid and non-Medicaid funded services. Providers billing for Medicaid send claims to the single state Medicaid agency, but there is a clear path-through the boards so that monitoring of claims can take place, assisted by the MACSIS data base.

(c) Pennsylvania

This analysis will address the state's system transformation through a statewide 1915 Medicaid waiver in 1997. Pennsylvania Commonwealth has a county-based system with strong county oversight. When the state received a 1915 Medicaid waiver approval for its general health and behavioral health services, the state gave the county governments the first right to apply as a managed care entity, or to make alliances with other counties, or

⁸ HB 215 passed in 1999 was intended to develop a framework for the MH and addiction services community Medicaid programs by establishing guidelines for payment methods, provider procurement, access/utilization management, and quality improvement (outcomes) monitoring.

to purchase the functions from a provider network. The three disability systems—mental health, developmental disabilities, and substance abuse—are decentralized to the county level, as part of the county structure. The Pennsylvania experience is germane to North Carolina's reform in that it is a mirror through which North Carolina can look into the future, should North Carolina be interested in pursuing a statewide Medicaid waiver. Pennsylvania was also cited in the 1999 North Carolina State auditor's report on MHDDSAS as an exemplary county-based system.

Since the state entered the 1915 waiver, HealthChoices, in 1997, it has had a slow implementation cycle, phasing in the waiver plan (including participation by public or private managed care entities) by regions and zones. Today, ten years after the waiver implementation, the behavioral health component of HealthChoices is still being phased in by planned zones; it is mandatory in three zones—Southeast Zone, Southwest Zone, and Lehigh/Capital Zone—with consumers in the remaining counties receiving services through a fee-for-service or a voluntary managed care program. For the non-behavioral health components of HealthChoices, the State halted the expansion of the HealthChoices program in 2003 and began to phase in an enhanced primary care case management program in counties without mandatory capitated managed care programs.

The pertinent questions about Pennsylvania's experience are: Is the county-based system conducive to embracing major change? What process did the state employ in promoting a major policy shift—the implementation of a statewide 1915 waiver program? What challenges have the state and counties encountered in bringing new players—managed care organizations—into the public system? The Pennsylvania experience is not so much about change in governance, but whether clear and stable governance structure support major statewide changes in a new environment with penetration of managed care organizations.

Some important features of the Pennsylvania experience are:

- Although the state Medicaid agency is the logical entity for providing Medicaid policy guidance, the Department of Public Welfare, under which the state

behavioral health authority resides, is an equal partner in waiver implementation; from planning to design and monitoring, the two states agencies have had a close and positive working relationship.

- The waiver has revealed some structural flaws in a predominantly county model. It has made statewide consistency a difficult goal to achieve, yet it may be a necessary trade-off to foster county ownership.
- In addition to the 1915 waiver, Pennsylvania has a number of long-term care waivers including the Home and Community-based Waiver, and the Independence Plus waiver. Coordinating different waiver programs has been taxing for the state agencies.
- Because of the higher penetration of managed care in the physical health of HealthChoices, the emergence of private management care organizations (MCOs) in the management and delivery of public services has brought a distinct private flavor to the State. Some of the MCOs are private for-profit entities and exercise considerable leverage in contract negotiations. During the early years of the waiver implementation, rate change dominated the discourse between the public sector and the private managed care organizations. As a result, the State agencies have had to learn how to navigate in an environment different from its previous comfort zone. The state agencies have had to develop the capacity for conducting performance review, quality management, and data support. The State's information system went through a major overhaul, ten years into the waiver implementation, it is still being modified.

(4) Texas

In many ways, Texas provides an example of a typical state-driven reform agenda: consolidations. In the case of Texas, it's a state consolidation plan to combine twelve agencies into five, while eliminating the mental health and mental retardation state authorities.

The state mental health and mental retardation authority was created in 1965⁹ as a free-standing governing body for the system, replacing the Board for Texas State Hospitals and Special Schools that was created in 1949. The Department of MH/MR reported to its governing board, the Texas Mental Health and Mental Retardation Board (Board), who was responsible for appointing the Commissioner of MHMR, while the governor appointed the chair of the Board. The same act in 1965 also created local centers of Mental Health and Mental Retardation; however, the Act did not specify types of services to be provided by the Centers, or the authority of the centers to purchase properties.

Some important features of the Texas reform history since 1965 include:

- The original 1965 Act that created local centers of MHMR is still intact. Currently there are thirty-nine local centers in Texas; each county is served by a center, and some centers serve multiple counties. Centers continued to provide direct services, and are increasingly serving the indigent consumers, while private providers have actively pursued Medicaid eligible consumers. The Centers also provide case management services in different tiers, Tier I, the lowest level of case management services provides one case manager to 150 consumers.
- Reorganization at the Department of MHMR in 1995 resulted in a Division of Managed Care (changed from Mental Health Services Division) and Division of State Operations (changed from Mental Retardation Division); both have overall responsibilities over state-operated hospitals and state schools.
- At the local level, the Community MHMR Centers, under contract with the DMHMR, provided community-based services. Each county has a mental health authority (MHA) and mental retardation authority (MRA) to authorize utilization of State-operated hospitals and MR institutions (State schools).
- With the passage of HB 2292¹⁰, the state further consolidated State agencies from twelve into five, thus abolishing the Department of MHMR (effective on September 1, 2004) and subsuming all functions under two departments, Texas Department of Aging and Disability Services (DADS) and Texas Department of

⁹ House Bill 3, 59th Legislature, Regular Session.

¹⁰ HB 2292, 78th Legislature; Regular Session, 2003, Texas, United States.

State Health Services (DSHS); both are under the Health and Human Services Commission. The substance abuse commission has also been subsumed into the State Health Services. The MHAs and MRAs continue with their inpatient gatekeeping role for state psychiatric hospitals and institutions, while reporting to different departments.

- There are regional offices reporting to each department under the Health and Human Services Commission with responsibilities for monitoring and oversight. The regional authorities are not clearly defined, and capacity to carry out monitoring and oversight functions vary from region to region.
- Texas entered Medicaid waiver programs in the late 1990s and has the 1915 waiver in a few counties, and the Home and Community waivers for MR and long-term care consumers. In 2006 it was estimated that state/federal funds for Medicaid in Texas constituted approximately 26 percent of the all the state expenditures; additionally, managed care has entered Texas with a high penetration rate. The projection is that 72 percent of Medicaid consumers will be enrolled in managed care plans in 2008, an increase from 40 percent in 2003¹¹.

Given the relatively recent restructuring at the state level, the jury is out on whether the restructuring has improved or hampered the state authority functions, or more importantly, resulted in improved services to consumers. There are troubling signs:

- A widening gulf between the public and private providers of services. Local centers of MHMRs are experiencing turnover problem, losing qualified clinicians to private managed care organizations or private providers that provide only Medicaid reimbursable services. The state has engaged several behavioral managed care organizations to perform utilization review functions, and some counties have also implemented 1915 (b) waiver programs.
- A continuing struggle between state-operated hospitals for consumers with mental illness and schools for consumers with MRDD conditions, and community-based services. Even with local MHA and MRA providing preadmission screening, the

¹¹ *Texas: Where We Are and Where We Are Going*: Texas Medicaid Policy Summit, Texas Health and Human Services Commission, November 16, 2006

continuity of care and consumer access are problematic, with admissions of consumers far from their home community and insufficient acute care capacity at state hospitals and schools. The fact that management of Medicaid and non-Medicaid services remains separate has not helped the cost shifting and people shifting from the Medicaid programs to public providers.

- A gradual loss of communication among the public disability systems with different state structure at the Health and Human Services Commission; the linear management structure has not been replaced with horizontal collaboration that must come with multiple state departments responsible for mental health, mental retardation, and substance abuse services.
- Although there are pockets of excellence in the urban region, rural regions have suffered recruitment and retention problem and a strong market penetration by for-profit providers.

(5) Other states with relevant experiences:

New Mexico:

New Mexico took on a major collaborative initiative at the state level under the leadership of the executive office, and its state collaborative planning has been well documented elsewhere¹². However, the progressive state leadership requires support from other public partners at the state and local levels; so far the jury on New Mexico's reform efforts is still out.

Some historic characteristics may play a major role in how successfully New Mexico can revamp its public system to become more community based with more horizontal integration among all service systems, while continuing to rely on private managed care organizations to provide utilization management. New Mexico is also interested in bringing evidence-based best practices to the state for both adult and children's services. Its State Collaborative Initiative had a good start, however, the key architect

¹² Transformation of a Behavioral Health System: The New Mexico Evaluation Project, The MacArthur Foundation Network on Mental Health Policy Research, November 21, 2005.

of the effort has left the state, and its continued stewardship will need to be carefully scrutinized.

Arizona:

Arizona implemented its 1115 Medicaid waiver in 1981 without having any fee-for-service system experience, and its behavioral health waiver program began in 1992 with the creation of five regional behavioral health authorities (today the state has more than five regions, if the Indian tribal regions are counted as well). The management of behavioral health at the state level is through the Bureau of Behavioral Health (mental health and substance abuse), which is part of the Department of Health Services, whereas mental retardation is managed by the Office of Long-term Care and Disabilities.

Although Arizona is considered a pioneer in launching an ambitious Medicaid waiver program, its state statutes have not addressed the governance issue as the state entered into a capitated managed care environment. In fact, the state statute is silent on the roles and functions of state and regional authorities¹³:

Areas of clarity:

- It allows the state the option to either contract with a management entity or service provider
- It requires the regional authorities to manage state hospital beds
- It allows the state to operate regional authorities when circumstances require a takeover
- It stipulates minimum capital requirement for operating a regional authority.

Areas of ambiguity:

- It does not describe whether the “authority” function differs from provider function

¹³ Arizona Revised State Statutes, Chapter 34, Division of Behavioral Health, 36-3410; Regional behavioral health authorities, 36-3412; Contracts.

- It does not address how the state's direct contracting with providers would affect the regional authority structure
- It does not explain how regions collaborate, especially around movement of consumers from one region to another
- It does not address consumers' role at the state or regional levels.

This lack of statutory guidance, coupled with an aggressive business marketing strategy and loss of the original reformers at the state level (who interestingly left state agencies to join private sector managed care companies), has meant that the state and regional authorities have had to go through necessary adaptations, some of which have led to questionable practices. Some characteristics of the change process from 1992 to 2006 are telling:

- The state authority, without providing policy guidance, assumed that regional authorities would be ready to take on delegated functions; in the first ten years of the regional authority structure, monitoring and oversight at the state level was weak to non-existent.
- Both the state and regions used "contractual governance" to manage the provider network; the result has not been satisfactory. For example, when Value/Options took over the management of the largest regional authority in Maricopa County, the state contract neglected to stipulate the deployment of the profit margin or separation of the provider role from the authority role. The result has been that Value/Options did not reinvest a portion of its profit into the community until the state belatedly amended the contract. Furthermore, by being able to operate case management and outpatient clinic services, Value/Options generated high billings, causing the state to reexamine whether conflicts exist in a capitated program that serves a dual role of management and provider. These deficiencies were corrected in the new RFP issued in 2007 for Maricopa County; however, there are other regional behavioral authorities with similar issues.

Washington:

Washington State implemented the 1915 Medicaid waiver in 1995 and established the Regional Support Network (RSN) to manage mental health services. Its DD and SA services are managed under a different structure.

During the initial years, the state authority learned to be smart purchasers the hard way; its purchasing practices have gone through several generations of modifications. Some lessons can be drawn from the state's experiment at improving state and regional governance:

- None of the RSNs are for profit entities.
- There are variations in the ability and capacity of the RSNs; some have been able to demonstrate good quality management and service improvement.
- A parallel initiative, No Wrong Door, has been implemented at the state level to address consumers with multi-system needs.
- The state authority has dedicated training funds to shoring up the regional capacity; the state has invested in quality management and regional capacity for managing the provider network.

B. Findings

Information gathered from the scan has been analyzed below according to the key study questions:

Level of authority: What is the balance between state and regional/local authorities? How have states achieved a proper balance? What processes have States employed to implement the state/regional/local governance? What functions are being assigned to different levels of the public system?

In actuality, there is no perfect balance or equitable distribution of power; whoever pays the most holds the most leverage, so the state authority is always respected. The critical issue for most states is clarity rather than a balance of power. All of the sampled states

have attempted to define the roles and functions of state and local/regional authorities either in statute (Ohio, Georgia, Texas) or in state plan (Arizona). Clearly, not all states have used legislation to guide their reform efforts, though having statutory base provides the clarity that might otherwise be missing.

Next to clarity, what is essential is the recognition that authority and control can take many forms in the current environment. It is no longer practiced as a linear administrative fiat, but a collaborative process that encourages open communication, exchange of ideas and strategies, and ownership of problems. One may argue that the existence of authority does not make or break a reform, but a shared commitment and willingness to set aside power or turf battles for the sake of the common good would. It also lies in the understanding that authority and power come from achieving excellence, for only then is there true leverage. Achieving excellence with results in improved service delivery is the ultimate test of authority. Celebrating each other's success is another test of true partnership.

Service delivery structure: How do other states ensure responsiveness to local needs and statewide consistency when a regional/local structure is employed? Is there an optimum number of regional/local entities? How do community services interact with hospital/institutional services?

The number of local/ regional entities can range from five (Georgia, Arizona; Arizona has additional tribal behavioral health authorities), to thirty-nine (Texas), to fifty-five (Ohio). Despite the interest in achieving economy of scale, many states have traded off economy of scale for the need to maintain local ownership, which is more important if county government is to play a significant role in financing and monitoring the delivery system.

One critical finding regarding regional structure is that to the extent it is an extension of the state authority, it is vulnerable, at risk of funding cuts, and has a high potential for loss of capacity to carry out regional functions, as in the case of Georgia. Regional

structure overtime has a tendency to lose its intended neutrality; instead of being the neutral arbitrator and technical assistance arm, it often becomes co-opted by the local entities. Georgia's regional entities were reduced from nineteen to five over a ten-year period, resulting in dismantlement of the regional capacity to effectively provide quality management functions; some regions in Georgia manage as many as forty-four counties.

Management of services in the community, a key function of any local/regional governance structure, should include effective management of state-operated hospitals and institutions. Ohio and Arizona have done the best, and even Georgia, with a diminishing capacity at the regional level, never relinquished this role for the regional office. Effective interaction supported by a clear and strong incentive/disincentive mechanism is necessary to avoid the continuation of the divide between a state hospital/institution system and community-based system.

Finally, in managing statewide standards with local and regional governance structure turned out to be the least of the problems facing other states. There is little ambiguity about state standards, and the responsibility of the state in establishing them. In states where governance is no longer a debatable issue such as Ohio, the state routinely invited local boards to the table—sometimes providers as well—to deliberate on changes or adaptation of standards. What is being discussed as the next generation of reform in more progressive states is improving not just the structure, but the content of services delivered, and the need for regulatory reform to keep pace with service reform.

Managing Medicaid in the changing environment: Where fee-for-service Medicaid is the driving force, how do states manage to implement certain regional/local governance functions without losing statewide characteristics or compliance with “any willing and qualified providers”? How do public governance structures at the state/regional/local level ensure access of all consumers, not just consumers with Medicaid eligibility?

Medicaid has become the primary funding source for the public MH/DD/SA system, and Medicaid policy inevitably affects state policy in terms of how public disability services

are funded and delivered. Ohio offers a good case example of how local boards can play a significant role in managing Medicaid services, even when the providers submit claims directly to the state Medicaid agency, by employing the following strategies:

- When Medicaid and non-Medicaid funds are managed together by a local or regional entity with strong clinical and fiscal competencies, the ability to influence the services delivered by providers, including services to non-Medicaid consumers, is enhanced. Private providers are less likely to deny services to the indigent poor when the same entity also funds their state and locally funded services. From the boards' perspective, this gives them the ability to assure quality of services from the providers.
- Developing standardized utilization review protocols so that providers and consumers receive consistent treatment. The development of such uniform utilization review protocols for Medicaid fee-for-service programs is a joint venture between the State Medicaid agency/Department of Mental Health and local boards in Ohio.

Many negative lessons come from separating the management of Medicaid services from non-Medicaid services. For one thing, as Texas has proven, it perpetuates a two-tiered system of care and reduces the public system's ability to manage scarce resources; over-utilization can easily occur in fee-for-service Medicaid programs while under-utilization often results from managing non-Medicaid services. More significant is the ability of the local management's ability to "influence" the providers in serving indigent poor when the same provider's Medicaid funded services are being managed by the same local management entity. Conversely, when both Medicaid and non-Medicaid funds are managed by an outside vendor, as in the case of Georgia, the state funded services suffer as a result of increased paper compliance and a tight authorization system that may be inappropriate for some services, such as residential support and psychosocial rehabilitation.

Interplay between state and local counties: What role do counties play in the transformation? Should counties be required to fund certain services? What is the relationship between state and local governments in monitoring and oversight?

To the extent that the county governments contribute financially to the public disability system, they will be more engaged in the performance of the delivery system. This is true regardless of the size of county contribution. Ohio does the best because of the unique local levies generated for mental health, addiction services, and mental retardation and developmental disabilities.

The second most important aspect of the county's involvement is in governance structure. Other than Arizona, all sampled states have provisions in their state statute that require county involvement in governing board membership and appointment of local directors.

Where county government is closely involved in sharing the monitoring role, the states have relied on the counties to take action when regional entities fail to deliver. This is the case in Pennsylvania's county-based system. In Ohio it is the local/regional governing board that takes action; dismissing the executive director is up to the board, but finding that the entity fails to deliver essential functions is up to the state, based on a set of performance measures and criteria and some audit/review findings. The state may also evoke receivership and take over the operation of the entity—or seek another entity to take it over. Arizona did so when its regional entity ComCare in the Maricopa region failed to become solvent. North Carolina has twice used the receivership authority in dealing with troubled area programs.

However, in all circumstances the state must prepare itself by establishing the following:

- A set of performance measures and indicators that are simple and meaningful, and grounded in the level of maturity of the system
- Clearly spelled-out incentives and penalties for the local partner, provider network
- Some auditing capacity to perform necessary review functions

- Close communication and monitoring so that early warning signals can be identified and dealt with
- Some technical assistance capacity to intervene when necessary

Underserved and gaps in services: How do states address the gaps in services? How is the provider network for substance abuse developed overtime? How are the indigent consumers being served? How is the safety net being addressed?

For the most part, if the regional entities are at full risk for developing the provider network, as in the case of Arizona, the state does not involve itself in provider network development. However, even in Arizona, the state continued to issue RFPs for training activities and other statewide functions, such as contract with consumer-run organizations or peer support programs.

Some trends can be identified:

- It is beneficial for the state to preserve some leverage in developing a cross-regional provider network that has been found to be insufficient, as in the case of substance abuse services. However, in doing so, the state needs to bring the regional/local entities to the table. In Ohio, for example, the Department of Alcohol and Drug Addiction Services has continued to issue RFPs for alcohol and drug prevention services, and routinely encouraged statewide providers to enter under-served areas. Ohio state authorities routinely meet with local boards and statewide provider organizations to hammer out certain pending changes. As a result of cutbacks in the regional budget and thus its capacity, the Georgia central office took over issuing private provider RFPs from the central office, while the CSBs' grant-funding will cease beginning in 2008.
- Certain services such as acute care or crisis services have a wide geographical reach and may cover several regions, in which case the state may step in to promote provider network development.

States have generally spelled out the “floor” the regional/local entities should assume, and used these basic expectations in their contractual agreement with the regional entities. This is true in the states surveyed with the exceptions of Georgia and Texas.

Once the floor is set, it behooves the regional/local entities to develop plans that address their unique regional needs. There should be some built-in local variations of the delivery model, especially in rural America (note, in Arizona, the tribal system and rural design are acceptable variations). In Maricopa County, Arizona, the regional behavioral health authority emphasizes supported housing as one added priority based on the increase of population in Maricopa County (one hundred percent increase over the last ten years). In Ohio several local boards have established unique screening, triage, and referral programs that are locally driven and designed. In Pennsylvania the design options for urban and rural zones are different. This is not considered inconsistent with the state standard because the standard has already included such variations. Consistency, rather than uniformity, is the driving principle. Overtime the state has become more comfortable in fostering local innovation within the general framework.

Improving services to indigent consumers is an area that none of the sampled States have done well. Even in the capitated environment such as Arizona, serving the indigent is constrained by available public resources. However, part of the indigent group is also the priority group for the public system; their poor access is sometimes affected not by available funds, but by the availability of competent and willing providers to serve them.

Major barriers to reform: What major obstacles have been encountered in the states’ transformation effort? What can be learned from them? How have other states managed the change process?

Two major barriers have confronted the sampled states: resources and political will to change. The former addresses the necessary financial support for reform, especially during a transition period—moving to a new policy direction may not produce cost savings during the initial years. The latter deals with the ability at the policy and

leadership level to make necessary, though unpopular, decisions. Ohio had support from its political leadership and agency leadership during the early years of the reform, but this will to change was no longer strong enough to move forward with the Medicaid 1115 waiver reform when the legislature declined to support the waiver. Georgia never had neither the required resources nor the political will to implement its regional structure and has suffered as a result.

In addition to these two major barriers, two less obvious but equally important barriers have also affected reform at the state and local level.

The first is lack of appreciation for the cultural change that must accompany most statewide reforms, namely, changing the habits of the mind and the heart at all levels and a willingness to reexamine prior assumptions and practices. This cultural change or lack of can have serious implications for the success of the reform. For ten years after the statewide Medicaid waiver was put in effect, Pennsylvania struggled to develop capacity in new ways of doing business at the state and local levels, and it is still a work in progress. Many of the struggles experienced in other sampled states are related to changing practices in business and service delivery.

The second is lack of understanding about forming a new partnership with all key players, including providers. Providers must be seen as important allies—and be held accountable when they fail to perform. The more the providers—for-profit and nonprofit—can rise to the occasion to serve the consumers, the more the reform will produce a win-win outcome. In the end, consumers benefit from those providers who are competent, cost effective, but above all compassionate and accountable to the public payers. Pennsylvania, Ohio, and Georgia have learned to work with their providers as partners with the clear understanding that while public accountability rests with the public system, the providers must share the responsibility for carrying out the public mission.

There are no clear strategies for addressing cultural change that can be discerned from these state examples, but rather a willingness to communicate about change, and to

understand that a certain amount of tension is healthy and necessary—as long as the change tasks are being carried out effectively.

Given the experiences from the sampled states, a final comparison between North Carolina and the selected states can now be made, as shown in the diagram below.

	Georgia	Ohio	Pennsylvania	Texas	North Carolina
Clarity	Low for community services; medium (for state hospitals and institutions)	High	High	Low for community services; medium (for state hospitals and institutions)	High in the original HB 381; not in implementation
Balance	Higher state control	Equal, slightly more local control	Equal	Higher state control	Shared governance, but clear state control of resources
Manage change	Medium	High (1980s) to low (1990s---)	Medium	Low	Low to medium
Services to consumers	Medium improvement	High improvement	Medium improvement	Uncertain	Uncertain
Comment	Good efforts at acquiring new technologies	Good at maintenance	Moving forward on all fronts	Moving slowly on the next phase of system improvement	Rocky course of change

C. Key lessons

It is obvious that North Carolina’s reform implementation was more complex, challenging, and multi-dimensional than the other states sampled:

- It covered all three disabilities concurrently, facing the challenge of responding to the differences in needs and characteristics between mental health and substance, both recovery-oriented; and developmental disability, habilitation and long-term care oriented.
- It changed the governance by divesting direct services, a dramatic transformation.
- It entered a Medicaid rehabilitation option by adopting new service definitions in the midst of a system transformation, thus introducing additional changes and the need for adjustment.

North Carolina can learn some valuable lessons from other states as well.

Lesson One: Most system reforms take time and effort, and the results may not be realized during the initial years.

Many of the sampled state are still tinkering with their reform direction decades later. For example, even with the relative ease in assumption of local authority functions because the local boards never had direct service provision responsibility, Ohio has still had to learn how to achieve balance of state and local governance. Currently the state roles are clearly defined in providing State standards, financing mechanisms, and quality management through a new consumer outcomes initiative that was implemented in 1999. Though still numerous in number, the local boards have also found close linkage to local communities and county structure that has provided the necessary stability. The local boards are considered the first line of local accountability.

It has taken Pennsylvania ten years to complete the partial phase-in of all counties in the 1915 Medicaid wavier program, and both Georgia and Texas have never stopped making changes to their service system during the last ten years.

Lesson Two: Managing gaps in provider network requires strong state authority intervention, whether or not the local/regional authority is in place

Certain critical policy and program directions, especially in transforming the delivery system, must have a strong state stewardship and support. In all the sampled states, the state has retained some role in issuing RFP for statewide training, consumer-run or consumer-sponsored services, technical assistance, and sometimes underdeveloped services such as addiction services, crisis services, and prevention services. Sometimes this is a stopgap effort; other times it is to make certain corrections of inequity in developing the provider network.

The lesson from the state examples is the process of consultation the states used in filling service gaps. It is not done in isolation, but a result of consultative dialogues with the regional and local governing entities and sometimes providers as well. This is a good

strategy to avoid miscommunication or mistrust of state intervention. When the state's intent and method are transparent, there is less likelihood of opposition.

Lesson Three: The involvement of counties, especially in funding the administrative infrastructure and services, goes a long way to assure local ownership of the public disability system.

Without a doubt, there is more county ownership—thus engagement—in Ohio because county funds support many of the services, and county priorities, voted on by local citizens on regular intervals, are treated with the diligent attention that they deserve.

Proponents of the county model would argue that the challenge is necessary and the slow pace acceptable in order to promote ownership and shared vision. Others would argue that there is a lack of expediency in reform, especially when counties are given the first right to apply, as in the case of Pennsylvania. The truth is somewhere in between—there is a necessary trade-off when more parties are involved, but in the end it may be the prudent direction in order for any system change to take root.

What is significant in Pennsylvania is that the state and local authorities operate as true public partners, and when there is a shared vision and strategy, this can be a potent force for change.

Lesson Four: The state and local authorities have had to learn how to navigate in a new environment where public/private partnership is the dominant mode of service delivery.

Independent of past history of implementing reforms, most state and local authorities have had to “learn by doing” in a new environment when the private sector has played an increasingly critical role in either service provision or service management. Very few guideposts are available, and those that have been available elsewhere may not be applicable to a particular state or local conditions.

Though the Medicaid waiver programs have brought expected savings and a more efficient delivery system to Pennsylvania and Arizona, it is with some recognition—and

cost—that certain unanticipated consequences are inevitable. Pennsylvania initially had to modify rates for MCOs. In 2003, when the state changed its phase-in plan to introduce an enhanced primary care case management program to HealthChoices, the Coalition of Medicaid Assistance Managed Care Organizations advanced an opposite policy argument to show that the MCOs have provided quality services and should not be replaced by primary care case management program¹⁴. In Arizona, the state had to modify its REF provisions so that for-profit entities entering the regional authorities would not be given provider and management roles, and that there is provision in the contract for reinvestment of profit margin into the local community.

This means that “public/private partnership,” a loosely used term in the new environment, should be grounded in a clear understanding of public accountability. No private vendors can be completely expected to carry out the public mission nor can they willingly comply with the public mission unless the accountability is specified in contracts. In other words, in the increasing involvement of the private sector in managing and delivering public services, contract management has become front and center as a required competence for the state and local authorities. The public sector can only exercise its governing function through contractual governance, for private companies will not deliver more or less than what is stipulated in the contract agreement.

Lesson Five: As more private providers enter the public system, serious attention should be paid to how ALL providers are being developed and monitored, so that Medicaid providers should not be treated differently from non-Medicaid providers, and consumers with similar needs should not be provided services that are widely apart in terms of levels and intensity.

No state, independent of its reform history, can avoid dealing with the increasing participation of private providers in public mental health, developmental disabilities, and substance abuse programs. The landscape has changed vastly over the last two decades, and states need to understand that while services can be outsourced, governance cannot

¹⁴ *Comparative Evaluation of Pennsylvania’s HealthChoices Program and Fee-for-Service Program*, Coalition of Medical Assistance Managed Care Organizations, May 2005.

and should not. Unless attention is given to providing the same degree of scrutiny as well as the support in filling service gaps, the market force will shift consumers and costs from one area to another.

In the increasing participation of private providers in Medicaid services, there will be an impact on services to indigent consumers. Unless the State has 1115 Medicaid waiver such as Arizona, certain safeguards should be planned so that mission-driven and safety-net providers can be nurtured and developed, especially in rural regions, and all providers taking on an equal share of the service burden is supported by regulatory changes. While the non-Medicaid funded services may not have an enhanced benefit package, the gulf between Medicaid and non-Medicaid programs should be narrowed, to closely align with consumer needs.

An important consideration is the increasing role MCOs or Administrative Services Only (ASO) firms play in the new environment. The last two decades have seen mergers and acquisitions that have resulted in fewer behavioral health firms available in the market place. States that have had contracts with these large firms have all discovered that their organizational capacity for entering a new public market is not unlimited, constrained by their ability to attract locally available professionals to perform the tasks. Although these firms have brought standardization to the states, and are generally welcomed by Medicaid agencies, they come at a cost of doing business, especially when there is usually a learning curve in start-up and capacity building. The unanswered question is whether the cost savings is matched by improved consumer and service outcomes. That being said, there is no denying that their presence is usually supported by state policymakers.

Lesson Six: Past roles and functions, as well as the culture of practices, cast a long shadow on the public system; some habits do not disappear

All states have demonstrated the difficulty in changing traditional practices in the public system. Even in Ohio, provider development has been stymied owing to the local boards' tendency to support the same providers over time; many boards do not issue RFP, relying on past contracts and Medicaid certification to enroll providers. The result is that

evidence-based or exemplary practices are more difficult to develop. Ohio was also late in seeking the Medicaid Rehabilitation Option (2006) in spite of its long history of the traditional fee-for-service program. In Georgia recent fidelity reviews showed that although some new services have been introduced through the state's Medicaid Rehabilitation Option, in practice many providers still followed the traditional approach and shied away from in-home support, mobile crisis teams, or community support grounded in recovery principles. The states that have implemented Medicaid Rehabilitation Options have all struggled to improve the ways that providers deliver evidence-based practices; changing the labels of the services rarely touches the fundamental content of the services delivered, but persistent training and re-training, followed by workforce development, can achieve the intended results.

V. The LME Implementation

This section will describe the tasks and results of LME implementation, based on the June and July site visits to seven LMEs and review of background documents, as well as interviews of involved leadership and staff at the state and local levels. None of the seven LMEs will be referenced in this report, consistent with the review purpose and protocol used for the study; however, common issues identified during the on-site review will be treated as representative of the LME implementation experiences.

A. Review Process

Each LME was given a copy of the areas of inquiry used for the review and asked to set up individual and group interviews and meetings with key players involved in the LME implementation. The following groups have been invited to participate in individual or group discussions with the consultant:

- LME CEO and management team
- Board members, including county commissioners, managers, consumer and family representatives, and others
- Consumer and Family Advisory Committee members, consumers at large
- Consumer Rights Committee
- Providers of MHDDSAS; some cover multiple LMEs
- Community partners, including representatives from school districts, social services, juvenile justice, criminal justice, local judges, and health/public health agencies. In some cases, community partners participating in System of Care for children and youth were invited.

The on-site review began with an entrance meeting with the LME management team to go over the purpose of the review, and ended with a wrap-up meeting with the management team, during which the consultant shared general observations and clarified issues that surfaced during the group interviews. LME management and staff had the option of joining the group meetings, but many chose to be excused to allow for open

dialogue. In one case, a member of the LME board sat through all meetings with community partners, consumers, and providers. Where necessary, the consultant made follow-up contact with individual LMEs to clarify information gathered.

All seven LMEs welcomed the on-site review and the opportunity to share their implementation experiences, and the consultant received full cooperation and assistance during these site visits.

B. Implementation Tasks

Information collected during the LME review has been incorporated with information collected from DHHS, LOC, and statewide groups (consumers, providers, NC Council). Thus the following is a composite description of varied perspectives on the LME implementation experiences.

Rather than providing a linear historical review of the implementation process, the analysis focuses on major LME implementation tasks that have bearing on the outcomes of the system reform:

Planning

Soon after the passage of the HB 381 Mental Health Reform Act and Governor Easley's signing it into law on October 15, 2001, the first order of implementation was the development of a state plan, to put in place statewide guidelines on major building blocks for the LME development; namely, the definition of targeted consumers in mental health, developmental disabilities and substance abuse services, guidelines for local planning and business plan development, and state reorganization, among others. There was wide participation in the development of the first state plan. The DHHS and the Division held regional public forums to invite comments from consumers, advocates, community partners, area programs, and county representatives.

A similar process also took place at the local level, in consolidations and local business plan development. The area authorities and county programs held public meetings with

their stakeholders to seek comments and suggestions. Though the degree and scope of participation varied from region to region, the local business plan development was an important vehicle for the local counties and their communities to design a future course. The state plan is updated annually; the local business plans, developed every three years, are updated quarterly.

A retrospective review of the planning process showed that despite the early active engagement of all players in the planning process, there has been some fatigue regarding all the routinely required reports, partly because of the lack of connection between planning reports and implementation—this is felt most strongly when the challenges in the present reality are left unresolved. There has also been a tendency to equate planning with compliance—the plan became the mandated product to meet requirements with their stringent timetables—instead of an instrument for addressing short-term and long-term goals, especially for confronting mounting challenges in the system. This has been most striking in the last two years when the relationships among the public partners—the DHHS, LMEs, and the LOC—have deteriorated. None of the plans addressed how the public partners should work in unison.

In reviewing the state and local plans developed over the last five years, some areas have not been fully addressed:

- The development and delivery of core services for all citizens was barely mentioned in the state and local plans, resulting in the current ambiguity about STR (screening, triage, and referral)—whether it should be statewide, LME-specific, or even county-specific, and whether it should be managed by each LME, combined LMEs, or an outside vendor.
- The problem with divestiture—the transition planning—was mentioned in the *2002 State Plan: Blueprint for Change*¹⁵ as a gradual process to ensure transition of individual consumers, staff, and the programs. However, for consumers who are non-Medicaid indigent, or not eligible as a targeted population, the plan noted

¹⁵ *State Plan 2002: A Blueprint for Change*, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services, July 1, 2002.

that “many community groups and organizations across the state that have long histories of helping people who need human services and supports”¹⁶ There was no corresponding reference in the local business plans to offer effective strategies.¹⁷

- Tools or design options necessary to assure consumer access across the state were not given any emphasis in the initial plans. Many were developed late and some are still awaiting development.
- The needs assessments and service gaps were not performed until several years into the reform, in 2006.
- Not all LMEs addressed needs assessment or service gaps in their business plans

Now that the state’s new strategic plan has been issued,¹⁸ follow-up activities have centered on how the state’s strategic objectives are being addressed in the local business plans. A parallel to the state and local planning process and documents produced has been the development of a state/LME contract and provider boiler contract, and more recently the MH/DD/SAS Community Systems Progress Indicators, which was produced in response to S.L. 2006-142 (HB 2077) that directs the DHHS to develop critical indicators of LME performance.¹⁹ The state’s new strategic plan and performance indicators are documents prepared in response to a legislative mandate.

What all the public partners need more urgently is an effective forum to resolve the barriers of the reform. It is obvious that unless trust and confidence are restored, complying with reporting requirements does not produce any real progress. It has forced those responsible for implementation to live in a parallel universe, doing what needs to be done and fulfilling paper work requirements, while continuing to struggle with unfinished tasks. Currently more reports are being demanded by the LOC because of the lack of

¹⁶ *Sate Plan 2002*, p.62.

¹⁷ Providing core services in HB 381 was considered a shared State and local responsibility, “within available resources.”

¹⁸ *Transformation of North Carolina’s System of Services for Mental Health, Developmental Disabilities and Substance Abuse: The State Strategic Plan: 2007-2010*, April 27, 2007

¹⁹ *MH/DD/SAS Community Systems Progress Indicators*, Report for Third Quarter SFY 2006-2007, January 1-March 31, 2007, NC DMH/DD/SAS, May 31, 2007.

confidence in the state's ability to carry out the reform tasks which then places the rest of the public system in a reactive mode, meeting unreasonable time tables for completing a succession of reports, or adjusting to changes in state guidelines without sufficient deliberation and planning.

Consumer Access

The reform legislation was intended to improve consumer access by first defining the priorities for using the public resources (targeted populations); assuring a floor of core services for all citizens of North Carolina; and finally, by establishing a local management entity to develop a competent provider network and monitor the quality of services. To improve access in a Medicaid fee-for-service environment, the design was to build on the success of the DD system's single portal by introducing a uniform portal for all three disabilities, defining the uniform portal process as "standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State plan."²⁰ In the subsequent legislation to further define the LME functions, the service management function was further clarified: "Utilization management, utilization review, and determination of the appropriate level and intensity of services including the review and approval of the person centered plans for consumers who receive State-funded services. Concurrent review of person centered plans for all consumers in the LME's area who receive Medicaid funded services...Authorization and the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver."²¹

In HB 2077 passed in 2006 the question of consumer access was addressed through the Screening, Triage, and Referral (STR). This became problematic in an "any willing provider" environment, and when dispute rose over the readiness of the LMEs to assume utilization review of Medicaid funded services, the state chose a statewide vendor in the summer of 2006 to perform Medicaid utilization review function, thus setting off a storming relationship between DHHS and LMEs. The cost overrun of Community

²⁰ HB 381, 122C-115.2, (c)

²¹ HB 2007, 122C-115.4, (3), (4)

Support services during the last few months, and the subsequent involvement of LMEs to perform post-payment audits and full endorsement have placed the public system in a crisis management mode. It is clear from the initial findings of the audits that consumer access to quality of services has been compromised and that the access system in a No Wrong Door environment requires modifications.

In discussions with consumers, advocates, and providers, feedback about whether consumer access has improved or not has been mixed. On the one hand, the affirmation of public policy in terms of use of public resources has brought more discipline into the service system, and the inclusion of “targeted populations” into state funds (using the Integrated Payment and Reporting System, IPRS) and Medicaid reimbursable services, is mostly welcomed. On the other hand, by defining what the public funds will give priority to removes the flexibility of the old system, when area programs were able to shift fund balances to serve the indigent poor. The reform did not have an answer for this group, primarily because of the limited resource base, and the lack of safety net in other segments of the service system, including parity of insurance coverage. To provide safety-net services, which the recently issued State Auditor’s report highlighted in its performance audit of New Vistas-Mountain Laurel, Inc.,²² would require support from more resources and change in state policies. To expect the state or counties to provide safety net functions for all comers would require an infusion of public funds that may not be feasible in the short run. To require all providers to provide services to indigent or challenging consumers would take draconian changes in practices and financing.

The problem with the safety net is more complicated than just resources. It is not successfully dealt with because of other barriers as well—the lack of expertise or willingness to serve consumers who pose challenges, those who are homeless and mentally ill, those with severe addiction problems that must be engaged in a timely manner for them to stay in treatment, and those children and adults with multiple system needs.

²² *Performance Audit: New Vistas-Mountain Laurel, Inc., Mental Health Service Provider*, Office of the State Auditor, May 2007.

The opening up of more providers in the field has an interesting consequence for consumer access. The choices have been increased for mental health consumers not so for the consumer of addiction services, and the quality of services is in doubt when consumers do not have adequate information about the providers or services. The result is that many consumers are more confused about where to go for services, especially consumers that are challenging to serve. The ease of No Wrong Door in the “any willing provider” environment has meant No Right Door for some who are denied access by providers who chose not to serve the non-Medicaid or challenging consumers.

An area often overlooked is whether having more choices has empowered the consumers, especially those with Medicaid eligibility. Experiences in other states have shown that they are in the driver’s seat, and can exercise their freedom of choice by changing providers. This is probably true with eighty-five percent of consumers. The real access problem is with those fifteen percent consumers who have had difficulty accessing services in the past, and those indigent and challenging to serve. The LME implementation needs to focus on them.

LMEs have implemented the STR function based on general state guidelines issued in August 2006²³. In this policy memo, STR performed by the LMEs include all consumers while stipulating that consumers may, at their choices, also request a screening from a provider. If a provider does a screening for a Medicaid-eligible consumer whose services will be authorized by ValueOptions, they must submit the consumer registration to LMEs within five days of enrollment. The intent is to ensure an open environment for any willing provider to provide the new service definitions, with utilization management performed by a private vendor. In April 2007, the State announced a modified authorization process for Community Support services, to be effective July 15, 2007. Some of the changes were meant to improve the current design of a two-tiered UR system.

²³ Enhanced Services Implementation Update #14: Uniform Screening and Registration, Memo from Director Mike Moseley to the field, August 10, 2006, DMHDDSAS, DHHS, North Carolina.

It is not possible to evaluate the effectiveness of the current STR system managed by LMEs because of two unsettled issues: Until recently, the LMEs have had no ability to track consumers entering Medicaid system served by private providers in terms of services authorized and utilized (Although DMA has recently shared Medicaid data with the LMEs to improve the LME's access). Secondly, expectations for LMEs still to be clearly communicated and LMEs should be held accountable to these expectations; LMEs have leverage on some but not all triage decisions. For example, many of the STR calls come from indigent consumers, and ones most time-consuming for triage are consumers who are discharged from state hospitals and facilities, and consumers the providers refused to serve because of the level of difficulty. LMEs use persuasion and advocacy to finalize linkage, but do not always succeed. Most intriguing is that even the Assertive Community Treatment (ACT) team refused to take on certain consumers, whether or not there is a reimbursable service. Thus the current access problem is more complex than simply having sufficient resources to pay for such services; even for targeted consumers access is a problem. It lies in the fact that no effective mechanisms are in place to promote a no reject/eject delivery system and adequate capacity to coordinate services for those consumers who require the public assistance.

Consumer access cannot improve until there is a clear understanding of the accountability of the providers to the payers and clear expectations of the LME performance. In an open enrollment environment with providers having the final say in the person-centered plan and denial of services to consumers without an honest brokering process or impartial assessment, problems of consumer access will continue. As the recent Community Support program cost over-run has demonstrated, many consumers are receiving services that may be inappropriate in intensity and scope. Several rural counties reported a triple increase in Medicaid expenditure since the implementation of new service definitions, mostly in the community support account. Already there is anecdotal evidence that many consumers fall into the cracks of a system that has yet to develop effective tools to improve timely access to qualified and competent providers, and there are service gaps in substance abuse services, crisis services, acute psychiatric inpatient, alternative in-home

treatment for children and youth, supported housing and supported employment, and psychiatry services in general.

Some of the concerns voiced by the consumers reflect a lack of public education about services in general. Despite the introduction of evidence-based practices through the adoption of new services definitions (note: introduction of new services does not guarantee that services are delivered as best practices because of the gap in provider competency), many people in the community do not understand the meaning and expectations of Medicaid reimbursable services such as community support, community support team, ACT, or intensive in-home support.

On balance, the review of consumer access is not all negative. Clearly more providers have entered the system, offering consumers more choices. The array of services has also increased in quantity and variety. In addition, in some parts of the state, System of Care has taken off, improving access for children and youth with multi-system problems. The downside, perhaps the inevitable growing pain, is that some valuable clinical resources have also been lost in the transformation, so that the gain in services for consumers may be minimized by these losses.

The Community Support funding crisis has brought the state and LMEs closer together: the need for monitoring and oversight is recognized for both Medicaid and non-Medicaid services, and LME's role in performing full endorsement and post-payment reviews is being supported by their state partners.

Improvement of consumer access is an unfinished task. There is a need to improve coordinated access and quality assurance of services provided.

CFAC Development

HB 381 established a State and Local Consumer Advocacy structure. Although this was never funded, DHHS in its state plan included this component to provide a voice for consumers and family members in the public system. Parallel to the state structure, a

Consumer and Family Advisory Committee (CFAC) is to be established at the LME level to provide a local voice for consumers and eyes and ears for the LMEs. CFAC is to work closely with LME management and boards, and has a close linkage to Client Rights Committee. All committees have been codified in the HB 2077 that was passed in 2006.

Since 2002, CFAC development has been a shining accomplishment in an otherwise turbulent reform process. Although many local CFACs are still a work in progress, learning more about their roles and functions, and their importance has proven to be invaluable during certain critical events.

For example, during the recent problem with Community Support, CFAC members actively sought feedback from consumers about fraud and abuse. Some CFACs are moving into developing information for consumers about avoiding poor providers.

CFACs have also been active in the divestiture process by being part of the RFP review process that rates the providers interested in doing business in the LME catchment area. Many CFACs have also sponsored Peer Counseling Specialist program and are becoming both a voice and knowledgeable source for consumers and the general public. The local CFACs work closely with their state representatives from DMHDDSAS and the statewide CFCS Committee. There are signs that cross-fertilization across LMEs has begun to take hold. All CFACs have reported their satisfaction with the LME management and staff.

There is good linkage between CFAC and the LME Board. Sometimes the CFAC chair is also a Board member, other times the Board member may be a CFAC member. Members of CFAC and the Board attend each other's meetings.

Concerns from CFACs are more about the amount of paperwork that passes through them (some not jargon-free), and the short time frame they were given to approve them. They acknowledged the lack of control of the timetable by the local LMEs. Also CFACs are at different stages of development; those at the beginning stage are struggling with

recruiting interested consumers and advocates and finding meaningful tasks to keep the new members engaged.

Yet there is untapped potential with the CFACs. Consumer voice can take many forms, and an advisory body can be more actively engaged in upfront planning and consultation, as well as support to a plan or existing policy. The future is bright for North Carolina's CFACs in moving in this direction.

Divestiture

Divestiture is at the heart of the LME implementation because it concerns shedding the old identity of a provider and assuming the new identity of a management entity. It is also, without a doubt, the most difficult aspect of the reform—some would consider it the most painful task.

Some background information about the divestiture from the perspective of the work force transition:

- It was done without resolving the transition of public employees at the area programs in terms of pension benefits, future employment, or any change in the benefit structure to ease the transition. There were some early attempts with the state civil service and labor relations, but the quick pace of moving the reform bill through the General Assembly did not allow this to be resolved.
- Resolving the transition of the workforce was left at individual area program level.

A review of LME experience in divestiture has revealed some interesting approaches to be workforce transition. There are three strategies used by the LMEs:

- (1) Spin off the entire service, such as turning a program into a 501-C organization with most staff intact.
- (2) Transition the staff to the new LME or existing providers. Some area program staff were joined in smaller number and to multiple providers. Many providers were encouraged to take on former area program staff in order to ease the

transition. Many LMEs have retained some former area program employees to assume new functions.

- (3) Turn over the management and staff to another provider. All staff and services remain intact, under a new management/new provider.

Unquestionably the process of divestiture has created disruption, gaps, and loss of professional resources. Although both the state plan and local plans expected a gradual process of divestiture, the fact remains that once the policy decision was made to divest, attribution immediately occurred—to other providers, even to other states. On the pros and cons of employing one of three staff/service transition strategies, the consultant's interviews with LMEs and providers indicated the following assessment:

- Because differences in culture and practices are more difficult to integrate, some providers felt a balanced mix of former area program employees and the provider's own staff was necessary, and when the balanced was tipped in favor of area program staff, the result would be ineffective business practices because old habits die hard.
- Perception about favored treatment of former area programs by LMEs lingered with some providers.
- Divestiture resulted in a gap in substance abuse expertise at the provider level and availability of psychiatrists because many could find better offers outside North Carolina.

Aside from the challenge of transitioning workforce, the divestiture was most painful in transitioning case management out of area programs across the state, an effect that is felt more acutely today as a result of the failure in using the new Community Support program to replace the case management function. A list of problems associated with the divestiture of case managers includes:

- The loss of continuity and personal connection for consumers with a long history in the system; current Community Support is embedded in providers whose ability to manage care on the continuum—or the incentive to broker services—is lacking

- A contact point for the other community partners. Staff from local social services and juvenile justice bemoan the unavailability of help directly from LMEs whose rule has changed from a direct provider with linear control of delivering services to a management entity who must work with a network of providers to make service linkage.

Another problem associated with implementing divestiture is the lack of appreciation of the differences between urban and rural models of service delivery. In many rural counties of North Carolina, there has not been a wealth of providers willing to enter the new market, compounded by the difficulty in recruitment and retention of scarce professionals such as psychiatrists and substance abuse service personnel.

HB 381 has a provision for area programs to retain the provider role by stipulating that “the area authority or county program shall indicate in its local business plan how services will be provided and how the provision of services will address issues of access, availability of qualified public or private providers, consumer choice, and fair competition. The Secretary shall take into account these issues when reviewing the local business plan and considering approval of the direct provision of services. The Secretary shall develop criteria for the approval of direct service provision by area authorities and county programs in accordance with this section and as evidenced by compliance with local business plan.”²⁴ However, in reality only one area program took advantage of this provision. The review of this lack of interest showed that many LME have considered it but have not pursued it for a variety of reasons:

- Many area authorities or county programs—and their county partners--decided to not remain as providers, because the guidelines for implementation required that they must be under the umbrella of another LME. Reluctance to relinquish control of resources was the primary concern for not moving in this direction.
- There were no state guidelines to allow for a partial divestiture. The LMEs were given an either-or proposition to implement.

²⁴ HB 381, 2001, Section 122C-141, Provision of Services.

- The area programs were challenged by being part of a future vision of a management entity and wanted to be part of the transformation process.

Each LME approached the divestiture of services differently:

- Some waited until the scheduled time table was approaching; others moved in and divested early and completely.
- Some planned for anticipated gaps in services by retaining psychiatry, crisis services, or access functions.

For LMEs that retained some of their service functions, their business plans indicated that the divestiture is a continuing process; and yet there has never been any serious dialogue with the state regarding criteria under which LMEs may retain some of their provider functions.

On retaining psychiatry services, LMEs have used the method of “contracting out” psychiatric time to providers so that there is psychiatric coverage in the community. However, there is also increasing concern that this is hardly an attractive proposition for the psychiatrists themselves; many have gradually left the system to go elsewhere. The recent provision to receive state grants to fund the psychiatrist position is perceived to be insufficient in the current labor market.

More creative recruitment strategies are needed in the rural region, and some incentives need to be offered so that psychiatrists will work in rural areas. In addition, there is an increasing awareness that the primary care delivery system is a potential point of integration so that primary care—with better availability than behavioral health—can be tapped to offer integrated primary care/behavioral health services. Some LME areas are experimenting with the integration model.

Given the divergent experience with divestiture, a few indicators have been identified for how strongly the current LME design holds:

- To the extent the former area program was not performing well, counties have viewed the newly formed LMEs in a positive light.
- LMEs with strong leadership generally weathered the divestiture process, however, most of the former area program CEOs have been retained by the counties. This has created an interesting dynamics: it has ensured continuity but has placed the burden of the transformation of identity on the same CEO who had managed a provider agency.
- Smaller counties that have joined bigger counties to complete the merger have generally been happy with the increased infrastructure support; however, for small rural counties, the loss of community-based substance abuse services has created hardship for consumers.
- For some of the LME boards and community partners that had a positive relationship with the former area program, there has been a sense of “mourning” for the good old days. This has been compounded by the change of expectation for community partners in the new environment, as stated by one member, “We didn’t have to worry about mental health before, but we do now.”

Provider Network Development and Oversight

Providers that were interviewed during the on-site reviews had mostly positive experiences with the LMEs and felt the service authorization function performed by the LMEs was efficiently carried out, but they complained about other LMEs not covered in this visit and saw variance among LMEs. Two problems linger on for the providers:

- For providers covering multiple LMEs, the inconsistent authorization practices for state-funded services across different LMEs have made conducting business difficult and time-consuming
- Even when LMEs complete the authorization in a timely manner, the late payment cycle by IPRS made the providers shy away from taking consumers paid for by state claims. Compared to more streamlined Medicaid payments, the providers are less motivated to take on IPRS consumers. Although some LMEs have advanced the payment based on authorization and reconciled the claims after

the state fund is allocated, many LMEs have also waited for state payment before reimbursing the providers.

The problem surfaced when new service definitions were approved by CMS in March 2006 with a three-month implementation time table. Provider training was offered but was insufficient for preparing them to deliver evidence-based services. There were good intentions on the part of the DHHS to quickly transition providers by the scheduled deadline without creating gaps in services. Thus a “conditional endorsement,” a paper compliance process implemented by LMEs, was given to the old and new providers. The initial conditional endorsement addressed “any willing provider,” without much weight given to “qualified provider” to turn the process into a meaningful endorsement process of “any willing and qualified provider” endorsement process. It was also done in a compressed time frame. In fact, providers quickly received their Medicaid certification without proving their competency. With a payment structure that gives the wrong incentive—paying the same for serving consumers with or without qualified professionals—the seeds of the problem were planted.

This initial conditional endorsement process has resulted in much finger-pointing by all parties. The LMEs blamed the loosely defined state guidelines that gave them no “teeth” in rejecting providers, whereas the state blamed LMEs for having done a poor job in letting in unqualified providers. The facts seem to point to a lack of appreciation for the critical importance of this task, and the necessary time and method for completing them. The rush to implement new service definitions, the fiscal incentive for providers to bill high and offer minimum services, the inadequate training and preparation, and the lack of indoctrination of LME’s new function (many LMEs did not believe they could have denied the applications), all contributed to the problem with Community Support. The change in vendor contract to go statewide created a heavy back log of unprocessed claims and difficulty to carry out utilization management functions.

Despite the current post-payment audit by LMEs and a “full endorsement process” to weed out providers who should never have entered the market, the basic issue of LME’s

role in their future monitoring Medicaid providers has not been fully clarified. The ineffective endorsement process has also created a large number of providers in the market. In some LMEs, the number of providers currently delivering services ranges from 100 to 300. This is an unsustainable situation for several reasons:

- The scarcity of qualified professionals to deliver the services created cut throat competition among the providers, and rapid turnover of professional staff, taking consumers with them.
- Managing the number of providers has placed a serious strain on the LME resources within the current cost model.
- LMEs can only retrospectively reduce the number of the providers, but have little ability to assure appropriate consumer access to competent providers when providers are openly recruiting consumers and there is inadequate information about Medicaid consumers' entry into the services.
- Another crisis is in the making when many providers, unable to deliver services either due to post-payment payback or not meeting full endorsement criteria, will leave a gaping hole in transitioning consumers.

There is also a shared concern about the loss of substance abuse providers to the system. The number of substance abuse providers was never plentiful prior to the reform; it is even more inadequate since the reform. To bring back substance abuse providers back would take creative development strategies, even state intervention, to shore up availability at local and regional levels.

One persistent area of concern is the lack of integration between state hospitals/facilities and community-based services. Despite the stipulation that LMEs manage state hospital/facility bed utilization, the methodology of managing by categories, rather than total bed days, did not facilitate creative solutions. Nor has there been any serious discussion about the future role of state hospitals and institutions.

Any discussions of State hospital/facilities utilization should include the acute care sector, the hospital and medical institutions, as well as LMEs. Because this is an unfinished task, tackling it would require a sustained working by multiple parties toward a joint resolution.

Consolidation

When the DHHS presented the consolidation plan in the 2005 report to the LOC, the governor, and the Board of County Commissioners,²⁵ the number of LMEs had been reduced from thirty-nine at the dawn of the reform to thirty-three. Consolidation activities continued so that by July 1, 2007, the total number of LMEs was further reduced to twenty-five. In other words, the reduction was nineteen percent between 2001 and 2005, but the pace was accelerated between 2005 and 2007 by a reduction of twenty-four percent. By any standard this is an impressive record, particularly in the context of rapid change and the complexity of consolidation tasks. All public partners—the LOC, the DHHS and DMHDDSAS, the counties, and the LMEs—can take some credit for making this happen.

The statutory requirement for consolidation and timetable is in the uncodified section of HB 381, in that certain targets were considered preliminary planning goals, subject to necessary changes as the reform unfolded. This section states that the Department of Health and Human Services shall “develop a catchment area consolidation plan. The Secretary shall anticipate receiving letters of intent from boards of county commissioners on or before October 1, 2002, indicating the intent of a county or counties to provide services through an existing area authority or through a county program established pursuant to G.S. 122C-115.1. The Secretary shall develop the consolidation plan based on the letters of intent, the State Plan, geographic and population targeted thresholds, and capacity to implement the business plan. The consolidation plan shall provide for consolidation target of no more than 20 area authorities and county programs. The Secretary shall...submit it no later than January 1, 2005, to the Joint Legislative and Substance Abuse Services, the Governor, and each board of county commissioners. The

²⁵ Area Authority/County Program Catchment Area Consolidation Plan, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, February 14, 2005.

total number of area authorities and county programs shall be reduced to no more than a target of 20 by January 1, 2007.”²⁶

Local counties and area programs went through a process of negotiation so that the minimum threshold of a population base of 200,000 could be reached for LME to be established. The first group of letters of intent from counties came in late 2002, and the DMHDDSAS developed a phase-in schedule to place applications in different stages of implementation, based on the target dates proposed by the applicants. Thus since 2003 more consolidations, done with counties’ active involvement, have taken place than in the first two years.

Consolidations require detailed planning of all aspects of the organization, from financing, accounting, treatment of transferred assets and debts, as well as transfer of workforce to ensure that employees are held harmless in their benefit package, not to mention that the organizational restructuring and assimilation that must accompany the new entity are time consuming and labor intensive.

The review of LME consolidation experience showed that:

- The public sector is capable of making major organizational realignment, especially when there is solid local support.
- LMEs that have made the strategic decision to voluntarily reach out to a potential partner tend to be happy in their new union, demonstrating the importance of ownership of such decisions.
- Not all mergers have ended in happy union. The process of assimilation is ongoing.

²⁶ HB 381 An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, General Assembly of North Carolina, Session 2001, Sec 3.(a),(8).

VI. Unresolved Issues

The previous section discusses the status of key implementation tasks. In this section issues that are pending resolution will be described. So that there is a reference point for future dialogue among the public partners and their stakeholders, some suggested steps for resolving these issues are offered here as food for thought.

A. Common vision for LMEs

Because this initiative was driven by the General Assembly in a compressed time frame of a single legislative session, there have been different understandings and interpretations of the vision of the reform. The fact that it was not only not well understood by the general public, but also not fully embraced by the executive branch responsible for executing the reform has created a dynamic that has been difficult to overcome. It is fair to say that all along the DHHS leadership would have desired a different direction for reforming the system, and indeed there are other options for improving the public MH/DD/SAS system than what was offered by the legislative branch. Yet instead of addressing the fundamental disagreements, the dissension has been allowed to linger on. The LOC has not been helpful by passing new legislation to make corrections, when the basic issue about lacking a shared vision is left unresolved. In all fairness, the pace and complexity of the system reform is such that none of the public partners have had time—or capacity—to sit back and reexamine the assumptions about the reform.

To date, it is not clear, notwithstanding the legislative framework, whether there is an agreement that LMEs are essential to assuring the public accountability. This is raised here to underscore the point that a shared vision should have been clarified before the implementation began: Is North Carolina committed to supporting a local governance model with strong county involvement and oversight of all services, or is it more interested in achieving economy of scale by reducing the number of LMEs further down to five or ten, similar to a managed care model? Should the authority and responsibility

be equally shared between the state and local counties or is the state more interested in a centralized accountability system, including managing service utilization and provider monitoring? Or, has the state felt uneasy about the perceived increased support for the LMEs at the expense of state authority?

These questions are difficult to answer because the answers may not be either/or but rather a combination of strategies that can demonstrate support for shared state and local governance even in a fee-for-service Medicaid environment. Ohio has done well by keeping the Medicaid payment process streamlined, thus fulfilling the State's fiduciary role in managing an important program such as Medicaid, but decentralized the UR function download to support an integrated delivery system.

The unresolved issue of the lack of a shared vision has left a sense of uncertainty for LMEs that have already moved into the new design. Unsure of the intention at the State level, there is a certain paranoia that the remaining LME functions could also be removed, leaving them without the tools to become effective managers of the local system.

Suggested steps to be taken:

Returning to the table for an honest discussion about shared vision seems appropriate at this juncture. The governor's policy staff could be the convener of such a working group as long as there is a shared interest in an open dialogue about the status of the implementation and future direction for North Carolina's MH/DD/SAS system. Public partners participating in this discussion should include at least the LOC leadership, DMHDDSAS, DMA, county and LME representatives, to reexamine the legislative framework and to affirm or modify current vision so that the end result is a shared vision. Even when a shared vision is reached, there should be some agreement on the broad strategies used to realize the vision.

B. UR function for Medicaid

The current tasks performed by the LMEs in response to the Community Support funding crisis—postpayment audit and provider full endorsement—should be concluded by fall.

Already, provider payback has been sizable enough to lead to the closure of many in the system. Addressing the aftermath of this pending problem should be on the agenda.

LMEs have been asked to assume the monitoring role, which is one of the given functions, but there is no serious discussion about the future responsibility for managing Medicaid UR function, or a proactive strategy to manage providers that is different from post-payment audits.

This is critical because if North Carolina has learned any useful lessons from this recent crisis, it is that proactive planning must replace reactive actions. The contract with the current Medicaid vendor will be expiring soon, and the public partners should not delay having a serious dialogue about which strategies to take to assure the public accountability.

Current budget bills pending resolution have included a selection of few LMEs to be phased in to manage utilization review for Medicaid as well as state funds.

Suggested action steps are:

(a) Criteria should be established so that LMEs can prepare themselves for this function. The criteria should include whether DMHDDSAS and DMA consider only those LMEs fully divested as eligible or if LMEs with limited service provisions can assure a “credible structure”, ie, discrete service function separated from the management function, and be a viable applicant.

(b) Instead of going through an RFP process, which is essentially a process to review proposals, a readiness review should be conducted by an independent firm specialized in conducting readiness review of UR function. This will alleviate anxiety about the capability of LMEs on the one hand, and eliminate concern about the RFP process on the other hand.

(c) For those LMEs not selected for the first round, some internal and external assessment should be made to determine if with additional preparation, this function can be effectively assumed, or allow another LME to perform UR function instead.

(d) The state needs to assure coverage by contracting with a private vendor during the transition.

C. Consumer Access

Improving consumer access in the current STR design requires further resolution as well.

The current conflict seems to be:

- Consumers and LMEs—as well as LOC—prefer a single point of accountability, whereas the state has difficulty supporting it in a Medicaid fee-for service program
- LOC considers STR a front-door access, which is in conflict with No Wrong Door policy

Issues in consumer access should be dealt with before making additional changes:

- How is consumer access assured in the “any willing and qualified provider” environment?
- As long as consumers can walk into any door, where does the accountability lie? Do all consumers want such choices made by an impartial entity, or just consumers who have difficulty accessing services?
- How is giving “clinical home” to providers assure consumer access?
- Is person center planning the best way to assess consumer needs?

Suggested steps to be taken:

- (a) Reexamine existing tools for assuring consumer access

Reexamine the current STR protocol and person centered planning instrument to see if additional improvement can be made to make them simple, user-friendly and achieve the purpose of statewide consistency.

The emphasis should be on improving the decision making about making front door triage and service linkages. A process of consultation should be held with users of the protocols to make sure the mutual goals of improving consumer access are achieved.

(b) Increase LMEs' role in providing targeted care coordination for special needs consumers

Part of the consumer access problem, as evidenced by the high percentage of calls into the STR, is the difficulty in navigating access for indigent or challenging consumers. Within LME function is the care and service coordination function (some are providing care management in this function). It is appropriate to perform focused case reviews or case brokering as a discrete care management function. Now that the LMEs have had some history in performing STRs, the workload need for increasing this function should be assessed.

The purposes of local STR and regional/statewide STR needs clarification, as well as whether there should be different models for delivering STR. The statewide model used in Georgia is akin to an enhanced 1-800 crisis line with a service linkage capacity, not an access system that can provide direct face-to-face contact, with care coordination and follow-up. In Georgia consumers self refer or providers can refer to themselves. In parts of rural North Carolina, a walk-in access with trained professionals to help navigate the system is more in tune with the local culture and consumer needs. In other words, going high-tech may not work as effectively as keeping low-tech options in some parts of the state.

By the same token, some LMEs may have better capacity and expertise in carrying out the STR than others and could make the function available across the LME lines. The goal needs to be ultimate improvement of consumer access, not merely economy of scale. Nor should STR be kept at LME level if the LME performance fails to meet the basic expectations.

(c) Continue with LME's monitoring function for both Medicaid and non-Medicaid programs

This has an indirect benefit for improving consumer access, however, the approach and method of continuing with this function should be discussed so that there is statewide consistency without duplicating what has already been put in place. This should be carefully developed so that the future monitoring is based on cost-benefit analysis, and some attention should be paid to incentives for the providers as well. Not all providers are alike, and past performance, the provider's proof of competency (national accreditation, previous monitoring results) should be taken into account. In many states, a tiered approach is used to provide incentives for providers: for those having achieved a certain level of excellence, there is an award of deemed status and less frequent monitoring. Moreover, LMEs should collaborate closely so that poor performing providers would not move from one LME to another without close scrutiny.

In the end, consumer access is not merely related to quantity of services, but to quality of services as well. In this endeavor, public partners and providers need to work closely.

VII. Findings

The answer to the study question “Has the implementation of LMEs been consistent with the statutory framework?” is a qualified maybe. The LME implementation has not met the statutory intent in terms of fulfilling the LME functions, but it has met some provisions of the statute in establishing a consumer advocacy program and consumer and family advisory committee structure, consolidations of area programs based on a population threshold of 200,000 have moved according to plan, and some of the key implementation tasks are in the process of being completed.

Because the negative perception about the reform is real and alive, a balanced view is offered in this section, by laying out the facts about the accomplishments to date, and discussing the weaknesses of the implementation.

A. Strengths

(1) More funding support has come to the public MH/DD/SAS system

More funds have been appropriated for the MH/DD/SAS system since the reform began. North Carolina was ranked low prior to the reform in terms of per capita expenditure on the public MH/DD/SAS system. It is still ranked low nationally, yet there is no doubt that the General Assembly, with the support of LOC, has put more funds into the system, from the establishment of the Mental Health Trust Fund, to additional crisis service dollars, to other initiatives supported by the DHHS.

Part of the funding support also comes with higher expectations—and increased oversight. On balance, the fact that the public MH/DD/SAS are on the legislative agenda must be viewed as a positive step and an important strength of the reform implementation.

Related to the funding support is the fact that for the first time, there is a rational cost model for LME infrastructure developed by the state. Though additional modifications

may be needed, there is a better comparison of infrastructure cost and organization across the LMEs than was possible with the former area programs.

(2) CFACs and consolidations are two important accomplishments

From the implementation arm of the reform, the state and counties and their sponsored LMEs have done an excellent job in establishing a viable consumer and family advisory structure and completed an important organizational change task—the consolidation of area programs from thirty-nine to twenty-five in a short six years. It is doubtful that other states could have moved so swiftly and efficiently for a system restructure of this magnitude.

Indeed, even when the rest of the reform is on a rocky course, having two concrete tasks successfully completed can give all partners some sense of satisfaction and confidence.

(3) Small and incremental improvements have been made

Equally important though less visible, are incremental tasks performed by the staff at the state and local levels on the one hand, and consumers and advocates on the other. They are the unsung actors in this complex process. They are the ones that provide feedback to the public partners, and they share not only problems but solutions.

At the DMHDDSAS levels, two technical assistance arms important to the LMEs implementation are performing well, with very few exceptions: the CFAC representatives and the LME liaison staff. Equally important are those LME staff who have transitioned from area programs to the current LME structure and have extended themselves in developing quality management, fiscal management, provider relationship capacity, and resolving consumer access problems, one at a time.

(4) Creative solutions at the local level

There are some innovative practices at the local level that deserve special notice, from taking the System of Care model to the next level, to developing psychiatry capacity in rural areas, to using crisis services to improve triage and referrals, to working

collaboratively with local hospitals to improve inpatient acute care and emergency capacity. There are numerous examples that demonstrate that when the attention is focused on consumers, good things happen.

In this regard, counties are part of the solution as well. Many counties have put more funds into the system to fill the gap or provide a new and needed service. One of the reform objectives was to improve county ownership, and to that end, the increased ownership has taken place. The governing board provides needed local governance for the LMEs.

B. Weaknesses

(1) Taking eyes off consumers

The most serious shortcoming of the implementation is that in the rush to complete structural changes, the public partners have jointly lost sight of the most important beneficiary of the reform: the consumers. With only a few exceptions—when LMEs deliberately set up alternative strategies to improve consumer access and ease their transition, or when the LOC appropriated funds for crisis services, or when the Division standardized STR protocol—there has not been a dedicated effort to confront the consumer access problem mentioned in this report.

(2) The pace of change has been too fast and not well managed

There is some consensus that the change tasks involved in transforming a large system are not only numerous, but the demand for completing them have placed such a strain on the resources that much time and energy is wasted in fighting the changes, rather than working toward solutions. Some of the unexpected changes have sent shock waves through the system that could have been avoided or better managed.

The state has a reason to be concerned that the LOC, in trying to right the course of reform, has placed additional strictures on the very system responsible for carrying out the reform. The LOC claimed that their overreaching is to fill a gap, that without periodic

interventions by the legislative branch more problems might have surfaced. Furthermore, LOC felt concerned about being responsive to their constituents.

The real issue is that large scale of change, especially change in practices, cannot be legislated; it must come from understanding the change course and that all public partners must be part of the solution. There does seem to be an urgent need to clarify state authority's role and establish an effective working relationship with all public partners.

(3) LMEs are uneven in acquiring tools and expertise to be effective

Despite the high expectations for LME functions to be fulfilled, not all LMEs have acquired necessary tools and expertise to be effective. Partly it is a learning process, such as learning how to develop and manage a diverse provider network, but part of it is the ambiguity about their roles in the Medicaid program.

In fact, one may argue that other than the unsettled UR function for Medicaid services, LMEs have most of the functions in place, and should be expected to perform at certain level. However, for many of LMEs, the transformation has been dramatic: from a provider of mental health services to a management entity for all three disabilities. This transformation, while assuring continuity by keeping most of the former area program management staff, carries with it a challenging shift in identity and orientation—some are still struggling with the new identity and new skills required.

There are realistic concerns about the performance of LMEs. Not all LMEs are alike nor are at the same stage of development. Here lies the basic tenet of a public governance model—growth and development will come slowly and gradually when the public system is learning new skills and knowledge. Building capacity to perform effectively at the LME or at the state level will take time, and the public partners need to agree what it takes to make this happen, or not. The public partners should also agree to a contingency plans so that the functions can be developed fully by existing LMEs, or by other means.

(4) LMEs need to develop a common agenda

There is also no common agenda developed by the LMEs to show solidarity on critical issues. There is a good competitive spirit among the LMEs, but there is also a need for developing a common agenda so that LMEs can effectively enter a constructive dialogue with their state partners.

LMEs need to realize that until they can present a common agenda for problem solution, they could not be effective in developing joint vision and strategy with their state partners. Moreover, as they justifiably request more consultative process from the state, they can do much by horizontally learn from each other and share successful lessons across all LMEs.

VIII. Recommendations

As the LME implementation experience has demonstrated, trust among public partners is fragile and needs to be earned continuously. Six years later, the mutual trust and confidence has not kept pace with the demand of the reform tasks. That in itself tells most of the story about the implementation of LMEs in North Carolina.

It should be kept in mind that North Carolina is the only state at present that has a strong legislative oversight over the reform process, through the establishment of the Joint Legislative Oversight Committee. Such a structure is missing in other states, and its presence in North Carolina carries opportunities but also a certain pressure—the pressure placed on the implementation arm of the reform. On the one hand, close monitoring by the legislative branch can ensure that the needs of the public MH/DD/SAS system are being met, and appropriate fiscal support has a proper home and identity. On the other hand, the legislative oversight comes with tension in the partnership.

For the public partners to work effectively to achieve common objectives, a good and effective working relationship must exist that supports problem solving while maintaining a mutual respect for different positions taken. In the final analysis, the execution of a reform plan rests with the executive branch and with the professionals who are knowledgeable about what is required in executing a plan, yet the executive branch needs to appreciate the involvement—and intervention—of the legislative branch if the implementation is to succeed.

The good news is that during the on-site visits the consultant found a willingness among the public partners —the LOC, the State, and the LMEs and their counties—to once again restore the goodwill in working together. This goodwill is present even with those LMEs that have had more adversarial relationships with DHHS in the past. Additionally, there was a shared belief that all partners would want to make a good faith effort at trying again, to make early corrections, to change the design, to turn a new page, and ultimately, to fulfill the promises of the reform.

To this end, the following sets of recommendations are broken down to include immediate steps to be taken, short-term and mid-term tasks, leaving the long-term goals to be addressed by the involved parties. If these immediate, short-term and mid-term tasks can be successfully dealt with, North Carolina will have a shining future, demonstrating that it can be a model for other states to follow.

A. Immediate

(1) Open the dialogue about the status of the reform among the public partners and develop a forum for dealing with unresolved issues

For quite sometime there has not been serious and sustained dialogue about the pressing issues facing the MH/DD/SAS reform. Instead, parties tend to gravitate to individual deal making and closing rank for survival. This has to change, and it cannot be changed by issuing state directives or passing legislation. In fact, some of the recent changes might have modified the intent of the HB 381.

As suggested before, getting back to a working dialogue may require the participation of a neutral member of the Governor's office. Short of that, any public partner can convene such a meeting.

(2) Consolidate LME functions, beginning with business functions

With several years of implementation experiences under their belt, further consolidations of LMEs should continue to assure service improvement and cost efficiency, while addressing the basic issues about the future vision and strategies. However, for those LMEs already planning to merge, the plan should move forward.

Economy of scale should be balanced against the need for local county involvement, and reducing the size of LMEs from twenty-five downward should not compromise this principle. In addition, there are opportunities to consolidate certain business functions, especially information system, accounting and human resource functions, as well as allowing strong LMEs to take over additional functions, to achieve additional efficiency

in the public system. For close monitoring of services to consumers there is a strong support for keeping it local. Because the potential disruption to consumer access is great, the consolidation of functions should be first focused on business functions, such as accounting system, information system development, and technology improvement. Further mergers will need to take into account the relationship with counties so that the county linkage and ownership will not be lost. The state may also need to develop an incentive plan to encourage consolidation of LME functions. The state should also be able exercise its authority in developing a contingency plan in the event that certain LMEs cannot meet threshold performance standards.

(3) Develop a problem solving agenda among the public partners, and if necessary, bring in the providers

Looming on the horizon is the aftermath of postpayment audit and full endorsement process that will shake up the provider network in a major way. Some of this is part of a natural attribution, and there should not be any draconian efforts to maintain a poor performing or poor quality providers.

However, the public partners should come together to develop an effective strategy to deal with the fallout of the audits. During this discussion, attention should be given to the future of Medicaid UR function, approaches to continued provider monitoring for both Medicaid and non-Medicaid services, and to discussing the options available to all public partners.

B. Short-term Tasks

(1) Improve consumer access

This is both an unresolved issue and an urgent task and should be given the highest priority in the joint problem-solving forum. The DHHS should not be burdened with the sole responsibility for coming up with the answers; many talented people in North Carolina can come to the table to lend a helping hand, including LMEs, counties, consumers and advocates, and providers.

This task should address whether independent brokering should be restored in the local community and the ways of doing so, as already suggested in the previous section under improving consumer access. It should also pay special attention to the Medicaid rules by establishing a protocol that can protect both the consumers and the state's Medicaid revenue.

(2) Improve state hospitals/facilities and LME collaboration

The intent of the reform was to close the gap between the state hospitals/facilities on the one end, and the community-based system on the other. The grim reality is that the implementation has not dealt with this successfully, and if anything, there is backtracking from the original intent.

Efforts must be directed at resolving this problem so that consumers will not continue to fall through the cracks at both ends, creating burdens on the limited resources in law enforcement (for transportation and emergency room waiting) and state hospitals/facilities (for overcrowding and inability to admit).

This should be done with considerable care and respect for what state hospitals/facilities can contribute in the new environment. Defining their future role, including creative ways of devising safety net functions beyond the hospital/institutional beds would be a good start. Alternative use of Staff workforce has been part of the new design in States that have attempted downsizing or changing public hospitals/facilities functions.²⁷

In the reform plan where management and service provision are separated at the local level, they continue to be connected at the state level. The state hospitals/institutions represent the final safety net for North Carolinians, but their utilization has been haphazard and skewed; most admissions in recent years have been for consumers with substance abuse or short-term stabilization, with short length of stay up to seven or eight

²⁷ Georgia has developed state-operated group homes and forensic for seriously mentally ill consumers discharged from state hospitals; New York has provided workforce redeployment by developing state-operated ICF/MR and community group homes for challenging consumers, especially those with behavioral management needs; Ohio had issued a policy guidelines for use of state hospitals in the 1990s to focus on forensic care.

days and lack of continuity of care upon discharge. Seventy-seven percent of the cost of state hospitals came from State appropriation, while its utilization doubles the national norm.²⁸

The future role of state hospitals/institutions should address the need for different product lines to be provided, including the potential in developing alternative, less intensive levels of care, while maintaining the state-operated status, to transition state workforce to work with consumers who have had long hospitalizations.

These options may include step-down units, transitional rehabilitation programs, quarter-way house on the campus, and community group homes dedicated to serving the most challenging consumers. These new alternatives can then be incorporated into the community continuum of care. LMEs will still be the management entity for the service continuum.

Finally, North Carolina should arrange a consultation with Ohio²⁹ to study how they have managed the efficient use of hospital beds at the local level and consult with other states on alternative use of state workforce in other states.

(3) Increase capacity for substance abuse providers and crisis services

It is within the state authority's purview to nurture a provider network that has regional reach, serving multiple LMEs. Some aggressive outreach and coordinated RFPs need to go forward to bring in substance abuse providers, with good involvement of LMEs. LMEs need to come together and work on common issues, independent of local interests.

The apparent lack of crisis services and inadequate number of substance abuse providers have been identified by the public partners as serious service gaps, but another that has been looming is the lack of acute care capacity in the local communities to divert or

²⁸ *Legislative Briefing: Mental Health Issues*, Fiscal Research Division and Research Division, General Assembly, February 7, 2007.

²⁹ It is not recommended that the state visit Arizona because their state hospital utilization is driven by a capitated plan, which does not exist in North Carolina.

provide acute inpatient and medically managed detoxification services, followed by intermediate treatment beyond what the state short-term substance abuse treatment facilities can offer.

During this review, the consultant has identified several improvement strategies for filling these serious gaps:

- North Carolina needs to develop a comprehensive crisis and emergency services to complement crisis beds, including in-home support, emergency respite for families, mobile crisis team, crisis stabilization, and effective emergency triage for consumers with psychiatric and addiction disorders.
- For substance abuse service development, state issued RFP must be accompanied by needed expediting with the licensing board, so that credentialed professionals in other states can be given a deemed status to increase the capacity for the workforce. North Carolina has had a good tradition in growing its own substance abuse associate professionals through competency based training; such efforts should be intensified so that there is sufficient workforce available to take on the increased demand.

(4) Review the status of LMEs with remaining divestiture of direct services

Not all current LMEs have fully divested their direct service provision role. The reform legislation allowed the continuing provision of direct services based on criteria established by the Secretary of DHHS. There seems to be a need to revisit this provision to determine:

- Whether the continuation of direct services is an attempt at easing transition for consumer access, or it should be considered a permanent aspect of LME operation. If the latter, some organizational design options should be put in place to assure credibility of the structure
- Whether the LMEs, having had a few years of implementation experience, would welcome the opportunity to resume the role of a provider
- Whether there is a rural provision in the criteria developed by the state so that there are different urban and rural models for LMEs

- The state needs contingency plans to address poor-performing LMEs following a reasonable time of providing technical assistance.

(5) Address Developmental Disabilities issues

Developmental Disabilities (DD) system is a long-term care system with a focus on habilitation, rather than rehabilitation and recovery. In the LME implementation, the energy devoted to the implementation tasks has been such that some of the DD issues have not been given an equal attention. Without sufficient attention to DD issues has cost the state huge budget shortfall when DD providers provided community support services using an old CBS model.

Following is a partial list of some of the urgent DD issues pending resolution:

- The status of targeted case management

Because the approval from CMS is pending, guidelines about case management in the new service definitions are not clearly understood—should the old guidelines be used or should the new ones?

Providers who continued to provide targeted case management have also concerns about the authorization system. DD system has to comply with the behavioral health system in terms of units of service, and short time span for authorization and reauthorization—all contribute to provider cost and paper work burden, not to mention a lack of “goodness of fit” with the tenets of DD system.

- The status of DD waiver

North Carolina is under a CAP/DD waiver that probably can benefit from a reexamination. There was serious consideration for an Independence Plus waiver a few years ago, but not enough attention has been dedicated to this.

- Interaction between state DD centers and community services

The same fragmentation experienced on the MH and SA side is also being felt on the DD side. There has not been an equal attention given to this unresolved concern.

(6) Develop workforce for urban and rural North Carolina

The erosion of public psychiatry and other mental health, substance abuse personnel in the provider system is also a serious concern. The workforce development should also apply to the state DHHS and LMEs as well, so that business management and clinical management for three disabilities can be improved.

North Carolina has already developed incentives to grow the workforce in rural areas for the primary care field, and there is no reason why the same strategy would not work in the public MH/DD/SAS system. Tuition forgiveness, and collaboration with local community colleges and universities to train new workforce schooled in the evidence-based practices could be tried. Clearly, workforce development is not a short-term task, but it must be jump-started to realize long-term gains.

C. Mid-term Tasks

(1) Develop rural delivery models

The rural nature of many of North Carolina's counties demands that program designs be tailored to rural needs. The consultant heard a strong plea during the visits for not having a one-size-fit-all in approaching the next phase of MH/DD/SAS reform.

Developing rural model of service delivery should be a joint endeavor, involving consumers, advocates, local delivery system so that unique rural issues of shortage in public transportation, need to provide travel time for professionals in delivering out-reach services, use of one-stop shopping service center, use of scattered sites to perform certain outreach functions, collaboration with primary care system, should all be considered.

(2) Study the pros and cons of pursuing additional Medicaid waiver

Currently, North Carolina has one 1915 (b) (c) waiver at Piedmont, and there seems to be some interest in pursuing additional waivers. North Carolina should not rush into it, thus introducing another change in the reform process, but deliberate considerations and a study of pros and cons should be made to give guidance to policy makers.

Such a study should include the level of readiness, resources required, and, more importantly, whether North Carolina's public system can demonstrate its ability to manage another major change. Ultimately, Medicaid waiver can bring more flexibility to the delivery system, but there are also stringent requirements to fulfill. To apply for another waiver that covers either part of or the entire state will depend on the performance from this point forward.

(3) Undertake regulatory reform and paper work reduction

Throughout the review of LME implementation experience, the consultant has heard strong sentiment about the conflict between new demand for performance and the weight of old rules and procedures. Since the reform, the perception is that there has been an increase, not a decrease, in procedural and paper work burden.

This is particularly unfortunate in the diversion of valuable clinical resources from working with consumer-related issues to bureaucratic, procedural requirements, so much so that fifty-percent of the clinical resources are lost³⁰.

States that have implemented large-scale reforms have also discovered that this is the hardest part about the public sector reform: there were reasons for creating these rules and procedures, and some of the reasons are still present today. The challenge is turning the attention to tackling something mundane and exciting, but absolutely necessary in order to free up human resources for the critical task of serving the consumers—pursuing regulatory reform.

³⁰ This statistic is based on an informal poll of providers attending the focus group meetings at seven LMEs; the range given is forty percent to sixty percent.