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Independent Evaluation of the Performance of Local Management Entities

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

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Contents

1. Introduction & Background 1
- Background 2

2. Methodology 7
- Request for information 7
- Desk review/initial data collection 8
- On-site review 9
- Analysis 10
- Post-review discovery 12
- Reporting 12
- Provider forums 12

3. Findings 13
- Overall rating of the LMEs 13
- Post-discovery review findings 15
- Rating the LMEs by functions 16
- Summary of LME ratings overall and by performance area 40

4. Recommendations 41
- Principles guiding Mercer's recommendations 41
- Consolidation strategies 42
- Regional models 43
- State resources and authority and direct service delivery in the regional models 45
- Centralized models 45
- LME roles, post consolidation 47
- Incremental versus comprehensive change 49
- Implementing RMEs 53
- Implementing a CME 53
- Support for Core Service Agencies 53
- Responsibilities of CMEs and RMEs and their local functions 54
- Consolidation conclusions 56
- Recommended guidelines for consolidation 56
- Recommendations related to management entity performance and technical assistance needs 57

Appendix A – Acronyms 63

1

Introduction & Background

The North Carolina (State), Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) engaged Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to conduct an independent evaluation of the 25 Local Management Entities (LMEs). The LMEs are responsible for managing the delivery of mental health, developmental disabilities and substance abuse services (MH/DD/SAS) in their local communities. Mercer conducted the independent evaluation between December 2007 and March 2008. This report summarizes findings on the DMH/DD/SAS evaluation objectives listed below:

Objective 1: Assess the performance of the twenty-five (25) LMEs in terms of their fulfillment of the key LME functions by grouping them into performance categories and rating them by overall performance and performance in specific functional areas.

Objective 2: Determine specific business functions that may lend themselves to further consolidations among the twenty-five (25) LMEs, and recommend which LMEs to be engaged in further consolidation based upon individual strengthens and weaknesses; especially determine the opportunities for consolidating non-business LME functions in the context of assuring local flexibility and improved consumer access.

Objective 3: Determine the readiness of the twenty-five (25) LMEs to assume the utilization review function for MH/DD/SAS consumers receiving Medicaid services; identify areas in need of improvement for those found not to be ready at present and recommend corrective actions.

Each of these objectives was considered throughout the evaluation of LME capabilities along with the potential to gain more efficiency through consolidation of business and non-business functions. The findings for each objective are integrated within the report for ease of review. Recommendations are summarized in the final section.

This report provides high level information on savings related to consolidation of the LMEs. A supplemental report expected to be released in early May will provide additional information on potential savings.

Background

In 2001, in an effort to transform the public MH/DD/SAS system to a unified community-based model, North Carolina mandated change requiring the Area Authorities[1] to divest of direct service provision and become LMEs. The Area Authorities were responsible for the direct provision of MH/DD/SAS prior to 2001. Under the mandated change, the LMEs would then contract with providers for services and manage access, quality and costs. The plan included integrating State dollars, Medicaid and other federal funding at the LME level. Medicaid inpatient and residential treatment were managed by a separate statewide entity, but outpatient Medicaid services were integrated with State and other federal funds through the LMEs.

Each LME was required to plan, develop, implement and monitor services within their geographic area through the following primary functions:[2]

- Access to services that include a 24-hour a day, 7-day a week screening, triage and referral (STR) process
- Development of a comprehensive community network of providers
- Utilization management (UM) with determination of the appropriate level and intensity of services for all State-funded services and Medicaid outpatient services
- Authorization of care provided by State psychiatric hospitals and other State facilities
- Authorization of eligibility determination requests for recipients under a Community Alternatives Program (CAP)-mental retardation (MR)/DD waiver
- Care coordination and quality management (QM)
- Community collaboration and consumer affairs
- Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services

[1] Based on North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. (1985, c.580, s.2; 1989, c. 625, ss.1,2)

[2] North Carolina General Statues – Chapter 122C-115.4.

Prior to 2001, there were few contracted MH and substance abuse (SA) providers in the State beyond the Area Authorities. The Area Authorities directly offered clinic-based services and other outpatient care, including emergency services and case management. Community DD services were delivered by a combination of Area Authorities, the State DD institutions and a set of residential and day services providers. Key tenets of the 2001 system reform included developing a broader array of community-based, evidenced-based and promising practices for individuals and their families within their communities, ending the practice of State institutions becoming the "default" service in the absence of appropriate community alternatives.

The goals of the transformation were ambitious. The new LMEs had to divest services while building the clinical, administrative, financial, and information systems to support improved access and service management. Significant reductions of LME direct care staff and the need to train their remaining clinical staff in service management principles were challenges. The administrative challenge of reducing the workforce and transitioning clinical staff to new provider organizations was particularly problematic. Furthermore, concerns about individuals and families "falling through the cracks" had to be continuously addressed. At the same time, the LMEs had to build a contracted provider network that would deliver basic psychiatric services and emergency services, and case management, as well as a full array of community-based, evidenced-based and promising practices.

Some LMEs and their local communities resisted the mandated changes and did not divest services or divested over an extended period of time. In January 2008, at least one LME still indicated that it would not divest services and others had sought approval to maintain basic psychiatric and emergency services. Others maintain administrative responsibility for provider services through a separate manager reporting to the LME director. The combination of service management and direct delivery is generally considered a conflict of interest due to the problems associated with more frequent self-referrals, the potential of higher payments for the LME-delivered services than payments to providers, and the risk of impingement on consumer choice.

DMH/DD/SAS made considerable effort to standardize policies and procedures to guide the operations of the LMEs and implement monitoring protocols. This finding was evident during Mercer's site visits to the LMEs. State resources were provided to the LMEs to cover administrative costs as well as to improve their information technology.

However, the number of LMEs and the large scale and scope of the changes required by the 2001 reform were beyond the capacity of DMH/DD/SAS to achieve, despite the provision of monitoring and technical assistance. Furthermore, legislation[3] that requires DMH/DD/SAS to provide technical assistance for six months on any one item of non-performance of a LME further drained the limited resources of the agency and delayed more assertive corrective action.

[3] North Carolina General Statutes – Chapter 122C-115.4(d).

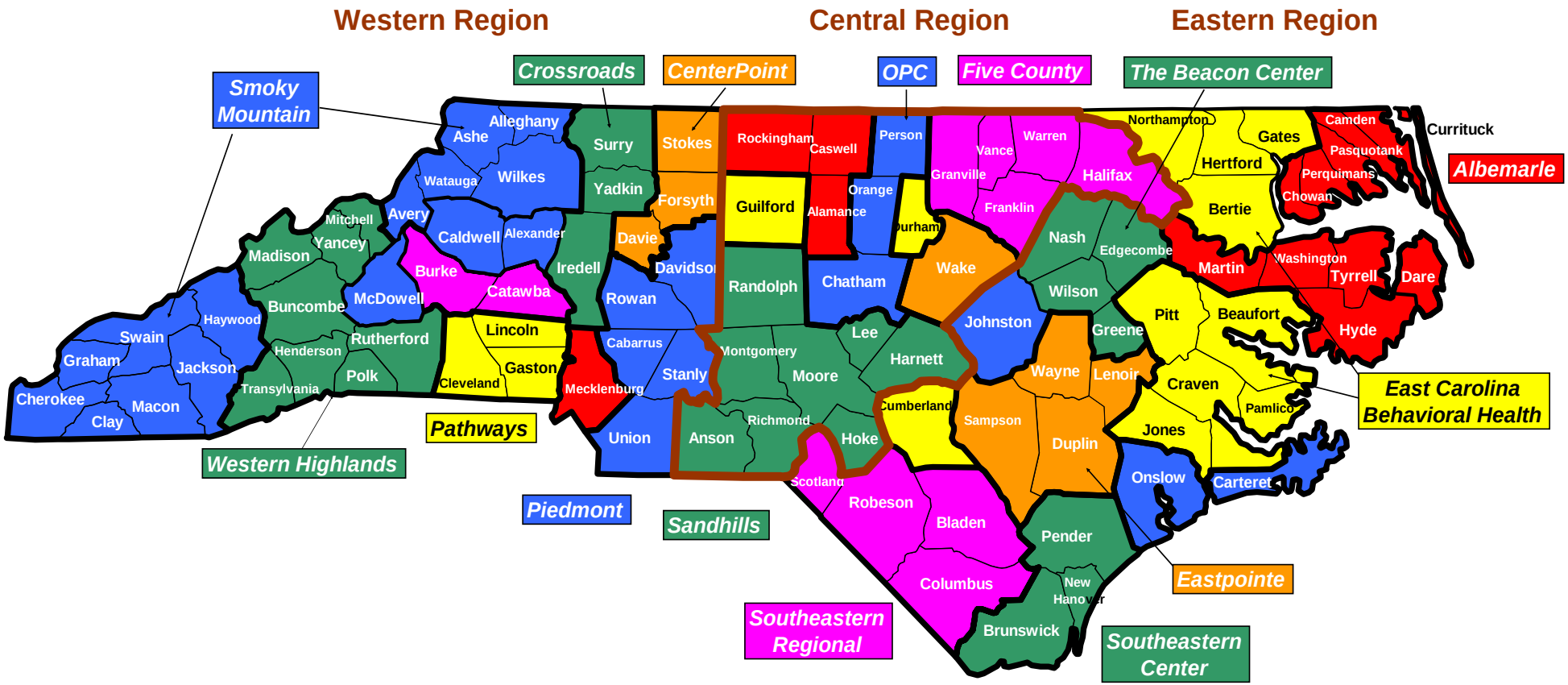
Throughout this period, several LMEs sought (as directed by DMH/DD/SAS) and five achieved national accreditation. Mecklenburg is accredited by the National Committee for Quality Assurance (NCQA), the "gold standard" for health and behavioral health (BH) managed care plans. Crossroads and Five County are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), and Albemarle and Onslow Carteret are accredited by the Council on Accreditation (COA). Both CARF and COA focus more on provider accreditation, while NCQA focuses on management entity accreditation.

In 2006, prior to the implementation of new service definitions under the Medicaid State Plan, DHHS made the decision to contract with ValueOptions® (the Medicaid Utilization Review vendor for residential and inpatient services since 1999) due to concerns that the then 29 LMEs would not be able to perform Medicaid UM in a sufficiently consistent manner. Findings from readiness reviews of the LMEs indicated that most did not have the appropriate personnel (licensed clinicians and psychiatrists) or policies and procedures to support Medicaid UM. Consequently, for most LMEs, the positions performing the Medicaid service management functions were terminated.

Over the past seven years, LMEs have adapted to other changes, including legislation[4] that resulted in voluntary consolidation to gain cost efficiency and economy of scale. As of July 1, 2005, the 40 former Area Authorities were reduced to 33 LMEs, by July 1, 2006 to 28, by July 1, 2007 to 25, and effective July 1, 2008 to 24 LMEs. A map of the remaining 24 LMEs within three DMH/DD/SAS Regions follows.

[4] Section 3 (a)(8) of HB 381, An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level.

Local Management Entities (LMEs) and their Member Counties As of July 1, 2008



Unless otherwise indicated, the LME name is the county name(s).

Reflects LMEs and Regions planned forJuly 2008

Despite these challenges, some LMEs have experienced successful outcomes through the transformation process from an Area Authority to LME, as listed below:

- Improved information technology infrastructure and other infrastructure changes from which to build high functioning management entities
- Experience in UM practices
- Experience with provider management
- Improved reporting and monitoring capabilities

While there are successes, the present call for change from the Governor, the Legislature, the public, the press and other stakeholders prompted DHHS to undertake this independent evaluation. All-in-all, stakeholders are calling for interventions that would result in fundamental changes: understanding who to call in an emergency; more community-based service alternatives to the State institutions; and improved State hospitals. Stakeholders also underscore the need for better control of costs while at the same time providing higher quality services delivered by qualified personnel to people in need.

2

Methodology

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. To ensure a thorough and careful analysis of all aspects of this review, Mercer brought together a team of personnel expert in a variety of specialties, including behavioral health (BH) and developmental disabilities, analytical, financial/claims management, Centers for Medicare & Medicaid Services (CMS) compliance, and information systems. Team members in the clinical operations group are doctoral level or master's prepared and those conducting the financial and information technology reviews are highly experienced.

The project was conducted under an aggressive time line in order to provide DHHS with information useful to improve the organization, management and delivery of services as quickly as possible. Mercer organized the review into five phases: (1) request for information, (2) desk review, (3) on-site review, (4) analysis and (5) reporting.

Request for information

Mercer prepared a data request for the LMEs and for DMH/DD/SAS on November 14, 2007. The data request letter informed the LMEs about the desk review and on-site reviews, and asked their executive management to register for one of three kick-off teleconferences held on November 16 and 19, 2007. The teleconferences focused on explaining the project's scope of work, reviewing the information request and discussing the agenda and dates for the on-site reviews with LME executive staff. The due date for the requested Information was December 3, 2007 to allow Mercer to have the minimum necessary time to adequately prepare for the on-site reviews, which were scheduled to begin the first full week of January 2008. Documents were requested in electronic format to expedite the review process and to minimize duplication time and costs.

Existing program materials only were requested. Mercer did not want the LMEs to create documents in order to fulfill the requirement.

Three attachments for completion by the LMEs were requested: Attachment A included a list of policies, procedures and other LME descriptive information. Attachment B included a preformatted Excel spreadsheet for administrative expenses by functional category as well as Full Time Equivalent (FTE) employees, inpatient utilization and claims statistics.. FTE staffing was requested as well as various operational and financial statistical measures. Our request for this data was based on the fiscal year (FY) ending June 30, 2007. A standard fiscal year ending was selected in order to compare the LMEs based on a consistent time period and to ensure that we could reconcile the administrative expenditure data to the LME's audited financial statements (AFS). The purpose for the Attachment B data request was to obtain data for the analysis of administrative expenditures; to develop a framework of consistency across LMEs; to analyze efficiencies; and to estimate cost savings in the event of LME consolidation.

Attachment C contained a checklist to identify materials each LME was or was not able to provide.

Desk review/initial data collection

Mercer developed and utilized a comprehensive desk review tool, which provided the evaluation framework necessary to assess the LMEs. The tool was created by blending Mercer's standard review tools, DMH/DD/SAS regulatory and operational requirements and CMS requirements for the management of Medicaid entities. The tool was then tailored to meet the specific reporting requirements and to address the key issues and priorities of DMH/DD/SAS. DMH/DD/SAS reviewed the draft tool and a final tool was in place by December 6, 2007.

The focus of the desk review was to provide Mercer with a preliminary assessment of each LME in terms of their fulfillment of the key LME functions, which included:

- Access to services
- Provider endorsement and management
- UM
- Authorization of State psychiatric hospital/facilities and utilization
- Care coordination and QM
- Community collaboration and consumer affairs
- Claims payment and coordination
- Financial management

These functions were then grouped into the following performance categories for lead functional assignment across the Mercer team:

- Financial and business management operations
- Information technology and claims
- Clinical operations and governance

The desk review was the first step in identifying the degree to which each LME had fulfilled statutory requirements and in determining potential business and non-business functions that might benefit from further consolidation among the 25 LMEs. The information obtained from the desk review assisted Mercer in focusing on-site observations and interviews in areas where additional information was needed. Desk reviews were completed by team members according to their particular expertise. Mercer reviewed and analyzed all documents submitted by the 25 LMEs over a period of about four weeks.

On-site review

The purpose of the on-site review was to verify the findings from the desk review and clarify questions that arose from the documents review. The on-site reviews took place during the month of January 2008. A Mercer review team conducted the one-day on-site reviews. The review teams had a minimum of two members for each LME, with at least one reviewer having expertise in financial/informational technology operations and the other having expertise in clinical operations and governance.

The review schedule included an introductory session with all the LME participants to facilitate introductions and discuss the agenda. LME executive staff provided an overview of the organization, responded to governance questions, and reviewed progress with the divestiture process.

The Mercer reviewers then conducted more focused interviews with clinical operations and business operations staff separately throughout the remainder of the day. The Information Technology/Finance reviewers also observed the operations of the information technology including those systems supporting access, STR, UM, and claims management. LME care management staff also walked the clinical reviewers through each step of the intake and service management process demonstrating how the information technology system functioned.

The clinical reviewers met with LME staff familiar with access to services; provider endorsement and management; UM, including authorization of State psychiatric hospitals; care coordination and QM; community collaboration; and consumer affairs in order to review capacity and key performance variables in each functional area. The on-site reviews concluded with a wrap-up session at the end of the day to acknowledge the LME's efforts during the review process and to request additional LME documentation required by Mercer to complete the analysis.

Analysis

Scoring was applied to the on-site reviews in a consistent manner with an emphasis on specific criteria. Following verification of the scores based upon a review of inter-rater reliability, the scores for 1) financial and business management operations; 2) information technology and claims management; and 3) clinical operations and governance were normalized for weighting factors of 30, 35, and 35%, respectively, for a total weighted score of 100%. The resulting product provided a normalized distribution curve listing LMEs determined to be in Tier One, Tier Two, and Tier Three. Tier One LMEs were determined to be 6% or greater of the average (mean) for total weighted points. Tier Three LMEs were determined to be 6% or below the average (mean) for total weighted points. Tier Two LMEs were within the boundaries of the 6% above or below cutoff for Tier One and Tier Three identification.

Considering that the scoring was numerically based, LMEs may be rated in an overall tier with higher or lower ratings for the finance, information system, or clinical tiers. This occurs due to scores and weighting factors on individual items and the performance areas. In addition, an LME may be close to the high or low end in a specific review area that would classify the LME into an overall Tier One, Tier Two, or Tier Three rating based on the total score derived.

For the financial and business management operations, 570 total points were available for the following areas:

- Organization and internal controls
- Business plan
- Audited financial statements (AFS)
- Accounting systems
- LME cost allocation methodology
- Provider reimbursement and prompt payment requirements
- Capital improvements/information technology planning
- Supplemental expenditure and statistical information
- Comparability of administrative expenses

Additional points were awarded based upon the operational and financial statistics measures listed below:

- Administrative overhead per individual served
- Salary per FTE
- FTEs per individual served
- Hospital utilization per individual served
- Medical spending per individual served

Total available points for each criterion above were 150 points for a total of 750 additional points. The on-site scoring tool had a total of 570 available points. Combined, this resulted in a total of 1,320 available points for the Finance and Business Management review.

For the information technology and claims management section, 1,485 total available points were available for the following areas:

- Coordination of benefits (COB)
- Use of standard service codes
- System initiatives and planning
- Electronic transactions processes
- Eligibility
- Information systems components
- System functionality
- Authorizations through system processes
- Claim adjustment processes
- Disaster planning
- Software control

Each of the above areas was weighted by importance in operating an efficient information system. The majority of points in the information technology section were rewarded based on electronic software solutions that integrate service authorizations, claim submissions, claim payment and remittance advice delivery. There were no additional innovative points available for scoring in the information technology section.

The total available points for the clinical evaluation and governance were 3,285, inclusive of the base score and possible additional points. The highest potential base score in clinical operations was 2,685. The following areas were evaluated to determine the base score for clinical operations and governance:

- Provider relations and support
- Access line, screening, triage and referral
- Service systems management (UM authorizations & care coordination)
- Community collaboration
- Consumer affairs and services
- Quality improvement and outcomes evaluation
- General administration and governance

In addition to the base score, LMEs could be awarded as much as 600 additional points for the following clinical operations:

- Level of divestiture exhibited
- Sophistication of UM functions
- Availability and quality of crisis service
- Degree of community involvement
- Efficiency of performance monitoring and measures

Post-review discovery

Following Mercer's scoring and analysis, Mercer obtained from DMH/DD/SAS updated financial and system performance information through February and March 2008 for all the LMEs and information on the requests from LMEs to waive divestiture and provide direct services. To maintain the integrity of the scoring methodology related to our comprehensive "point-in-time" reviews, the post-review discovery items are noted as separate findings in this report. The post-review discovery items did not impact the actual ratings of individual LMEs but were considered as part of the recommendations. Mercer anticipates that there will be additional events that occur throughout the remainder of the FY and beyond that DMH/DD/SAS will have to incorporate into the ultimate decisions about LME performance and consolidation.

Reporting

The results of the scoring and comprehensive analysis are included in this report. The findings section outlines the strengths and gaps of the LMEs and their technical assistance needs. The recommendations section discusses options for further consolidation of business and non-business functions, the LME's capacity to manage Medicaid, and potential cost efficiencies.

Provider forums

At the request of DHHS, Mercer also conducted two provider forums with representatives from organizations throughout the State. Most of the twelve providers in attendance worked with two or more LMEs, and some worked with a large number of LMEs statewide. The on-site evaluation tool was modified and used as a guideline for the discussion. Its focus was on the systemic issues providers faced while working with the LMEs rather than on the individual performances of the LMEs. The findings section of this report incorporates the systemic issues raised by the providers in the performance categories of the review (financial and business management operations, information technology and claims management; and clinical operations and governance issues). The providers' input did not impact the actual ratings of individual LMEs but was considered as part of the recommendations.

3

Findings

This section will discuss findings for the evaluation objectives:

1. Overall ratings of the LMEs and the ratings by performance areas: financial and business management operations; information technology and claims management; and clinical operations and governance that may guide future consolidation
2. Findings from the post-review discovery: financial performance of the LMEs since June 30, 2007 and requests to waive divestiture of direct services through March 2008
3. The LMEs that should be considered for consolidation, and opportunities for consolidating non-business functions in the context of assuring local flexibility and improved consumer access
4. The readiness of the LMEs to assume utilization review functions for Medicaid services
5. High level cost savings from consolidation of additional LMEs

Overall rating of the LMEs

The overall ratings of the LMEs include the combined scores for the following performance groupings: financial and business management operations; information technology and claims management; and clinical operations and governance. The LMEs were rated and assigned into three tiers. Tier One represents the highest performing LMEs. Tier Two includes those LMEs that would benefit from technical assistance to meet DHHS requirements and to develop the capacity to conduct Medicaid UM. Tier Three represents the lowest performing LMEs. Table 1 below identifies the LMEs by overall rating. Note that LMEs are listed alphabetically within tiers (that is within Tier One, all LMEs fall into that tier and no relative ranking within the tier is implied).

Table 1 – Overall Alphabetical LME ratings by tier	
Tier One	
	Crossroads Behavioral Healthcare*
	East Carolina Behavioral Health*
	Mecklenburg County Area MH DD & SA Authority
	Mental Health Services of Catawba County*
	Piedmont Behavioral Healthcare
	Smoky Mountain Center*
	Western Highlands Network
Tier Two	
	Alamance-Caswell-Rockingham LME
	Albemarle MH Center & DD/SAS
	The Beacon Center
	CenterPoint Human Services
	The Durham Center
	Five County Mental Health Authority
	Foothills Area MH/DD/SA Authority
	Guilford Center for Behavioral Health and Disability Services
	Onslow Carteret Behavioral Healthcare Services
	Orange-Person-Chatham MH/DD/SA Authority
	Pathways MH/DD/SA
	Southeastern Center for MH/DD/SAS*
	Southeastern Regional MH/DD/SA Services
Tier Three	
	Cumberland County Mental Health Center
	Eastpointe
	Johnston County Area MH/DD/SA Authority
	Sandhills Center for MH/DD/SAS
	Wake County Human Services

* See post-review discovery findings.

Most of the LMEs had strengths in one or more of the performance areas and gaps in others. Two LMEs achieved high scores in all three-performance areas; the remaining LMEs fall short in some area and are in need of improvement through either technical assistance, consolidation, or both.

The highest overall scoring LMEs comprise Tier One. Based on findings from the review, even some of the Tier One LMEs may require technical assistance to improve their capabilities in performance areas where they scored in the middle or lower ranges, but the Tier One LMEs could assume Medicaid UM functions and take the lead in consolidating other LMEs in Tier Two or Tier Three.

LMEs in Tier Two could achieve the capacity to manage Medicaid services as well as expand their management functions through consolidation, either in a lead or secondary role; however, Tier Two LMEs are in need of more intensive technical assistance than the Tier One LMEs require. Tier Three represents the lowest performing LMEs where consolidation with higher performing LMEs should be a strong consideration.

Post-discovery review findings

Mercer became aware of the following items after our on-site reviews and during the report writing process of our findings and recommendation. These areas should be further reviewed prior to consolidation decisions.

Financial and business management operations

DMH/DD/SAS provided financial information through the end of the third quarter State Fiscal Year (SFY) 2008, which impacts the assessment of LME budgetary management:

- Southeastern Center LME overspending: the LME had used over 97% of its budgeted funding for SFY 2008. The LME is requesting additional funding from DMH/DD/SAS to subsidize service delivery through the end of this FY.
- Catawba LME under spending: Catawba had only expended 55% of their budgeted funds through the third quarter SFY 2008.

Over- and under-spending of budgeted dollars undermines the basic tenets of an LME operating as a business enterprise. Budgetary planning should not be considered as a surprise factor given the LMEs Business Plan objectives. Determining factors of the over- and under-spending should be evaluated to determine financial management capabilities.

Information technology and claims management

DMH/DD/SAS also provided information as of the end of February 2008, which impact LME information system performance:

- Smoky Mountain LME: The LME has submitted only 7.66% of shadow priced claims compared to their Single Stream funding allocation. The explanation from DMH/DD/SAS is: “Smoky Mountain has experienced delays in converting New River data (the entity which merged with Smoky Mountain) for shadow claims submission. DMH/DD/SAS is working with Smoky Mountain to facilitate this process for shadow claims submission for consumers served in the New River area.”

- East Carolina Behavioral Health (ECBH) LME: The LME has submitted only 7.16% of shadow priced claims compared to their Single Stream funding allocation. ECBH did not start single funding until October 1, 2007. The explanation from DMH/DD/SAS is: "East Carolina Behavior Health (ECBH) is also transitioning to single billing from the merged entities of Roanoke-Chowan, Neuse, Pitt and Beaufort County; also, ECBH management indicates a high level of non-unit cost reimbursement (UCR) provider allocations and expenditures, which are not yet billable via the Integrated Payment and Reporting System (IPRS), to bring up additional services in the newly merged catchments area."

Under-reporting of services and spending of budgeted dollars does not allow the State to compare LMEs and the quantity of services rendered for the members. It undermines the basic requirement of an LME operating as a business enterprise in accurately and timely reporting to the State. Determining factors of the under-reporting should be evaluated to determine information systems issues and reporting capabilities.

Clinical operations and governance

Following the site review in January 2008, Crossroads requested a waiver from DMH/DD/SAS to directly provide SAS due to provider instability. Subsequently, the waiver was withdrawn. The factors associated with the waiver request should be further explored.

Divestiture of direct services is a key requirement for a management entity to minimize conflict of interest. The management entity must operate in a way to promote provider stability.

Rating the LMEs by functions

Table 2, Table 3 and Table 4 highlight the performance of LMEs by the following essential functions:

- Financial and business management operations
- Information technology and claims management
- Clinical operations and governance

Financial and business management operations

The overall financial and business management operations ratings are listed in Table 2. Note that LMEs are listed alphabetically within tiers (that is within Tier One, all LMEs fall into that tier and no relative ranking within the tier is implied).

Table 2 – Alphabetical LME ratings for financial and business management operations

Tier One	
	CenterPoint Human Services
	Crossroads Behavioral Healthcare
	Five County Mental Health Authority
	Guilford Center for Behavioral Health and Disability Services
	Mecklenburg County Area MH DD & SA Authority
	Mental Health Services of Catawba County*
	Onslow Carteret Behavioral Healthcare Services
	Smoky Mountain Center
	Southeastern Center for MH/DD/SAS*
	Southeastern Regional MH/DD/SA Services
Tier Two	
	Alamance-Caswell-Rockingham LME
	Cumberland County Mental Health Center
	Foothills Area MH/DD/SA Authority
	Johnston County Area MH/DD/SA Authority
	Pathways MH/DD/SA
	Western Highlands Network
Tier Three	
	Albemarle MH Center & DD/SAS
	The Beacon Center
	East Carolina Behavioral Health
	Eastpointe
	The Durham Center
	Orange-Person-Chatham MH/DD/SA Authority
	Piedmont Behavioral Healthcare
	Sandhills Center for MH/DD/SAS
	Wake County Human Services

* See post-review discovery findings above under financial and business management operations.

Business management systems and reporting capabilities were reviewed for each LME with the focus of evaluating financial and operational performance. LMEs that scored higher in the review had a better understanding that they are a business enterprise and manage their available resources accordingly.

Low scoring LMEs were observed as having high administrative and salary overhead, higher than average FTEs per individual served, more hospital usage per individual served, and high medical spending per individual served in addition to operational and administrative deficiencies. Typically, high medical spending results from use of higher cost services such as inpatient treatment instead of community-based, outpatient alternatives. The LMEs that had high medical spending also had more hospital usage.

The discussion below highlights the strengths and gaps of the LMEs in the financial and business management operations.

Organization and internal controls

Successful LMEs should have appropriate organization structures, committees and financial internal controls in place to ensure that staffing structures are adequately segregated and aligned for the most effective delivery of administrative services. The review included analysis and discussion of functional requirements in conjunction with appropriate information system security and role controls within the LME's information technology environment.

Business plan

The Annual Business Plan is a required document for each LME in order to establish the LME budget. Excellence in this area was observed when time lines, budgets, and capital planning was monitored and subsequently used to update the Business Plan that had been initially approved by DMH/DD/SAS. Discussion of the Business Plan was conducted during the on-site review to determine that the LME was monitoring their business plan expenditures and goals.

Audited financial statements

The AFS were reviewed to evaluate the opinions expressed by the independent auditor. Revenues and expenditures were used from the AFS to ensure that the administrative expenses reported by the LMEs in our data request reconciled. Also, the county-based Comprehensive Annual Financial Report (CAFR) that combined LME expenditures with other public health programs required additional evaluation to determine the accuracy of administrative expenses reported directly by the LME since an independent AFS was not available. Additional reconciliation was performed to ensure that the administrative expenses requested from the plan agreed to the CAFR.

Accounting systems

Accounting systems should be designed with adequate detail for the LMEs categories of medical and administrative expenses. The general ledger was requested from the LMEs in order to review appropriate accounting for service delivery category of expenses, in addition to detailed administrative general ledger accounts. The general ledger trial balance was also reconciled to the AFS and administrative expense data request.

LME cost allocation methodology

A managed care business enterprise that either receives allocations from a parent or affiliate organization or allocates indirect expenses to internal departments should have a solid and generally accepted accounting methodology for this purpose. LMEs that have allocation methodologies in place were reviewed to determine that the methodology was appropriate.

Provider reimbursement and prompt payment requirements

Mercer requested information from the LMEs to analyze their reimbursement methodologies, including prompt payment requirement reviews. Successful LMEs were able to produce schedules of provider payments, as well as claims aging reports. The aging reports were evaluated to determine if there were backlogs in payments to providers, as well as to evaluate timeliness of claims processing. This evaluation was also compared to the balance sheet for the plans for reasonableness to the assets and liabilities reported.

Capital improvements/information technology planning

Costs related to capital improvements with a specific focus on information technology, including changes, upgrades, and new software implementations are typically among the most costly investments for organizations as they strive to keep up with changes in the health care industry. Mercer discussed this issue with each LME and evaluated how each LME plans for upcoming information technology initiatives, including their assessment and estimates for the related project costs and time frames associated with completing and implementing each initiative.

Excellence in this area was achieved by those LMEs that have documentation of planning for their upcoming initiatives including information regarding cost estimates, staffing requirements and/or the timing for accomplishing the planned initiatives as well as the return on investment for information technology development. Many LMEs identified their upcoming initiatives, but did not necessarily address important factors such as costs, time frames, or staffing requirements, and functionality enhancements. Some LMEs rely on the county or outside vendors to address software enhancements. However, understanding the software costs and functionality and establishing project plans with time frames and integrated planning with clinical operations should still be performed by the LME with a detailed cost to benefit analysis.

Supplemental expenditure and statistical information

Mercer requested additional financial information from the LMEs for analysis purposes in a preformatted report. This included detailed administrative expenses by functional category, as well as FTEs, inpatient, and claims statistics. Higher scoring LMEs had lower than average administrative expenses per individual served, lower hospital usage, and more efficient staffing and claims processing efficiencies.

Comparability of administrative expenses

Data received from the LMEs regarding administrative expenses as a percentage of State-reported total LME expenditures was observed at greater than 18% for FY 2006/2007. Mercer believes this to be very high as compared to other states that delegate BH management operations to local or regional BH entities. In general, a range of 10 to 15% is more typical of total administrative expenditures depending on the delegated responsibilities of the BH managed care entities. Placing a cap on administrative expenses for the current LMEs at 15% or less would produce estimated savings of at least $25 million or greater dollars for the State. Further administrative savings will be accomplished with a reduced number of LMEs that serve more individuals.

Information technology and claims management

Table 3 highlights the ratings by tier of information technology and claims management to support the financial and clinical operations of the LMEs. Note that LMEs are listed alphabetically within tiers (that is within Tier One, all LMEs fall into that tier and no relative ranking within the tier is implied).

Table 3 – Alphabetical LME ratings by tier for information technology and claims management

Tier One	
	Alamance-Caswell-Rockingham
	Albemarle MH Center & DD/SAS
	Crossroads Behavioral Healthcare
	The Durham Center
	East Carolina Behavioral Health*
	Foothills Area MH/DD/SA Authority
	Mecklenburg County Area MH DD & SA Authority
	Mental Health Services of Catawba County
	Piedmont Behavioral Healthcare
	Smoky Mountain Center*
	Western Highlands Network
Tier Two	
	The Beacon Center
	Guilford Center for Behavioral Health and Disability Services
	Onslow Carteret Behavioral Healthcare Services
	Pathways MH/DD/SA
	Sandhills Center for MH/DD/SAS
	Southeastern Center for MH/DD/SAS
	Southeastern Regional MH/DD/SA Services

Table 3 – Alphabetical LME ratings by tier for information technology and claims management	
Tier Three	
	CenterPoint Human Services
	Cumberland County Mental Health Center
	Eastpointe
	Five County Mental Health Authority
	Johnston County Area MH/DD/SA Authority
	Orange-Person-Chatham MH/DD/SA Authority
	Wake County Human Services

* See post-review discovery items for information technology and claims management.

Performance of the LMEs' information technology environments was assessed in multiple areas including claims administration and system operations such as eligibility, provider management, electronic transaction capabilities, reporting, software maintenance, version control and disaster planning. The LMEs consistently performed well in their use of state approved and industry standard coding; they were found to have adequate capabilities for submitting claim encounters to IPRS; and their claims turnaround time based on claim received dates compared to when providers are actually paid was found to be within acceptable duration.

There are many factors that differentiated performance across the LMEs' claims delivery and adjudication solutions. While some LMEs performed very well in these functions, some were found to be significantly inferior. The LMEs that did not perform well have systems that require manual processes, duplicate data entry and low levels of integration for eligibility, authorizations, field edits, service counters and COB. In addition, some LMEs did not have adequate system backups or policies and procedures for disaster planning. None of the LMEs had adequate quality control for claims payment reviews.

Information management analysis and reporting

Provider claims/encounter data submission

Providers employ a variety of ways to deliver fee-for-service (FFS) claims and encounters (shadow claims) to the LMEs including electronic submissions, paper, fax, Excel spreadsheets, and e-mail. Electronic solutions for claims delivery should include both real-time direct data entry (DDE) and batch formats using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 claims transaction. Per federal government guidelines, LMEs must have the capability to accept batch 837s from providers that wish to submit electronic transactions. The on-site reviews revealed that some LMEs do not have the capability to receive 837s and are not complying with the federally-established mandates for electronic data interchange. LMEs in the top tier are meeting the Federal requirements for electronic claims delivery and may have additional capabilities like web-based or DDE mechanisms. The web-based and DDE solutions are advantageous because they apply edits during provider data entry giving providers the opportunity to fix data errors immediately. They also give providers a mechanism to

submit and receive immediate feedback on their claim status. These methods of claim submissions provide a single claims entry point and eliminate the need for re-keying claims data. Lower performing LMEs fell below industry standards by only accepting claims in paper or spreadsheet formats and do not have real-time electronic solutions in place for providers to deliver claims.

All of the LMEs recognize the need to provide electronic claim delivery solutions for their providers and most are aware of the steps they need to take to accomplish this. The review assessed the processes that are currently in place and did not take into account steps the LMEs may be contemplating to improve their electronic claim acceptance processes.

Encounter data submissions to the State

LMEs submit encounters to the State's IPRS system consisting of both FFS claims and capitated encounters. As noted above, the format that is used to submit encounters to the State is the federally-mandated HIPAA 837 electronic claim format. Most LMEs achieved a top tier status in this section due to the fact that they are submitting all of their records with a high level of file submission acceptance by IPRS. In addition, LMEs are correcting and resubmitting any submission errors that are identified by IPRS. A few LMEs did not achieve the highest rating for this item because they either have problems getting their records accepted by IPRS or they do not collect and submit all of their encounters. Collection of data for services rendered is important to the State for reporting purposes, identifying LME financial accuracy and efficiency, and assisting the determination of future county allocations.

Management of capitated and fee-for-service providers

LMEs manage provider contracts differently. LMEs may contract with providers on a FFS or capitated basis. Either way, timely collection of provider data through claims and/or encounter submissions is necessary in order to monitor and report the services that are rendered. Effective LMEs utilize their data collection and reporting systems to perform the necessary monitoring. Authorizations and accepted claims/encounter data, combined with the funding allocation and provider contract comparisons, provide information that the LMEs should analyze.

IPRS generates electronic remittance advice information using the HIPAA 835 remittance advice transaction. The 835s are sent to the LMEs and contain payment or shadow pricing against the various categories of service. LMEs that perform well systematically load the 835s into their system. This can assist the LME in managing services the providers render against the State allocations for the categories of service. Without accurate collection and reporting processes for provider monitoring, monies allocated to provider contracts may create a shortfall or impede the continued delivery of services needed by members.

Service authorizations

Providers are required to preauthorize specific services in order to receive approval prior to service delivery and in order to obtain State funded reimbursement from the LMEs. In addition to telephonic authorizations, submissions by the providers to the LMEs can occur via various mechanisms, including electronic submissions using web-based applications, direct data entry and fax, as well as via paper requests delivered by mail. LME solutions for authorizations varied from highly automated and integrated solutions to those that were very manual and, in extreme cases, required entry into multiple systems and manual tracking. LMEs that rated very high typically had solutions that allowed providers to enter the initial information directly into the LME's system and obtain updated status on their requests. Some LMEs could automatically authorize some services electronically. Lower tier status was assigned for those LMEs that had systems that did not check for authorizations on file during claims data entry or systems that did not automatically track either the number of services authorized or the number of services utilized.

Eligibility

Initial recipient enrollment for State funded services is initiated by providers when they first see a consumer. Demographic information is provided to the LMEs and the information is then sent electronically to the State via the HIPAA 834 enrollment transaction. Discussions revealed that reconciliation of eligibility data with the State's systems are not in place. This may be an area of opportunity for the State to ensure that the data they have in their systems aligns with the data residing at each LME. LMEs utilize the State's systems to look for current Medicaid eligibility to route the providers to the Medicaid authorization vendor when applicable. LMEs currently have limited functionality with regards to inbound eligibility verification and reconciliation.

Quality audit

Industry standards indicate that approximately 2 to 3% of all paid claims should be routinely audited to determine claim payment accuracy and system integrity, regardless if the claim is processed by the system or LME staff member. The majority of the LMEs perform either no claims quality audit or at a much lower level than industry standards. Many of the LMEs depend on IPRS for claim pricing, approval and reimbursement. The role IPRS has should be limited to data collection, not a substitute for the LMEs payment determination. This is an area for future improvement for most LMEs.

Data entry and system edits

Significant effort was spent during the on-site process to review each LME's claims system in order to confirm how claims are entered into the system, as well as to review the system edits invoked during data entry and through claims processing. Edits upfront during claims entry usually include confirmation that the values entered are acceptable and match system variables set by the organization, including whether the member matches the provider and the authorization for the services rendered. System edits are then applied during the adjudication process and include checks for duplicate claims, validation of recipient data, matching service authorization data, provider validation and pricing. Top performing LMEs had systems that provided automated solutions that are applied during the claims entry and adjudication process. Lower performing LMEs had systems that did not allow entry of certain types of data (e.g., claim-billed amounts), required manual application of certain edits, or required manual authorization validation prior to completing the claim adjudication process. There are also some LMEs whose vendor-supplied systems did not allow entry of industry standard procedure codes. In those instances, the LME must maintain a crosswalk of codes to be able to produce compliant encounters for submission to IPRS and remittance information for their providers.

Pricing

Claims adjudication systems utilize fee schedules that are date sensitive and used to pinpoint the payable amount based on the service code and date of service submitted on the claim. Top performing LMEs maintain fee schedules and routinely apply and track updates to calculate the payable amounts that are due their providers. The lowest performing LMEs do not require or accept billed amounts from their providers. Instead the LME relies on IPRS payment information to determine how much to pay their providers for each service rendered.

System integration

The way that each LME's system processes claims was assessed for integration of key components, including eligibility, recipient data, service authorizations, provider payment, and reporting. Top performing LMEs had systems that integrated these components effectively, thus eliminating the need for duplicate data entry and manual processing. Lower performing LMEs had systems that required manual processes in order to complete the claims adjudication process or make provider payments, or had systems that required duplicate or additional data entry.

Coordination of benefits

The ability to collect payment from other insurers should occur prior to paying out State funds. The State funds should be the payment of last resort. LME capabilities to identify, track, and apply COB data varied greatly. Top performers recognize the need to collect other payor information and use this information during claim adjudication to prevent claims payment when other coverage is in effect. These LMEs also pursue claim recoveries when other insurance coverage is discovered retroactively. Other LMEs coordinate claims, but only when the inbound claim includes the primary payor's payment information. Most of the remaining LMEs have systems with the ability to maintain other insurance data, but the LME does not collect this data in all cases.

Most LMEs treat COB as a provider issue and rely on their providers to bill the primary payor. The providers may notify the LME of remaining balances or may use the money to perform additional services. Most LMEs do not monitor the providers' collection of other insurance monies. The lowest performing LMEs have systems that do not even allow the collection or maintenance of third party information and perform coordination on an exception basis only.

Adjustments to claims

Various situations may require LMEs to apply adjustments to previously processed claims, and LMEs should therefore have the ability to apply adjustments that change the payment amount, payee, clinical information and/or the recipient data. LMEs varied widely in the level, method and ability for applying claim adjustments. LMEs that performed in the top tier had adjustment processes that were in line with industry standards. Specifically, adjustment processes were an integral part of the claims software application for these LMEs, and adjustments result in changes to claims that do not adversely affect the ability to track the original claims data. Their systems also provided an audit trail of the changed information in the recipient's claims history within the same system. Information that providers are able to view online should also reflect the same history information. Lower performing LMEs do not have capabilities for all types of claim adjustments. Instead, these LMEs apply adjustments directly to the payment and remittance information, as opposed to claims history. This method of applying adjustments results in an inability to track claims history from a single source, impacts customer service functions, and may result in inaccurate match of encounter data to the correct authorized services or reporting.

System backups, recovery and disaster planning

In the event of an information system disaster, service could be disrupted to members without proper system backups with recovery and disaster planning. Most LME organizations recognized the importance for administering regularly scheduled backups and have processes for recovering their systems, data and applications in the event of unforeseen events such as natural disasters. Top performing LMEs have backup mechanisms that include incremental backups for operational data. They also have hot sites for bringing their systems up in the event of damage to their primary physical site. Top performers have tested their ability to recover their systems and data on a regularly scheduled basis, doing so at least annually. Low performing LMEs have a combination of problems in this category. Some LMEs do not perform backups of all of their data or they do not take full system and data backups often enough. Other LMEs lack policies or procedures for disaster planning.

Software maintenance

Enhancements to the software code are applied in a variety of manners. Most LMEs rely heavily on external software vendors to make necessary coding changes, which are received via software enhancement releases. A few LMEs own and maintain their own software applications and have programmers that code and test all application changes. Some LMEs have a combination of both external vendor-supplied software as well as internally developed applications.

Mercer's review assessed how each LME tested changes and confirmed whether they have in place documented processes for performing and implementing software changes. Top performing LMEs had policies and procedures that identified steps for performing testing, including business user involvement in testing prior to implementation, as well as steps to confirm code accuracy once placed into the production environment. Lower performing LMEs did not have policies and procedures that addressed testing requirements and may not always include business area experts to confirm test results. Some of the low performing LMEs also did not maintain a log of changes implemented within their system or applications.

Clinical operations and governance

Table 4 provides LME ratings by tier of the clinical operations and governance of the LMEs. Note that LMEs are listed alphabetically within tiers (that is within Tier One, all LMEs fall into that tier and no relative ranking within the tier is implied).

Table 4 – Alphabetical LME ratings by clinical operations and governance	
Tier One	
	CenterPoint Human Services
	Crossroads Behavioral Healthcare*
	East Carolina Behavioral Health
	Five County Mental Health Authority
	Mecklenburg County Area MH DD & SA Authority
	Orange-Person-Chatham MH/DD/SA Authority
	Piedmont Behavioral Healthcare
Tier Two	
	Alamance-Caswell-Rockingham LME
	Albemarle MH Center & DD/SAS
	The Beacon Center
	Cumberland County Mental Health Center
	The Durham Center
	Foothills Area MH/DD/SA Authority
	Guilford Center for Behavioral Health and Disability Services
	Mental Health Services of Catawba County
	Onslow Carteret Behavioral Healthcare Services
	Pathways MH/DD/SA
	Smoky Mountain Center
	Southeastern Center for MH/DD/SAS
	Southeastern Regional MH/DD/SA Services
	Western Highlands Network
Tier Three	
	Eastpointe
	Johnston County Area MH/DD/SA Authority
	Sandhills Center for MH/DD/SAS
	Wake County Human Services

*See post- discovery review items under clinical operations and governance.

Overall clinical operations and governance performance

The evaluation of LME clinical operations included an assessment of the organization's structure and the status of transfer of direct services to local providers. Overall, LMEs have a basic structure and organization in place to manage and provide oversight of LME functions. It is of concern that most LMEs do not have the Psychiatric Medical Director supervising the QM function, or demonstrate active oversight of QM by the Medical Director. Some LMEs have part-time Medical Directors, which is not consistent with industry practice. In some situations, the Medical Director oversees UM and the direct provisions of services, which is a conflict of interest. A smaller number of LMEs would enable consolidation of their Medical Director positions allowing them to focus on service management full time, leaving other psychiatrists to provide or supervise the provision of direct care.

Many LMEs are still acting as quasi-provider organizations as distinct from divested management entities. The few that have truly separated their functions would be best candidates for leading the consolidation of other LMEs. The success achieved by each LME in transitioning from the role of service provider to the entity responsible for management and oversight of the public system of MH/DD/SAS is widely variable. Furthermore, a number of LMEs that had not fully divested employed "firewalls" between oversight and service delivery that were not complete. Fully divested LMEs attributed their success to a number of strategies, including early commitment by the LME to meet this requirement and a strong belief in the distinct roles of the provider and the LME.

The following key LME functions were also evaluated: access to services; provider endorsement and management; UM, including authorization of State psychiatric hospitals; care coordination and QM; community collaboration; and consumer affairs. Mercer found significant variability across these functional areas among LMEs, which is described in more detail below; however, overall areas of strength and areas for improvement were identified, including the following:

- All LMEs provide consumer access to 24-hour a day, 7-day a week STR. One-third lacked the technology to track call volume, making it impossible for the LME to quantify telephone access performance using industry standard metrics. Consequently, some LMEs cannot determine when a call is dropped by the phone system after ringing beyond 30 seconds. As a result, the LMEs have no way of tracking or calling back someone that might be seeking urgent or emergent care. Training and supervision of staff, which is important to ensure consistency of interactions with consumers and to provide oversight of quality, is highly variable. Tier Two and Tier Three LMEs generally do not have a formal process for auditing staff performance, lack supervisory processes and technology for live call monitoring, do not audit staff documentation, and provide supervision "as needed."

- While LMEs conduct annual or periodic needs assessments, and generally appear to know and interact on a regular basis with service area providers, not all LMEs perform an annual network assessment driven by consumer needs that results in identifying key services for priority development. Rather, they follow a provider community development plan that is used throughout the year to monitor the outcome of network development activities.

- Service management/UM, while also variable, is an identified area of strength for just a few of the LMEs based on our review of staffing, policies and procedures, supervision/quality review process, availability and use of reports to monitor over- and under-utilization, and training of clinical staff. It is important to highlight that Mercer's review did not include a clinical record review, thus, the application of clinical guidelines and appropriateness of authorization decisions were not evaluated.

- Most LMEs demonstrate established and functioning processes for community collaboration and system of care (SOC) coordination.

Consumer affairs and customer service are also functions in which LMEs performed well. Across the State, LMEs describe a "no wrong door" policy for consumer complaints, with complaints and incidents typically reported through LME management to the Board of Directors, and with an active Consumer Rights Committee and Consumer and Family Advisory Committee.

Findings also were impacted by performance in the information systems reviews. Most notably, LMEs lacking an information system that provides accurate, timely data to manage clinical operations scored low in the UM and QM sections of the review. For example, only 13 of the 25 LMEs utilize system-generated reports to systematically analyze over- and under-utilization of services across multiple levels of care. Also, eight LMEs with a lower score had the infrastructure to generate reports but did so only on an *ad hoc* basis or focused solely on State hospital bed day allocation, a State required report. Utilization data and internal QM data on telephone answering times, inter-rater reliability of call center staff and UM staff, and complaints and grievances all need to be collected, analyzed, and trended over time to provide the LME with a analysis of internal operations. QM of network provider services using data generating tools is also essential to monitor the quality of services and outcomes. Thus, deficiencies in information systems also affected clinical operations functioning.

Structure of the organization

Requirements for the structure and organization of the area board are defined by the State's General Statute.[5] Our review focused on the LME structure in place to manage and provide oversight of LME functions. Higher scoring LMEs are organized with clear lines of responsibility and position titles that clearly communicate the position function or role. QM and Network Management/Provider Relations are also included in the organizational chart, with QM reporting to the LME's Medical Director and UM reporting to a licensed clinical professional. In Mercer's experience, it is an industry standard for clinical functions to report to a clinical lead to ensure clinical oversight. In contrast, LMEs in Tier Two or Tier Three had some or all clinical areas reporting to a non-clinician, such as a non-clinical Chief Executive Officer, Chief Operations Officer, or Business Manager.

Service divestiture

LMEs were formed as a key component of the State's ongoing system transformation to ensure local oversight and increased consumer input. With this change, LMEs were required to shift from being a service provider to take on a role of managing services provided by a network of providers. Divestiture – the process of transferring the provision of services from the LME to local providers – is an important part of system transformation, as access to a wide range of community providers gives consumers greater choice and improved options for recovery and growth. The LMEs have the option to submit waivers to DHHS to continue some direct service provision in the absence of qualified providers. However, LMEs providing direct service are in the difficult position of self-monitoring for these continued clinical functions. The creation and maintenance of an effective "firewall" between LME management functions and direct clinical care, critical in this situation, is difficult to achieve. In addition, LMEs not fully divested may inadvertently shift their focus from developing services in the community to the services provided by the LME.

The success achieved by each LME in transitioning from the role of service provider to the entity responsible for management and oversight of the public system of MH/DD/SAS is widely variable. Each LME's approach to the challenges presented by divestiture was unique due to the existing number, type and geographic distribution of provider services. Higher scoring LMEs are either fully divested or able to demonstrate a clear firewall separating LME system management functions from service delivery functions. As noted above, this separation of functions is important to ensure that the integrity of service management is not compromised. A number of LMEs not fully divested presented a "firewall" that is not complete, as evidenced, for example, by identification of the same manager for both LME and direct services or having LME UM staff that also provide direct service.

[5] North Carolina General Statutes – Chapter 122C-118.1, 22C-119.

Fully divested LMEs attributed their success in this area to a number of strategies, including early commitment by the LME to meet this requirement, a strong belief in the distinct roles of the provider and the LME, and developing contractual relationships that allow the LME to support and assist providers in becoming more efficient and effective in the provision of needed services, such as mobile crisis.

Committees

All LMEs have active Governance, Consumer and Family Advisory (CFAC) and Client Rights Committees. These committees have a chairperson to organize meetings through an agenda, minutes, and convene on a regular basis.

It is an industry standard that health care service management organizations also maintain standing Quality Management/Quality Improvement Committee (QM/QI Committee) and a Utilization Management Committee (UM Committee). All LMEs have a QM/QI Committee as required by contract with DHHS; however, one LME scored low because the Committee has not met in over a year. Service management/UM is also a key LME function. The UM functions should include a UM Committee to analyze aggregate data and identify trends by level of care and by provider. This type of analysis helps clinical staff actively monitor how services are utilized and identify providers that may be offering more restrictive and costly services versus more integrated community-based services. Further, it provides information on the gaps in the SOC and situations where intermediate levels of services are required. This is particularly useful in preventing over-reliance on State institutions and in assessing current capacity for community-based alternatives. The presence or absence of a UM Committee was a clear differentiator among LMEs. Higher scoring LMEs had UM Committees that addressed UM performance and service needs based on trend analysis. Partial scores were awarded to LMEs without a formal committee structure that nonetheless are performing key UM Committee functions. It is concerning that two of the LMEs placed in Tier Three on this measure do not have a UM Committee and did not provide evidence that UM Committee activities are occurring in other areas of the organization. In addition, LMEs with a committee or comparable structure to address provider appeals, consumer appeals, provider endorsement and finance scored higher than LMEs not presenting evidence of these functions.

Active membership of consumer, family members and other external stakeholders on committees demonstrates the level of LME commitment to ensuring active stakeholder participation in key policy decisions. All LMEs support consumer and family participation in Governance, Client Rights and CFAC Committees. It is positive that three-fourths of the LMEs with active QM/QI Committees include consumer and family members in committee membership and, of the 10 LMEs with formal endorsement committees, one-half include stakeholders.

Information Technology Help Desk

Information technology staffing that the LME has in place to perform information technology development and support is an assessment component for all LME operations, including clinical operations. Each LME was evaluated for their ability to identify, track and resolve issues related to software and hardware through their Information Technology Help Desk. The assessment identified differences in how each LME performs these functions and how the organization uses staffing and technology to resolve their system issues. Top-level performers have dedicated staff known throughout the organization responsible for addressing system-related issues. Top performers may also have dedicated help desk phone numbers in place that they use to route, track and resolve issues. Lower tier ratings were designated if the LME relies on outside assistance or does not have policies and procedures or dedicated LME staff responsible for the Information Technology Help Desk functions. Some LMEs' information technology functions are supported within county operations, complicating efforts to determine how the LME could operate as a separate entity and whether the LME has the ability to expand to include other geographical areas within their own operations.

Provider relations

Endorsement

All LMEs scored high in performing the standard provider endorsement process, enforcement of endorsement requirements, and contracting. An additional issue identified by a number of LMEs during the on-site review was the complexity that arises when a provider endorsed by one LME is authorized to provide service by another LME, or a quality of care concern warrants investigation and the provider is serving consumers managed by multiple LMEs. In each instance, LMEs expend additional time and resources in care coordination and QM activities. Providers also described as burdensome the requirements to be endorsed by multiple LMEs.

Network adequacy/access

Network assessment compares access to services and the needs of consumers to the capacity of the existing provider network in terms of office locations, provider disciplines, clinical specialties and levels of care. This analysis is used to design a provider community development plan that addresses access issues and is further used throughout the year to monitor the outcome of network development activities. A well-run program does not limit network assessments to those requested by the State, but will conduct at least an annual analysis of access to care that is driven by the service needs of local consumers. High scoring LMEs assess network adequacy yearly and use this information to inform network development decisions, as evidenced by current geographic access reports, active tracking of network development activities in response to consumer complaints, and targeted development activities for services such as Mobile Crisis, Substance Abuse Intensive Outpatient and Telemedicine. Lower scoring LMEs lack current network development plans, are not able to provide documentation that information obtained in community forums is used to assess the network, or simply described network access as "contracting with any willing provider" without consideration of adequacy.

Network management

National standards in this area focus on: planning for network adequacy, recruitment, endorsement, contracting and managing communications with providers to ensure consumer access to cost-effective and quality care. It takes significant work over time and a consistent level of management to achieve and maintain a high functioning network of quality providers. This part of the review focused on communications to orient, train and support network providers.

An Operations Manual/Provider Manual was developed and is used by each LME to address frequently asked provider questions and provide detailed information on services covered, the authorization process, how to file claims, Person Centered Plans, the role of the LME, and where to call for technical assistance. With few exceptions, the Operations Manual of each LME is comprehensive and sufficiently user-friendly given its complexity. The majority of LMEs require new providers to attend orientation meetings or receive individual face-to-face training. With one exception, the LMEs have a website for providers to access the Operations Manual and information on new documents or forms. LMEs with multiple methods of communication (i.e., newsletters, network-wide emails, Community Happenings Alerts) scored higher than LMEs without a standard process for ongoing communication. While most LMEs offer workshops and training on topics of interest, those not doing so scored lower. A concern expressed by providers that contract with multiple LMEs is the different procedures listed in the various LME Operations Manuals/Provider Manuals, which creates confusion about the procedures for authorizing care, billing and other important issues. This is a key area for potential standardization.

Provider satisfaction

Provider satisfaction surveys are used to seek provider feedback that can improve processes and, ultimately, impact provider retention and consumer access to care. The satisfaction of providers is monitored by all LMEs, although not always through an industry standard survey methodology. The survey process varies from a Provider Satisfaction Survey sent to all providers, with tabulated results and action planning, to limited satisfaction information gleaned from focus groups or ad hoc provider feedback. High scoring LMEs conducted network-wide provider satisfaction surveys in 2005 and 2006 using an instrument with balanced scoring (equal number of positive and negative response items). LMEs using less robust methods or relying solely on the DHHS Provider Satisfaction Survey received lower ratings. Providers that contract with multiple LMEs reported having to complete several surveys, but not always receiving feedback on the findings of the surveys or the LMEs' responses to issues raised in the surveys.

Access and screening, triage and referral

The review focused on consumer access to 24-hour a day, 7-day a week STR[6] with specific attention to transition of after-hours call information to daytime staff and emergency calls. All LMEs provide the required 24/7 access. Staffing among the LMEs also appears sufficient to manage call volume in most cases, with call rollover to UM staff as needed. However, the inability of some LMEs to electronically track call volume (see below) made it impossible in these cases to quantify access using standard telephone metrics. Two LME reported that calls are dropped when the call volume is higher than expected.

Generally, the process is for calls to be answered, demographic information collected, the State standard screening completed, an appointment scheduled and service authorized. After-hours coverage is provided by each LME, or another LME or vendor contracted to provide this service. The process for transferring information from after-hours staff to daytime staff must ensure consumer access and referral information is not lost in the process. LMEs passing this information verbally from after-hours staff to day staff with no documentation of the process scored low. However, the vast majority of LMEs using an outside vendor have a written protocol and active process in place for electronic transfer of after-hours data.

During and after business hours, crisis calls must be handled appropriately. Most organizations that manage care have a well-defined process for routing crisis calls to the appropriate clinicians for crisis stabilization or emergency response. LMEs scoring high in this area of the review have a Policy and Procedure for Emergency Calls that includes, at least in part, the following: definition of routine, urgent and emergent calls; scripted questions for STR staff to screen consumers for emergency; the requirement that emergency calls are never transferred or put on hold (i.e., STR staff stays on the line with the consumer in crisis); physician availability 24/7 for crisis consultation; and LME clinician follow up until crisis is stabilized.

Call tracking and performance monitoring

The electronic tracking of calls at the consumer point of access (uniform portal of entry to care[7]) allows the LME monitor access through call performance metrics. The review in this area focused on the LME's ability to track and trend two industry standard call metrics: average speed of answer (which should be within 30 seconds) and call abandonment rate (the number of callers that hang up before the call is answered, which should be less than 5% of all calls). LMEs that (1) possessed an electronic call tracking and documentation system that also provided evidence of tracking and trending calls, including the defined performance metrics, and (2) achieved industry standard for both metrics, scored the highest. Lower scores were assigned to LMEs without an electronic call tracking system in place, LMEs with call tracking capability that nonetheless reported not finding it necessary to track and trend calls, and LMEs tracking calls but not achieving call standards.

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6 North Carolina General Statutes – Chapter 122C-115.4(b)(1).

7 North Carolina General Statutes – Chapter 122C-115.4(b)(1).

Supervision/quality review process

LME Access and STR staff is currently functioning in their roles and are able to describe the process for logging and responding to calls, following up on after-hours calls, and responding to crisis calls. Training and supervision of staff are necessary to ensure consistency of interactions with consumers and provide quality oversight for all calls: routine, emergent and crisis. Training and supervision was found to be highly variable among the LMEs in these areas. The review concentrated on the presence of a formal process for auditing staff performance, including training for low performers. Characteristics of high scoring LMEs include: a formal procedure for staff training and supervision; supervision provided by master's level licensed clinicians (which was in place for only 21 LMEs); presence of a clinician "on the floor" at all times; live call monitoring via a phone system with silent monitoring capability, followed by comparison to established performance standards and immediate feedback to staff (only three LMEs met this standard); and a documented process for auditing documentation on a routine basis, with feedback (only 9 LMEs met this standard). Other examples of specific deficiencies resulting in lower scores included: lack of technology for monitoring live calls; warm transfers of individuals in crisis; live call monitoring technology in place but not utilized; LME audits of staff documentation discontinued because "the State catches errors"; and supervision provided "as needed".

Service management

Utilization Management program components

Service Management and UM is the cornerstone of the LME's responsibility to manage and provide oversight of MH/DD/SA services. UM should consist of a comprehensive approach that is based on data analysis and that targets oversight toward high cost and complex cases across all levels of care. This segment of the review targeted the following basic components of a UM program: clinical guidelines for UM and Care Coordination; staffing; standardized processes for appeals, complaints and grievances; Person Centered Plan (PCP) oversight; and service coordination. It is important to point out that Mercer's review did not include clinical record review; for this reason, the application of clinical guidelines and appropriateness of authorization decisions were not assessed.

Overall, the level of UM was found to be inadequate except for some of the Tier One LMEs. These higher scoring LMEs have UM programs that include: a well-defined program documented in policies and procedures; an emphasis in program materials on quality over cost and on appropriate care in the least restrictive environment; UM reporting to a licensed clinician; staffing that included a Medical Director Psychiatrist, Child Psychiatrist (direct hire or contractor), health care data analyst for report development and analysis; licensed care managers with combined experience in MH, DD and SA services; and physician access for real time physician to physician discussion of non-authorization discussions. With one exception, all LMEs provided evidence of clinical guidelines, tracked complaints, grievances and appeals, and carried out review and approval of Person Centered Plans. All LMEs scored high in service coordination; for example, LMEs coordinate with schools, courts, Division of Social

Services (DSS), participate in consumer discharge planning at State hospitals, and check jail census daily to identify consumers for outreach. With a few possible Tier One exceptions, most LMEs could not take on the Medicaid utilization function currently provided by ValueOptions without technical assistance. All LMEs would need sufficient time to hire, orient and train clinical staff (except Piedmont Behavioral Health, which is currently managing Medicaid service).

It is critical that LMEs continuing in the dual role of direct service provider and manager of service conduct adequate UM review of all services, including services provided by LME staff. As noted earlier in the report, LMEs not fully divested and with a “firewall” that is not complete may inadvertently self-refer more and have less of an interest in self-monitoring for service quality and appropriateness or building needed capacity within the provider community.

Policies and procedures

UM policies and procedures should provide evidence of a comprehensive approach to service management that includes monitoring for both over- and under-utilization of care. Over-utilization occurs when an LME provides more services than are medically necessary or delivers services that do not provide an increased health benefit. Under-utilization occurs when an LME or service provider does not provide the services needed to appropriately treat the consumer’s diagnosed condition. Most LMEs have a policy addressing over- and under-utilization or other documentation describing active management, yet evidence that the policies were implemented was found to be inadequate for most of the LMEs during the site reviews.

Over half of the LMEs have policies and procedures reflecting a comprehensive approach to UM, including: authorization of care (inpatient and outpatient); review of Person Centered Planning; DHHS bed-day allocation oversight; discharge planning; crisis services monitoring; crisis plan coordination; and definition of routine, urgent and emergency care. LME scoring was negatively impacted if policies and procedures were not fully drafted or appeared to be complete but lack key content. In the example of inpatient authorization of care, the policy and procedure was reviewed for the following: specific authorization criteria; a process for bed-day allocation management; requirements for alternative treatment consideration prior to authorization to State hospital; discharge planning; and oversight bed days at Alcohol Drug Abuse Treatment Centers (ADATC). The lack of consideration of consumer-specific factors in UM policies and procedures resulted in a lower score as well. LMEs that did not have policies and procedures and did not report active review of inpatient authorizations, including psychiatrist-to-psychiatrist case review, also scored lower.

Community collaboration and care coordination

All LMEs scored high in this area of review, reflecting their strong ties to their local communities and agencies. LMEs demonstrated success in maintaining collaborative working relationships with agencies within their service area. SOC coordination, which helps families help their children succeed at home, in school and in the community,[8] is one component of this collaboration. Other examples of community collaboration included planning for crisis services, coordination with the county jails and local police and discharge planning with local hospitals.

Supervision/quality review process

Clinical staff making UM decisions should be formally supervised. This should include formal face-to-face supervision by the Medical Director and senior clinical staff, monitoring of inter-rater reliability for UM decisions, and blind call monitoring to observe and document staff's clinical customer service skills and ability to apply medical necessity criteria of the LME. LMEs not providing formal supervision of clinical staff cite the reasons for less structured supervision as due to fewer clinical staff because of the transfer of Medicaid to ValueOptions® and subsequent staff terminations and having experienced staff that do not require routine supervision. This is a concern given that, of the 25 LMEs, only three reported supervising clinical staff through live call monitoring and only 10 currently review clinical documentation for appropriateness of utilization decisions.

Orientation and training of clinical staff

Clinical staff should be provided formal orientation and ongoing training designed to improve the quality of clinical staff's UM activities. On a day-to-day basis, the Medical Director and senior clinical staff should be involved in ongoing training through review of complex clinical cases. As expected, LMEs with low scores in the area of Access and STR staff training tended to score low here as well, for some of the same reasons. LMEs with supervision of UM clinical staff by a non-clinician and lacking a phone system with live call monitoring capability were also scored low on these items. On the other hand, LMEs with a training plan for clinical staff that encompasses training in Medical Necessity Criteria and Level of Care Guidelines, ensures supervision of clinical staff by a master's level licensed clinician, includes case conferences with the Medical Director Psychiatrist, and uses inter-rater reliability testing received a high score in each of these areas.

[8] North Carolina System of Care Handbook for Children, Youth & Families – Rev January 2006 – NC Families United, Inc./FFCMH.

Consumer affairs and customer service

All LMEs have processes in place to protect consumer rights. Consumer Rights/Human Rights Committees are active in each LME. Materials on consumer rights have been distributed to consumers and providers, including brochures, posters, and Client Rights Handbooks. Across the State LMEs describe a “no wrong door” policy for consumer complaints, citing web access, consumer forums, calls to the Access line, and calls to provider and LME offices. Consumer rights issues, complaints, and incidents are reported through LME management to the Board of Directors and the CFAC. The CFAC reviews consumer rights information, requests additional investigation or information, and is active in policy issues). It is commendable that CFAC representatives were present at a number of reviews.

LMEs do not consistently monitor consumer satisfaction. Only one-third of LMEs conducted surveys in both 2005 and 2006. LMEs with the highest score conducted surveys yearly, included all consumers, sent multiple mailings to improve response rate, and report consumer overall satisfaction in the 80% to 90% range. Some LMEs rely on the survey conducted by the State; others surveyed only in 2005 or 2006, performed a limited survey at stakeholder forums or a consumer fair or focused the survey on consumer experiences with only one function of the LME.

Quality management

An effective QM program emphasized quality improvement (QI) using a collaborative approach between QM staff and providers. QM should monitor internal LME clinical functions, as well provider quality and service. Typically, Mercer recommends the Quality Manager report to the Medical Director. Our review focused on the Quality Management Plan (QMP), system generated reports used to track and trend performance, complaints and grievances, and outcome of utilization reporting to the State. Each LME should have a QM/QI plan describing the LME’s overall approach for improving quality of care with a focus on consumers, care systems, use of data-driven decision-making, active involvement of staff, and an emphasis on continuous QI.

Not all LMEs presented QMPs; however, a range of basic QM activities is occurring in each LME and the LME was credited for each activity identified in the review. For example, QM planning was found in Annual QI Reports and LME Business Plans. Findings resulting in low scores include: no evidence of actions to track and trend grievances, appeals and/or quality of care concerns; no existing QM/QI Committee; no internal audits performed to identify areas for improvement; and inadequate monitoring of provider and consumer satisfaction with results analysis and action planning. LMEs lacking an information system that provides accurate timely data to manage clinical operations scored low in this section of the review. Thirteen of the 25 LMEs had higher performance in this area, utilizing system-generated reports to systematically analyze over- and under-utilization of services across multiple levels of care, discussing results weekly with care coordinators, and having in place action plans to address issues.

Eight LMEs with a lower score had the infrastructure to generate reports but did so only on an ad hoc basis or focused on State hospital bed day allocation (in response to a State required report). The remaining LMEs scored in Tier Three and currently lack the infrastructure to generate these reports or produced reports limited to providers using the LME web-based system (i.e., LME direct services and not all network provider data captured). Generally, LMEs with the ability to generate over- and under-utilization reports use system generated reports to coordinate care and track and trend utilization by level of care. LMEs currently lacking the information system infrastructure to access and use data to manage care scored lower.

Community Systems Progress Indicators[9] are one aspect of LME performance monitoring by DHHS. The indicators measure LME progress in reaching access, quality of care, and cost effectiveness goals. The review focused on four of the 21 progress indicators: (1) emergency care provided within 2 hours; (2) urgent care provided within 48 hours; (3) routine care provided within 7 days; and (4) State bed day utilization within allocation. For the first three indicators, LMEs were assessed based on DHHS appointment access performance standards that 85% of persons requesting emergency, urgent or routine service be seen within the relevant time period. For the fourth indicator of system management, Mercer examined whether LMEs manage State hospital bed-days within the annual allocation. Results are variable among the LMEs. The lack of uniform achievement on the selected indicators may indicate lack of QI initiatives to improve performance in the provision of emergency, routine or urgent care, or in the case of the fourth indicator, inadequate UM.

[9] MH/DD/SAS Community Systems Progress Indicators; Report for First Quarter SFY 2007–2008; NC Department of Health and Human Services.

Summary of LME ratings overall and by performance area

The table below summarizes the LMEs ratings overall and by performance category. Note that LMEs are listed alphabetically within tiers (that is within Tier One, all LMEs fall into that tier and no relative ranking within the tier is implied).

Table 5 – Alphabetical overall rating of the LMEs	**Financial and business management operations**	**Information technology and claims management**	**Clinical operations and governance**
Tier One			
Crossroads Behavioral Healthcare	Tier One	Tier One	Tier One
East Carolina Behavioral Health	Tier Three	Tier One	Tier One
Mecklenburg County Area MH DD & SA Authority	Tier One	Tier One	Tier One
Mental Health Services of Catawba County	Tier One	Tier One	Tier Two
Piedmont Behavioral Healthcare	Tier Three	Tier One	Tier One
Smoky Mountain Center	Tier One	Tier One	Tier Two
Western Highlands Network	Tier Two	Tier One	Tier Two
Tier Two			
Alamance-Caswell-Rockingham LME	Tier Two	Tier One	Tier Two
Albemarle MH Center & DD/SAS	Tier Three	Tier One	Tier Two
The Beacon Center	Tier Three	Tier Two	Tier Two
CenterPoint Human Services	Tier One	Tier Three	Tier One
The Durham Center	Tier Three	Tier One	Tier Two
Five County Mental Health Authority	Tier One	Tier Three	Tier One
Foothills Area MH/DD/SA Authority	Tier Two	Tier One	Tier Two
Guilford Center for Behavioral Health and Disability Services	Tier One	Tier Two	Tier Two
Onslow Carteret Behavioral Healthcare Services	Tier One	Tier Two	Tier Two
Orange-Person-Chatham MH/DD/SA Authority	Tier Three	Tier Three	Tier One
Pathways MH/DD/SA	Tier Two	Tier Two	Tier Two
Southeastern Center for MH/DD/SAS	Tier One	Tier Two	Tier Two
Southeastern Regional MH/DD/SA Services	Tier One	Tier Two	Tier Two
Tier Three			
Cumberland County Mental Health Center	Tier Two	Tier Three	Tier Two
Eastpointe	Tier Three	Tier Three	Tier Three
Johnston County Area MH/DD/SA Authority	Tier Two	Tier Three	Tier Three
Sandhills Center for MH/DD/SAS	Tier Three	Tier Two	Tier Three
Wake County Human Services	Tier Three	Tier Three	Tier Three

4

Recommendations

Mercer based its recommendations on the performance of the LMEs in comparison with the State's requirements, as well as additional industry criteria, including the federal CMS rules for Medicaid managed care programs, national standards for behavioral health managed care organizations (BH-MCOs), and Mercer's experience with other public and private sector BH programs.

Principles guiding Mercer's recommendations

The following principles guided Mercer's recommendations:

1. Preservation of local influence, authority and knowledge of local resources for clinical management and when otherwise functionally relevant
2. State authority to oversee the management entities and take corrective action
3. Management competence, experience and tools
4. Improved access to services, including emergency services, community-based services, and empirically-supported practices
5. Administrative and financial efficiency
6. Elimination or appropriate management of potential conflicts of interest
7. Integration of State and Medicaid funds at the management entity level

Consolidation strategies

Duplicated functions of the LMEs: One objective of the independent evaluation was to identify duplicated business and non-business functions that could be consolidated. Many functions of the LMEs are currently duplicated resulting in inefficiencies and warrant consolidation.

Duplicated functions

- **Governance and administration**
- **Finance**
- **Access, STR**
- **Service/UM**
- **Information systems**
- **Claims management**
- **Provider network management**

While identifying business and non-business functions that could be consolidated is possible, separating the two sets of functions can be challenging given their necessary degree of integration throughout the LME's management activities. For example, providing access, STR; service authorization; and UM functions all require sophisticated information technology to be effective. Additionally, the management entities' UM plans must address the clinical needs of people as well as manage financial risk, so that financial and clinical incentives for early access to services before emergencies arise are aligned and budgeted resources can be made to last for the entire budget period. Also, to accomplish effective service management, the LMEs must have the technology to link service authorizations to claims payment. Thus, successful integration of business functions and non-business functions must be a priority of any system reform or consolidation approach.

Some proposals under discussion by the LMEs suggest that it will be more efficient if one LME handles the finances for two or three other LMEs, another LME handles the technology systems, and yet another handles the STR functions. This approach does not appear to be efficient in the long term unless the LMEs truly consolidate, because it results in maintaining multiple LMEs with split functions and management overhead in all. In fact, such a strategy appears likely to increase fragmentation of responsibility and reduce performance, while maintaining redundant administrative infrastructure.

Having fewer management entities differentiates between functions that should optimally occur at a regional or centralized level and those that are best maintained at a local level. Mercer identified possible options for further consolidation of the LMEs that address the need for fewer LMEs and consolidated functions.

A more efficient approach would be to have fewer LMEs that centralize all core business and non-business functions under a unified management.

The two organizational models that are most representative of BH management carved-out of health plans are regional and centralized.

Regional models

Regional models have designated geographic regions that are managed by a range of potential vendors, including counties, LME-like entities, or specialty BH managed care vendors, or partnerships between counties/LMEs and specialty BH managed care vendors.

The regions are typically single or multiple counties, based on population size, distance and other patterns of use factors. The State defines the standards for the operations of the regional entities and monitors compliance. A regional model similar to that implemented in Arizona or Pennsylvania would provide flexibility in customizing a service delivery system for different areas of the State to leverage available resources.

Arizona has six Geographic Service Areas (GSAs). Each GSA is served by a Regional Behavioral Health Authority (RBHA) that is selected through a competitive procurement process. Contracts with the RBHA are for three years with two 1-year renewal options. Currently, four companies act as RBHAs (two of the companies manage two RBHAs). Two are non-profit and two are for-profit management entities. The RBHAs manage State and Medicaid funds for a single county or multiple counties depending on the size of the population and geographic area and manage the financial risk associated with these funds. The Department of Health Services, Division of Behavioral Health Services (DHS/DBHS) manages the contracts with the RBHAs and has the responsibility for oversight of contract compliance. In this model, there is strong local stakeholder involvement and one of the specialty managed care vendors has a voting board comprised of stakeholders from the community that provides direction on service management functions. About 88,000 individuals are served through the RHBAs.[10]

The State of Arizona integrates management of state and Medicaid funds at the regional level and requires the regional entities to manage financial risk through capitation. While providers may be paid on a FFS basis, the regional entity must develop a UM plan that is linked to both service utilization and financial resources. If there are cost overruns, the regional entity bears the cost.

This is different from North Carolina, where Medicaid dollars are paid to providers on a FFS basis, following authorization by ValueOptions, as an Administrative Services Only (ASO) vendor that does not share risk with the State. Thus, North Carolina assumes all the financial risk pertaining to Medicaid, with the exception of the Prepaid Inpatient Health Plan (PIHP) program operated by Piedmont Behavioral Health. This pilot program has two concurrent Medicaid waivers and assumes financial risk for Medicaid funds through a capitated arrangement with the Division of Medical Assistance under DHHS. As a pilot program with an overall rating in Tier One, Piedmont is a good example of how Medicaid and State funds can be managed through a capitated arrangement, assuming financial risk**.**

[10] Based on 2006 figures as reported by CMS.

Pennsylvania has a county-based model for management of its BH services for its 67 counties covering about 1.28M members.[11] Through its HealthChoices program, a Medicaid managed care initiative, the Department of Public Welfare (DPW) through the Office of Mental Health and Substance Abuse Services (OMHSAS) established standards and guidelines for the management of State and Medicaid funds and is responsible for oversight of all county contracts. In the early phases of HealthChoices implementation, 35 of 67 counties were given the first opportunity to participate as the direct contractors in HealthChoices. Thirty-four counties chose to participate as direct contractors and subcontracted with five BH-MCOs. OMHSAS directly contracts with a BH-MCO for the remaining county that chose not to participate in the early phases of the HealthChoices Medicaid program.

More recently as HealthChoices has expanded statewide, OMHSAS required the counties to be of a certain size to participate as a direct contractor or combine with enough counties to have a total Medicaid population of at least 10,000 lives. Again, counties had the right to opt out as well. Twenty-three counties opted out and OMHSAS manages a contract with one of the specialty BH managed care entities for these counties. Counties opt out of directly managing BH services, due to size, resources, and their capacity to manage the financial risk associated with Medicaid.

The remaining counties have subcontracts with for-profit and non-profit specialty BH managed care vendors. Presently, there are five BH-MCOs that contract with either Pennsylvania or the counties through 25 individual contracts. It is also important to note that each of the counties in Pennsylvania contract with one of the same five BH-MCOs. Consequently, there are multiple contracts that each BH-MCO manages. Thus, at times, the BH-MCOs may be implementing different standards for management of the care in different counties.

To support county leadership, OMHSAS has made a strong commitment to invest its resources in financial oversight and quality monitoring of the 23 contracts held by the counties. Each of the county contracts with BH-MCOs have rates set by credentialed actuaries and participate in External Quality Reviews (EQRs) conducted on behalf of the State by an EQR organization. Furthermore, OMHSAS has sizeable QI staffing resource that also provides ongoing quality monitoring of the two BH-MCO contracts managed by Pennsylvania and the 23 BH-MCO contracts held by counties.

A well-developed implementation plan could "roll out" regional management entities within a realistic and manageable time frame.

[11] Based on 2006 figures from CMS.

State resources and authority and direct service delivery in the regional models

Unless North Carolina requires the LMEs to further develop their competencies without State support, DHHS would need to expand its available expertise to include additional specialists in the following areas: UM clinical specialists, provider network management specialists, information technology experts and financial and business management staff, all with experience in managed care. As identified in the findings section of this report, all the LMEs would benefit from additional technical assistance, and many from intensive technical assistance to achieve the level of quality and efficiency demanded by contract requirements and stakeholders alike. Alternatively, North Carolina could competitively procure specialty BH managed care vendors (either for-profit, non-profit, or both) that are fully prepared to operate a managed care program.

For North Carolina to maintain 24 LMEs, or even 10 LMEs, DHHS would need to increase its staffing significantly or contract to provide the technical assistance and ongoing monitoring of each LME due to the level of technical assistance presently needed.

In some regional models, there has been some blending of service delivery into the management entity. However, this has caused criticism from a variety of stakeholders regarding the management entity having high levels of self-referrals and paying itself higher rates for service provision than paid to contracted providers. Consistent with the principle on “elimination or management of conflict of interests,” Mercer recommends separating direct service delivery from the LMEs or any future management entity.

Centralized models

In centralized models, specialty BH managed care vendors provide a statewide infrastructure for access, UM, provider management, clinical quality and financial and information systems. Typically, specialty BH managed care vendors or a partnership of a specialty BH managed care vendor and coalition of local agencies are selected because they have established infrastructures and financial resources to ensure coverage for the entire State for all services needed. Services are delivered through contracts with network providers. The State oversight agency has the responsibility to procure, manage and monitor the overall contract. Local functions are carried out by staff of the BH managed care vendors placed in local communities. The burden on the State oversight agency is significantly reduced due to working with only one centralized administrator. Local staffing patterns, ombudsmen, regional committees and tiered governance structures can be used to ensure responsiveness to local area needs.

Not only is a single contract administratively simpler to administer from a State perspective, but each provider only needs to contract with one vendor. The contractor is able to receive incentives to maintain cost control to preserve cost-effectiveness, whereas, when there are multiple vendors, a single contractor could jeopardize the financial stability of the entire program.

Iowa's centralized BH managed care program has been operated by a statewide specialty BH managed care vendor since 1995. Operating as a PIHP, the Iowa Behavioral Health Plan (IBHP) serves approximately 285,000 members,[12] and assumes financial risk for all Medicaid services through a capitated arrangement. The IBHP manages MH and SAS, including those funded by the State. Two State agencies have oversight roles with IBHP: the Department of Human Services (DHS) for MH services and the Department of Public Health (DPH) for State funded SAS. IBHP is known for its efforts to work with the six regions comprised of 99 counties to reinvest savings into best practice and empirically based services. A portion of the savings generated through UM has resulted in development of the following empirically-supported practices, among others: Assertive Community Treatment (ACT); Illness Management and Recovery; Motivational Interviewing, Intensive Psychosocial Rehabilitation, Self-directed Care, and Consumer and Family Peer-to-Peer Education.

The specialty BH managed care vendor operating this program has an administrative cap of 15%. IBHP also uses teams to work with local communities in the development and expansion of services. Contract specifications reinforce the goals of DHS and DPH, including the potential for sanctions. State oversight was critical to the development of the competitive procurement and contracts, as well as to the ongoing operations of the program, including the transition of specialty BH managed care vendors when a new vendor purchased the original vendor.

Prior to the capitation of IBHP, the Iowa Counties were contributing half of the federal share of Medicaid for certain services (targeted case management, day treatment and partial hospitalization) and paying for all community support services. Savings have accrued to the counties through improved leveraging of State funds to maximize Medicaid reimbursement. It is important to note, however, that Iowa has a smaller population (3 million as compared to North Carolina's population of about 9 million) and less geographic diversity than North Carolina, factors that may contribute to the success of the centralized model.

This model demonstrates that a single statewide entity can be responsive to counties and local communities and increase efficiencies while maximizing resources and revenues.

[12] Based on 2006 figures reported by CMS.

LME roles, post consolidation

Roles of the LMEs

The current LMEs could have one of the following roles in the regional or centralized models:

1. Consolidate into a consortium of LMEs to develop a centralized management entity, including consideration of teaming with a private or non-profit specialty BH managed care vendor

2. Consolidate to operate as one of three to five regional management entities

3. Select the option to return to direct provision of services as a provider in the management entity network.

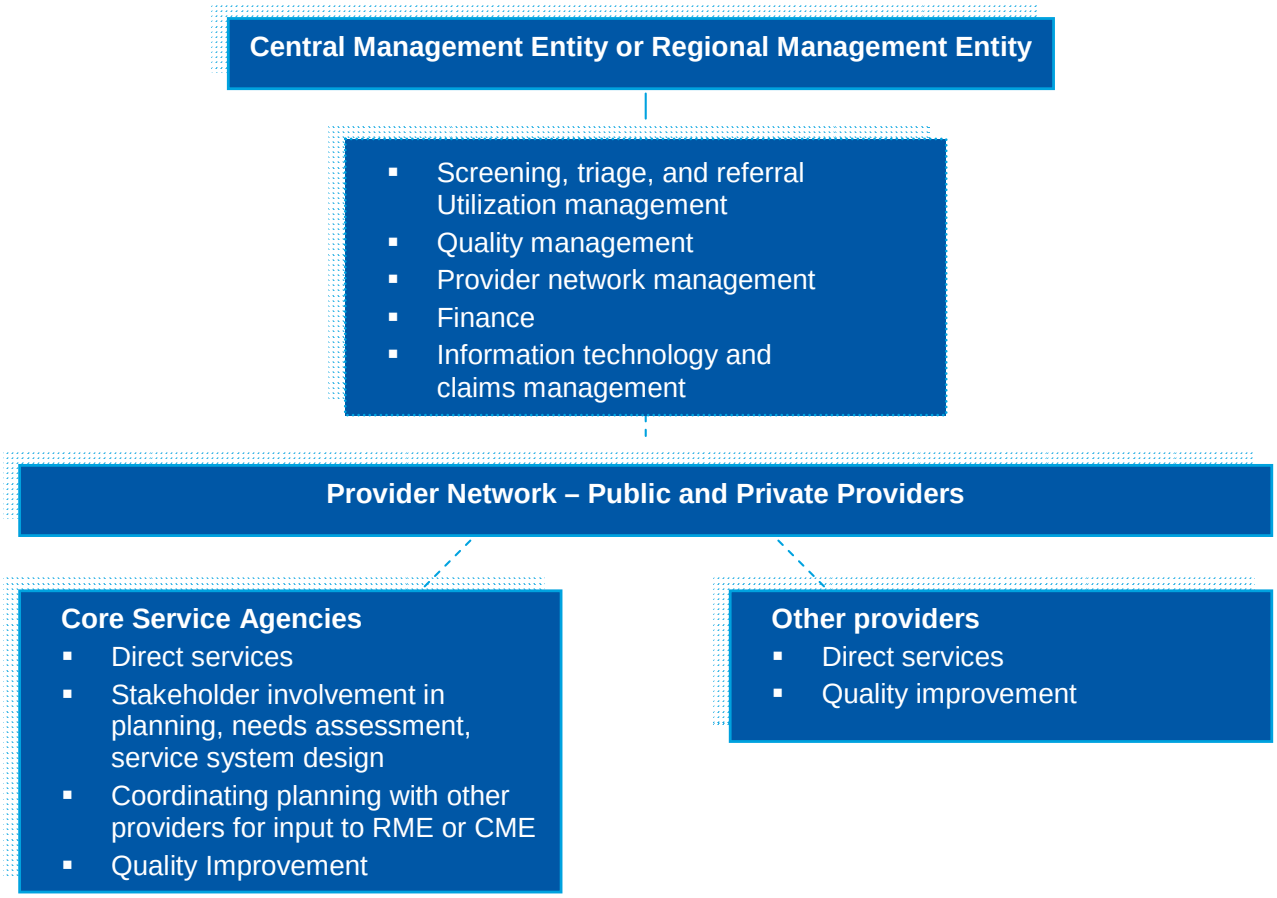
4. Select the option to develop into a direct services Core Service Agency for the CME or RME to provide a comprehensive array of services and perform local planning, stakeholder and community collaboration functions.

The Core Service Agency model preserves local influence, authority and the knowledge of local resources.

The Core Service Agency approach offers the opportunity for LMEs to both continue representing local communities and involving stakeholders in determining needs as well as renew their previous clinical role providing direct services possibly even expanding upon their previous service arrays. As a Core Service Agency, an LME can opt to become a comprehensive service provider for the CME or RME as a lead provider within their networks. With a CME, the Core Service Agency might help anchor a geographic service area as the primary provider of intensive and empirically-supported treatment. With a RME, there would likely still be a need for Core Service Agencies in distinct communities (in multi-county RMEs) or in particular neighborhoods (in single county RMEs). In either case, the Core Service Agency would have certain management functions delegated to them by the RME/CME. Not all areas of the State would necessarily have LMEs ready to take on such a role immediately. In other states where this has been implemented, a Core Service Agency develops a full range of services that include evidence-based and empirically-supported practices, while working closely with other network providers to cross refer when necessary. DHHS and the RME/CME would promote standards and performance expectations for Core Service Agencies and require their participation in the regional or centralized provider network. The Core Service Agencies must demonstrate cost effectiveness and have positive consumer outcomes, and DHHS and the RME/CME would need to provide technical assistance to many LMEs to help them achieve this level of performance. For this option, a transition period would be necessary for the LMEs to assume a fully functioning Core Service Agency role.

All the current LMEs, regardless of tier rating, would have the option to become Core Service Agencies. Six-month performance goals would be set during the transition process. Successful implementation of the Core Service Agency could result in more referrals to the Core Service Agency from the RME/CME and assignment of certain privileges such as conducting their own credentialing or partial delegated review of their service utilization (based on demonstrated results of effectiveness and efficiency). The Core Service Agency would be well positioned to help the RME/CME anchor cross-system coordination and stakeholder involvement. This approach allows the LMEs that prefer to combine direct care and area management functions to have a role within their local systems of care and capitalizes on their knowledge of local systems, organizations and needs.

Typical Functions of a CME/RME and Core Service Agency:



Incremental versus comprehensive change

North Carolina has the choice of continuing with incremental voluntary consolidation of LMEs over time. Alternatively, the State could initiate more comprehensive change and develop a smaller number of RMEs or a CME. In the latter two options, it will be critical to maintain local capacity for performing key local functions in order to meet North Carolina's goals for maintaining strong local involvement.

Mercer identified three strategic options for consideration:

- Option 1 – Maintain the LME structure with fewer LMEs (20 or less)
- Option 2 – Develop RMEs with three to five regional vendors and provisions for maintaining limited infrastructure for local systems of care
- Option 3 – Develop a statewide CME that consolidates functions for efficiency, but maintains a limited infrastructure for local systems of care

As mentioned above, for Options 2 and 3, it will be critical to retain local capacity for performing key local SOC support functions, including emergency response, coordination, inpatient diversion and multi-agency collaboration. The Core Service Agency model described previously would facilitate local input in either the centralized or the regional options. In all of these options, the need for significant State agency-level oversight is also essential, though the level of effort varies in proportion to the number of entities requiring oversight.

The advantages and disadvantages of these three options are described in the following tables.

OPTION 1 – Less than 20 LMEs

Pros	Cons
▪ Modest opportunity for efficiency by reducing number of LMEs from 25 ▪ Maintains strong local presence and control ▪ Responds to local priorities and local planning ▪ QM is close to service area ▪ Strong identity for local staff, consumers, public agencies (police, fire, etc.) ▪ Preserves LME infrastructure ▪ Close coordination of State and county BH funds	▪ Redundant administrative costs remain across multiple organizations ▪ Continued duplication of functions more optimally consolidated (e.g., administrative staffing, information technology, UM, STR, provider management, QM) ▪ Voluntary consolidations take time and are not the most efficient option ▪ Service access and array remains highly variable across the State ▪ Bureaucratic barriers to care and inefficiency for providers working with multiple LMEs (e.g., multiple contracts and policies, QM and claims management systems) ▪ Continued lack of standardization of business and non-business functions ▪ Most difficult for DHHS to oversee, monitor and provide the extensive technical assistance necessary to operate within industry standards ▪ Each provider must contract multiple times to be in multiple networks – this discourages independent providers from participating ▪ Each entity may not have a financially viable number of enrollees and the State ends up subsidizing financial structures that a market-based solution would not support ▪ Less likely to have capacity in each LME to comply with Medicaid fund management requirements

Option 2 – Three to Five RMEs

Competitive procurement of three to five RMEs with local functions – no direct service functions

Pros	Cons
▪ Larger population base than Option #1, more efficient, particularly in preparation for addition of management of Medicaid FFS or waiver funds ▪ Eliminates conflict of interest of LMEs providing direct services ▪ Eliminates duplication of functions at local level, though some duplication is maintained across RMEs (e.g., information technology, claims systems, UM, State oversight) ▪ Key local functions provided by locally stationed staff of the RMEs or shared with Core Service Agencies (e.g., SOC activities, stakeholder involvement, consumer services, and participation in QM initiatives) ▪ Better able to manage quality by assessing trends and needs across a broader system ▪ Provider management more consistent, with streamlined reporting, claims payment, and endorsement/credentialing ▪ Service development leverages broader array of resources, while remaining sensitive to local and regional needs, improving access to high cost, low incidence services and other specialized services ▪ Administrative costs would be reduced due to economies of scale ▪ Some administrative simplification but still more complicated than a single contract	▪ More efficient than 25 LMEs but not as efficient as CME ▪ Local concerns about decision-making and authority, though this can be functionally mitigated through the Core Service Agency role ▪ More difficult for DHHS to oversee, monitor and provide the extensive technical assistance necessary to operate within industry standards ▪ Each provider may need to contract multiple times to be in all networks -- discourages independent providers from participating ▪ Incrementally more complex coordination with county BH funds for RMEs involving multiple counties, similar to current multi-county LMEs ▪ Apparent abandonment of the LME model, absent transition of LMEs to the Core Service Agency role

OPTION 3 – CME

Competitive procurement of Statewide Centralized Management Entity (CME) with local functions

Pros	Cons
▪ Promotes maximum standardization of operations ▪ Most efficient in terms of reducing duplicative administrative services (e.g., information systems, claims) ▪ Facilitates STR function with one central point of access for the public statewide ▪ Centralized UM that standardizes processes across providers and promotes analysis of trends across the State ▪ Centralized provider endorsement and credentialing ▪ Centralized claims payment ▪ Centralized QM ▪ Centralized advocacy for consumer and family involvement ▪ Service development leverages broader array of resources, while remaining sensitive to local and regional needs, improving access to high cost, low incidence and specialized services ▪ Easiest for DHHS to oversee, monitor and provide the extensive ongoing technical assistance necessary to operate within industry standards ▪ Each provider only needs to contract with one vendor ▪ Financial accountability is clearer with a centralized vendor ▪ Core Service Agency role could facilitate local input and provide direct care ▪ A consortium of LMEs could subcontract with a private vendor to perform all administrative functions on a centralized basis to maintain local involvement.	▪ Inconsistent with county and State goals for more decentralized approach and public sector management unless coupled with strong mandates for a Core Service Agency model ▪ Local concerns about decision-making and authority will persist despite mandates for local involvement ▪ Apparent abandonment of the LME model, absent transition to Core Service Agency role ▪ Complicates integration of county BH funding ▪ Single vendor ends up with significant leverage during negotiation, requiring careful procurement and performance-based contract oversight processes ▪ May need to procure a specialty BH managed care vendor or partnership between consortium of LMEs and a specialty BH managed care vendor due to the size and scope of the program as no current single LME could manage a statewide program and oversight of local functions ▪ Shifts some of the burden of system oversight from State to CME ▪ Implementation time frame to consolidate 25 LMEs to 1 CME, unless open procurement involving specialty BH managed care vendors is pursued ▪ Internal politics of selecting a single LME, consortium of LMEs, or private vendor – LME or a consortium of LMEs must be willing to shoulder the responsibility of becoming the prime contractor if a private vendor is not to become the vendor.

Implementing RMEs

Should DHHS pursue Option 2, Mercer recommends Tier One and Tier Two LMEs have the option to form three to five RMEs within a defined geographic area comprising the regions. Mercer also recommends competitive procurement of the three to five RMEs. The procurement should be open to LMEs, specialty BH managed care vendors and a combination of both. A competitive process will allow DHHS to select the RMEs from the best bids.

It would be expected that voluntary associations among the LMEs in contiguous areas would occur as part of the bidding process. Each successful bidder would operate one or more of three to five RMEs. Other LMEs would have the option of becoming a Core Service Agency or a direct service provider. Staff from the remaining LMEs would have the option of applying to open positions in the new RMEs.

Under this consolidation strategy, an RME would be responsible for a larger number of consumers and families, thus obtaining economies of scale in administrative activities. Under this option, DHHS may also want to consider expanding its Medicaid waiver for the PIHP program once the RME demonstrates its capacity to manage care and assume financial risk.

Implementing a CME

Selection of this option would represent a significant change, but also create the most efficiency. Under this option, an LME or consortium of LMEs could bid on becoming the CME; however, due to Mercer's findings of the LME reviews, it does not appear feasible for any existing LME alone to manage the entire State. Furthermore, the LMEs could subcontract with a specialty BH managed care vendor to provide service management functions. The remaining options would be for the LMEs to become a Core Service Agency that provides direct services, planning and stakeholder services, or return to the provision of direct services.

Mercer also recommends consideration of a competitive procurement for a CME. The procurement should be open to LMEs, specialty BH managed care vendors and a combination of both. A competitive process will allow DHHS to select the CME from the best bids.

Support for Core Service Agencies

DHHS, through the RMEs/CME could also consider funding LMEs that want to become Core Service Agencies to provide direct services as well as facilitating local community functions described earlier in this section. As mentioned previously, DHHS would develop operating standards with the Core Service Agencies and provide technical assistance during a transition period. Mercer also recommends that the RMEs or CME (whichever is selected by DHHS) endorse and credential Core Service Agencies using the same criteria for all providers in the network. Also, the RMEs/CME must make every effort to offer at least two provider choices for any services, leaving the option open for other providers to offer services also provided by the Core Service Agencies.

Responsibilities of CMEs and RMEs and their local functions

A potential division of responsibilities between regionalized or centralized management functions and local functions is outlined in Table 6. The responsibilities identified in Table 6 assume there is an enhanced authority of DHHS to develop standards and provide oversight of the management entities, intervene when necessary, require corrective action and assess financial sanctions. Local functions could be provided by Core Service Agencies in conjunction with the CME or RMEs.

Table 6 – Potential division of responsibilities

Functions of the CME or RMEs	**Local functions (Including potential Core Service Agency roles)**
▪ General administrative and governance ▪ Organization ▪ Service divestiture ▪ Committees ▪ Staffing ▪ Information technology help desk	▪ Local participation in administration and governance ▪ Identification of committee members;
▪ Business management and accounting ▪ Cost estimates and methodology ▪ Statistical analysis ▪ LME independent evaluation and accountability (audit) ▪ Financial reporting requirements ▪ Information technology planning	▪ Local input into and review of financial planning
▪ Information management analysis and reporting ▪ Provider claims/encounter data submission ▪ Management for capitated and FFS providers ▪ Service authorizations system capabilities ▪ Eligibility ▪ Information management quality audit ▪ IPRS linkage	▪ Reporting

Table 6 – Potential division of responsibilities

Functions of the CME or RMEs	Local functions (Including potential Core Service Agency roles)
▪ Claims processing ▪ Data entry and edits ▪ Pricing ▪ System integration ▪ COB ▪ Adjustment to claims ▪ System backups, recovery, and disaster planning ▪ Software maintenance	▪ Not applicable
▪ Provider relations oversight ▪ Contract with Core Service Agencies to facilitate local input and provide services ▪ Endorsement ▪ Credentialing ▪ Overall network adequacy ▪ Provider network development ▪ Network management (contracting, oversight) ▪ Provider satisfaction	▪ Network adequacy assessment ▪ Provider capacity development, particularly for empirically-supported community-based practices
▪ Service management ▪ UM program ▪ Staffing ▪ Policies and procedures ▪ Community coordination oversight ▪ Supervision/quality review process ▪ Orientation and training of clinical staff	▪ Community agency involvement and coordination ▪ SOC planning for all services (MH/DD/SAS) ▪ Management of emergency services continuum ▪ Hospital diversion and discharge planning support ▪ Intensive case management ▪ County and locality planning initiatives
▪ Consumer affairs oversight ▪ Customer service line ▪ Centralized or regional CFAC committee ▪ Oversight of consumer satisfaction and consumer rights	▪ Involvement in consumer affairs and quality oversight ▪ Consumer rights monitoring and enforcement ▪ CFAC subcommittees to CFAC at the CME/RME level

Consolidation conclusions

The State must weigh the pros and cons of the three options:

There is no single option that will address all of North Carolina's goals and preferences.

- Option 1 – Continue the voluntary consolidation of the existing LMEs
- Option 2 – Consolidate into three to five RMEs with local functions that preserve local participation
- Option 3 – Move toward a CME with local functions that preserve local participation

Option 3 provides the most efficiency and could be consistent with North Carolina's goals of having local authority, particularly if the centralized model includes decentralizing key local functions and the use of former LMEs as Core Service Agencies. Under this option, a consortium of LMEs, perhaps with a specialty BH managed care vendor, could bid on becoming the CME. Option 2 would best capitalize on the resources invested in the LMEs to date, while moving the system forward to achieve better access to services, improved quality and significant efficiencies. This option could allow some of the LMEs to become RMEs and others to become Core Service Agencies with local functions that preserve local input.

Mercer does not recommend Option 1, continuation of voluntary consolidations, due to inefficiency, duplicated functions and possible consolidation among entities that are in the lower performance tiers. Option 2 and Option 3 would facilitate integration of Medicaid funding into the management entity, allowing more consistent application and management of Medicaid regulations.

In all of these options, Mercer strongly recommends that the management entity focus on management of services and public and private providers focus on direct delivery of services.

Recommended guidelines for consolidation

Mercer offers the following guidelines for any options involving consolidation of LMEs:

1. Claims management should occur either at the CME or at the RMEs, depending on the option selected. Mercer does not recommend a separate State-operated or subcontracted claims management system outside of the CME/RME structure, based on findings from Mercer's review of other states.

2. One statewide toll-free access number should be available to the public and providers to promote easy access to STR and emergency services in any of the options identified. The toll-free line would automatically be routed to the management entity covering the area of the caller's telephone number if the regional option is selected.

3. If considering an RME model, a competitive selection process that includes the LMEs in Tier One and Tier Two should be considered to obtain the most competitive proposals based on the quality of the response (assuming the administrative and service dollars are capped). The more open the competitive process (for example, allowing both non-profit and for-profit bidders and including specialty BH managed care firms), the more likely the State will maximize the responsiveness of bids.

4. If considering the CME model, the procurement should be open to both non-profit and for-profit bidders, including specialty BH managed care entities, as well as LMEs, including partnerships between LMEs and specialty managed care vendors.

5. The competitive procurement should include the standards that are referenced in the findings section of this report, as well as current DHHS requirements.

6. Finally, an essential element for successful change in North Carolina is the development of community-based and empirically supported services. Expansion of emergency services is an important step, but these services will only become overloaded without development of more community-based alternatives. These services are essential to the health and stability of people with MH and SA issues, as well as those with developmental disabilities.

Recommendations related to management entity performance and technical assistance needs

The follow recommendations focus on the specific requirements of a management entity and are based upon Mercer's review of current LME requirements and issues identified through the independent evaluation.

Financial and business management operations recommendations

As part of our review, Mercer was presented with meaningful data from DMH/DD/SAS to analyze costs and utilization for the LMEs. In addition to the data requested directly from the LMEs, we were able to conduct additional cost and statistical review of the LMEs. However, the financial reporting requirements for the LMEs should be more comprehensive as Mercer has observed in other states with BH delivery systems carved-out from health plans. The following are recommendations for improvement that DMH/DD/SAS could pursue to ensure more consistent and meaningful financial and utilization reporting requirements from the LMEs.

1. Conduct independent audits. Although the LMEs do have an annual audit requirement, the county-based LMEs are generally summarized within the overall county Comprehensive Annual Financial Report (CAFR) along with other public health programs. A more meaningful and consistent auditing requirement is recommended for the county-based audits to include a separate audit and review of internal controls for the county's individually sponsored LME.

2. Implement quarterly financial reporting requirements. This should include at a minimum standardized reporting package including:

   - Balance Sheet
   - Income Statement – to include predefined revenue and administrative expense
   - Utilization and individuals served reporting
   - Accounts receivable reporting
   - Claims payable reporting to include aging reports
   - Related party transactions and cost allocations

   Reporting on these items will enhance the current requirements of the monthly financial monitoring and statistical reports submitted by the LMES.

3. Implement single stream funding for all State funds. The State should move towards Single Stream State funding for all LMEs. As of this report date, eight LMEs had been approved for Single Stream funding. This practice reduces administrative burden to request appropriation transfers from DMH/DD/SAS from one category of service to another. In conjunction with the budget estimates, DMH/DD/SAS and the Controller's Office should evaluate estimates as compared to actual results by service category on a monthly basis to determine the accuracy of anticipated expenditure categories to actual service expenditures. Although this is a current practice, LMEs that consistently over/under estimate expenditures by category of service should be elevated to a higher level of scrutiny through requests for variance explanations as well as on-site reviews to further evaluate the causes for cost overages.

4. Review variance in county contributions as a percentage of total expenditures. County data obtained from DMH/DD/SAS shows a wide variance of contributions to LMEs for FY 2006/2007. This ranges from 0.79% to 69.14% of total LME expenditures. County fiscal restraints are an important factor in the ability to subsidize service expenditures to LMEs, but a minimal amount of contribution would place some equitable relationships to LME service delivery and operational effectiveness. Consolidation of LMEs on a regional or central basis with county representation would enhance an equitable service delivery pattern and provide DMH/DD/SAS with more focused oversight responsibilities to ensure that the management entities are compliant with State policies and operating at a high level of efficiency.

5. Stabilize service rates. Provider reimbursement increases in service rates and utilization of community support services has caused substantial increases in costs at a pace that cannot be afforded by the State. Increased provider auditing with a focus on more effective use of time spent with clients and differentiating the service rates for licensed professionals and paraprofessionals would be useful in managing care and costs.

6. Place a cap on administrative expenses for the current LMEs at 15% or less would produce savings of approximately $25 million or greater dollars for the State. This estimate assumes that the existing LME structure is maintained.

7. Consolidate to five LMEs. Fewer LMEs would also generate significant savings. The administrative expense data received from the plans provided a direct correlation of less administrative burden for LMEs serving larger populations. Reducing the number of LMEs to five would provide approximately $25 million savings in administrative overhead.

Information technology and claims management recommendations

For the LMEs, or other future management entities, specific recommendations for their information technology and claims management include the following:

1. Encounter submissions to IPRS from all LMEs should be mandated and include both FFS (non-capitated) and shadow (capitated) encounters. The content of submissions should be validated for content and the financial aspects compared to the general ledger reports made available by the LMEs. However, the State may want to consider updating the platform and software of the IPRS system, further integrating it with the Medicaid claims system if the LMEs manage Medicaid services. The different requirements for each of these systems will be burdensome to LMEs in the long-term, particularly if the LMEs are capitated for Medicaid services.

2. All LMEs should be required to implement quality review processes for claims payments. This process should include randomly selecting 2% – 3% of all processed claims for review. Each LME should also create policies and procedures for performing quality audit and implement a process for tracking and reporting the results.

3. The State should require LMEs to improve COB efforts with other carriers when other insurance is available. The State could look at options to perform some of the collection. The LMEs could request, collect and store COB information. In the LME claims processing function, the system should have the ability to stop claims from paying unless other insurance information has been coordinated when applicable. The State could implement a back-end process using the claim submissions to IPRS and a vendor. COB is an area with potential savings for the State.

4. Processes to reconcile eligibility data between the State and LMEs' systems should be performed on a regularly scheduled basis. Currently the State does not provide a file of recipient eligibility to the LMEs that can be used by the LME to compare to the data in their systems. Discrepancies between the systems will require research to identify where corrections in the data and process improvements can be made.

5. The State should require that each LME have adequate system backups and disaster planning. Backups should be taken at regularly scheduled times. The LMEs ability to use these backups for disaster recovery should also be tested on a regular basis. Policies and procedures should be documented, outlining the processes for running system and data backups, including the frequency, and location information for cyclical recovery testing.

Clinical operations and governance recommendations

Specific recommendations for clinical operations and governance of the management entities are listed below.

1. All clinical areas of the management entity should report to a licensed clinician.

2. All management entities should have a full time psychiatric Medical Director that has a formal oversight role for all clinical functions, especially UM and QM.

3. All management entities should maintain a standing QM/QI Committee and UM Committee that meets regularly and involves the Medical Director and clinical supervisors/administrators of QM/QI and UM.

4. A standard set of staffing guidelines for local function offices for either the Central or Regional management entities should be developed if one of those options is selected.

5. Staffing templates for the ratio of staff to eligibles/enrollees should be developed for the following types of positions:

    a. Call center staff (STR)
    b. Service management, including care management and UM
    c. Supervisor to staff ratios for the above positions
    d. Consumer affairs/customer service staff to enrolled population ratios
    e. Physicians reviewers/advisors to the management entity

6. Staffing templates for the ratio of provider relations staff to contracted providers should be developed.

7. Staffing guidelines for the number of QM/QI positions should be developed based on consolidation options.

8. The management entity should have dedicated staff responsible for information technology help desk functions to support the STR, UM, Consumer Affairs/Customer Service, QM/QI and Provider Relations staff.

9. Clinical staff making UM decisions should be both licensed themselves and formally supervised by licensed clinicians. This should include formal face-to-face supervision by the medical director and senior clinical staff, formalized monitoring of inter-rater reliability for UM decisions, and formalized blind call monitoring procedures to observe and document staff's clinical customer service skills and ability to apply medical necessity criteria of the LME.

10. Clinical staff should be provided formal orientation and ongoing training designed to improve the quality of clinical staff's UM activities. On a day-to-day basis, the medical director and senior clinical staff should be involved in ongoing oversight through review of complex clinical cases.

11. Management entities should be required to have the technology for and routinely conduct live monitoring of all consumer and provider calls on behalf of consumers by clinical supervisors.

12. Management entities should implement procedures to credential providers for the provision of specialty services beyond the current Medicaid endorsement process.

13. Develop a standard provider endorsement and credentialing process statewide so that a provider only has to be endorsed and credentialed once to contract with a management entity and the endorsement and credentialing materials can be shared across management entities.

14. Develop a standard policy and procedure for emergency calls that includes: the definition of routine, urgent and emergent calls; scripted questions for STR staff to screen consumers for emergencies; the requirement that emergency calls are answered via warm lines, (e.g., never transferred or put on hold); physician availability 24/7 for crisis consultation; and LME clinician follow-up until crisis is stabilized.

15. Utilization data and internal QM data on: telephone answering times; inter-rater reliability of call center staff and UM staff; and complaints and grievances need to be collected, analyzed, and trended over time to provide the LME with a analysis of internal operations.

16. Provider monitoring should include collection and analysis of performance data that is trended and tracked over time to drive QI initiatives.

General recommendations

Mercer recognizes the proposed options require significant change. During the implementation of the selection option, Mercer recommends the following strategies for DHHS action:

1. Facilitate a stakeholder advisory committee to review the proposed options, and advise on the implementation feasibility and ongoing implementation strategies.

2. Consider drafting enabling legislation defining intended system changes to facilitate efficient and effective implementation.

3. Develop performance goals and desired outcomes for the transition, implementation, and ultimate operations of the management entity(ies).

4. Prepare a detailed implementation plan with deliverables, due dates and responsible parties for all aspects of the transition. Assign a senior level implementation manager with the authority to make and implement decisions.

5. Determine DHHS resources necessary to provide oversight, including staffing and tools.

6. Develop incentives to encourage current LME staff to stay employed throughout any transition period and provide job counseling and identification of other employment opportunities during the final phase of the transition.

7. Assist LMEs that choose to return to become Core Service Agencies with transition resources.

8. Consider establishing a communications plan to provide information to the public and stakeholders, including a toll-free line for Questions & Answers.

Appendix A

Appendix A – Acronyms

ACT	Assertive Community Treatment
ADATC	Alcohol Drug Abuse Treatment Centers
AFS	Audited Financial Statements
ASO	Administrative Services Only
BH	Behavioral Health
BH-MCO	Behavioral Health Managed Care Organization
CAFR	Comprehensive Annual Financial Report
CAP	Community Alternatives Program
CARF	Commission on Accreditation of Rehabilitation Facilities (CARF)
CFAC	Consumer and Family Advisory Committee
CME	Central Management Entity
COA	Council on Accreditation
COB	Coordination of Benefits
DD	Developmental Disabilities
DDE	Direct data entry
DHHS	Department of Health and Human Services – North Carolina
DHS/DBHS	Department of Health Services, Division of Behavioral Health Services – Arizona
DHS	Department of Human Services - Iowa
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services – North Carolina
DPH	Department of Public Health – Iowa
DPW	Department of Public Welfare – Pennsylvania
DSS	Division of Social Services – North Carolina

Appendix A – Acronyms

ECBH	East Carolina Behavioral Health
EQRs	External Quality Reviews
FFS	Fee-for-Service
FTE	Full Time Equivalent
GSA	Geographic Service Area
HIPAA	Health Insurance Portability and Accountability Act of 1996
IBHP	Iowa Behavioral Health Plan
IPRS	Integrated Payment and Reporting System
LME	Local Management Entity
MH/DD/SAS	Mental Health, Developmental Disabilities, and Substance Abuse Services
MR	Mental Retardation
NC	North Carolina
NCQA	National Committee for Quality Assurance
OMHSAS	Office of Mental Health and Substance Abuse Services
PCP	Person Centered Plan
PIHP	Prepaid Inpatient Health Plan
QI	Quality Improvement
QM	Quality Management
RBHA	Regional Behavioral Health Authority
RME	Regional Management Entity
SA	Substance Abuse
SFY	State Fiscal Year
SOC	System of Care
STR	Screening, Triage, and Referral
UM	Utilization Management

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Mercer Health & Benefits LLC
3131 East Camelback Road, Suite 300
Phoenix, AZ 85016
602 522 6500

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