Mental Health Reform and Waiver Implementation in North Carolina: Carving In, Out and Integrating Care

Brian Ingraham, CEO Smoky Mountain Center
brian@smokymountaincenter.com

The Evolving World of Behavioral Health on the Eve of the Affordable Care Act (ACA) Implementation

11/11/13
Public Sector Community Mental Health Policy 101: The Challenge

- How to take various forms of funding (Federal, State, County) and transform it into services that citizens need
- How to do this for individuals who have an entitlement for care based on their Medicaid eligibility and “medical necessity” and
- For individuals who are not Medicaid eligible and have no other insurance to pay for their care
A Quick NC Scouting Report...

- As a result of vastly different implementation dates, the State now has all 100 counties under a Medicaid 1915(b)/(c) Waiver; a “Behavioral Health and I/DD Carve Out”
  - NC is one of only three States with a combo (b)/(c) Waiver
- NC has chosen **not** to expand Medicaid enrollment through the Affordable Care Act.

- So far in 2013:
  - A new Governor took office: Pat McCrory
  - A new Secretary of HHS was appointed: Aldona Wos M.D.
  - A new Medicaid Director was appointed: Carol Steckel (left after 9 months)
North Carolina started off like any other state: Area Programs

- In the 1970s, Area Programs were established to provide community mental health services.
- Some of these programs were organized as single counties, but most were made up of small groups of counties.
- Area Programs functioned much like County Departments, and the predominant funding was State Aid and County Support.
Area Programs: “The Good Old Days”

- Area Programs wore two hats; typically, they directly delivered mental health services and contracted for other services (intellectual/developmental disability and substance abuse).
- As reimbursement for services changed from grant-based or net deficit funding to Medicaid fee for service it changed everything.
The counties within an area program share the same color. Programs with names not based on the counties have labels attached.
Mental Health Reform 2001: Landmark Legislation, NC House Bill 381

• Acknowledged and attempted to offer correction to much of what was learned in the PCG Study:
  – Given limited resources, assistance should be targeted to those with the greatest need; and
  – Given insufficient and uneven community services, a core set of services was needed statewide.

• Acknowledged the need for greater participation of families and consumers by establishing Consumer Family Advisory Committees
NC House Bill 381: Results

- Drastically changed the role of Area Programs by requiring their transformation into Local Management Entities (LMEs):
  - Separated payer and provider roles; and
  - Changed population requirements to force consolidation and greater economy of scale
The PBH Pilot

• In 2005 one of the LMEs, PBH, had the opportunity to expand the scope of Mental Health Reform by operating a Medicaid 1915 (b)/(c) Waiver.

• Participation in the Waiver allowed PBH to employ managed care tools to increase cost effectiveness, efficiency, consumer access and provider quality.
What is different under the Waiver?

- PBH paid for and authorized all public MH/IDD/SA services, including those funded by Federal, State, County and Medicaid dollars.

- As an at-risk, Prepaid Inpatient Health Plan (PIHP), PBH managed Medicaid-funded services within the framework of a per-member-per-month (PMPM) capitation rate.

- The Waiver allowed PBH to operate a closed provider network; provider contracting was based on need, desired utilization, outcome and quality as opposed to “any willing provider” standards used in fee-for-service networks.
The PBH Waiver Experience

- PBH operating under the Waiver worked!
  - Access to care increased.
  - Member satisfaction increased.
  - Outpatient services stabilized.
  - Unnecessary hospitalizations decreased.
  - Savings were reinvested in additional services.
  - In contrast to the rest of the State, stable and predictable Medicaid expenditures were realized.
Managed System vs. Fee-for-Service Costs

![Graph showing comparison between Managed System and Fee-for-Service costs over time.]

**KEY:**
- □ State Average Per Member Per Month under Fee For Service Medicaid
- ◆ PBH Per Member Per Month costs under Managed Care

*Fee for service rates include state administration, HP Enterprise Services, Value Options/local management entity administration. PBH rates include PBH administration and state administration; 2010/2011 estimated.*
Why not expand the Waiver?

- In 2011 the General Assembly passed HB 916 to expand the Waiver statewide and limit operation authority to LMEs only.
- LMEs were required to apply and meet readiness standards, including population criteria, before 7/1/13 to be deemed eligible to “go live” under Waiver.
- If standards weren’t met, the LME must merge with another Waiver entity or be assigned by the DHHS Secretary by 12/31/13.
Capitation and Risk are introduced...

- A prepaid inpatient health plan (PIHP) is based on an insurance model.
- Bigger is better in an insurance model, because risk is shared across a broader membership pool; but, when does size compromise rich public engagement?
- Size drives mergers to reduce the number of LME-MCOs to 11; failure reduces the number to 10; the number will soon be nine.
Serious carving has happened...
Local Management Entity - Managed Care Organizations (LME-MCOs) and 1915 b/c Medicaid Waiver Implementation Dates

Western Region
- Partners Behavioral Health Management
  - Feb 2013
- Smoky Mountain Center Jul 2012
  (Western Highlands Network - Jan 2012)
- MeckLINK Behavioral Healthcare
  - Mar 2013
- Cardinal Innovations Healthcare Solutions
  (PBH-Jul 2005, Alamance-Caswell-Oct 2011,
  Five County-Jan 2012, OPC-Apr 2012)

Central Region
- CenterPoint Human Services
  - Feb 2013
- Sandhills Center Dec 2012
  (Guilford Apr 2013)
- Eastpointe
  - Jan 2013
- East Carolina Behavioral Health
  - Apr 2012

Eastern Region
- East Carolina Behavioral Health
  - Apr 2012
- Alliance Behavioral Healthcare
  - Feb 2013
- CoastalCare
  - Mar 2013

- Reflects LME-MCOs as of 10/1/13.
- Western Highlands Network operating under a management agreement 10/1/13, merger date 7/1/14.
Success, failure and a big **SURPRISE!**

- Between Jan. 1, 2012 and Feb. 1, 2013 all LMEs pass readiness reviews and go live on the 1915(b)/(c) Waiver.

- By March 2013, the State terminates its contract with one of the MCOs, Western Highlands Network (WHN), for the management of both Medicaid and State funds. WHN consolidates with Smoky Mountain Center on Oct. 1, 2013.

- In May 2013, the NC Secretary of Health and Human Services announces the Governor’s “Partnership for a Healthy North Carolina” plan, promising another reform – this time of the Medicaid system.
“Partnership for a Healthy North Carolina”

• Plan calls for:
  – Repair of a “broken” Medicaid system to create a predictable and controllable Medicaid budget;
  – Greater integration of care through the creation of Comprehensive Care Organizations (CCEs) that are the entry point for all services;
  – Creation of CCEs and risk-based financing system to be enabled via Medicaid 1115 Waiver; and
  – RFP approach to be used to select three to four large vendors (CCEs) capable of competing for business statewide.
How do we get there?

- The “Partnership for a Healthy NC” plan
  - is in stark contrast to historic NC investment in public management of “carve out” or “specialty care system” supported by 1915 (b)/(c) Waiver,
  - does not account for Community Care of NC, a public Medicaid medical care management network, and
  - only large commercial plans are seen as being capable of managing a risk based contract of this magnitude...$2.3 billion for behavioral health and I/DD alone; $12 billion total Medicaid budgeted for the state.
Good News and Bad News...

- The good news is that the carve outs are accomplishing much of what is desired; the capitation rates for all the sites reflect reductions in Medicaid.

- The bad news is that further calibration and standardization is needed; too many LME-MCOs are doing business too many different ways.
The Solution...

- Reduce the number of LME-MCOs from ten to four
- Assure a minimum Medicaid-eligible population of 300,000 for each region
- Assure geographic contiguity and a mix of rural and urban populations for each region
- Provide a fit for the existing publicly-managed specialty care system
What could be achieved by a regional plan?

- A better business environment for providers through standardization of business processes.
- Streamlined oversight activities for state agencies by having only four contractors.
- Increased administrative efficiencies and reduced overhead costs for LME-MCOs.
- As a result of an increased number of Medicaid enrollees in each Regional LME-MCO, reduced financial risk.
- A way to sustain the investment in the public “Specialty Care System” currently managed through the 1915 (b)/(c) Waiver.
MCO Regions Proposed

Goal: to establish contiguous regions and balance population density by including both urban and rural counties in each Region. Each region has a minimum general population of 2 million and minimum Medicaid population of 300,000.

Western Region:
(Smokey + WH + Partners + Centerpoint)
Pop: 2,538,782
Medicaid: 392,125

Central Region #2:
(Durham, Wake, Johnston, Cumberland
+ Sandhills - Guilford - Randolph)
Pop: 2,263,083
Medicaid: 307,457

Central Region #1
(Cardinal + Guilford + Meck -
+ Randolph - Halifax)
Pop: 3,541,046
Medicaid: 510,327

Eastern Region:
(ECBH + Coastal + F.D. + Halifax)
Pop: 2,159,286
Medicaid: 379,898
A Different Perspective...

Photo used for entertainment purposes only
Population Scale for Western Region

- **July 2006:** Smoky’s original seven counties (Total: 7)
- **July 2007:** Smoky adds five NRSA counties (Total: 12)
- **July 2008:** Smoky adds three Foothills counties (Total: 15)
- **July 2012:** Smoky begins MCO Operations
- **October 2013:** Smoky adds eight WHN counties (Total: 23)
- **Date TBD:** Proposed Western Regional Partnership (Total: 35)
Financial Scale for Western Region

- July 2006: Smoky’s original seven counties (Total: 7)
- July 2007: Smoky adds five NRSA counties (Total: 12)
- July 2008: Smoky adds three Foothills counties (Total: 15)
- July 2012: Smoky begins MCO Operations
- October 2013: Smoky adds eight WHN counties (Total: 23)
- **Date TBD: Proposed Western Regional Partnership (Total: 35)**

Budget amounts:
- 2006: $16,131,772
- 2007: $28,560,751
- 2008: $45,266,911
- 2009: $50,811,445
- 2010: $41,468,703
- 2011: $48,815,178
- 2012: $154,774,907
- Jul-2013: $159,843,252
- Oct-2013: $335,000,000
- Date TBD: $750,000,000
Will it work?