

Managed Care: Right or Wrong for North Carolina

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Since 2005, Piedmont Behavioral Healthcare (PBH) has operated North Carolina's only managed care Medicaid waiver program. Legislation was recently passed requiring that the waiver program be expanded statewide by January 2013. Experience with the PBH model suggests that this expansion can result in significant savings without compromising quality or access.

The Affordable Care Act of 2010 opened the door to vast changes in the US health care system. As a result, innovations are sweeping across that system, changing it irrevocably. Fundamental reforms in health care operations now taking place include an expansion in the use of electronic health information technology, a greater emphasis on producing positive health outcomes, the development of reimbursement models that will reward attainment of improved health outcomes rather than productivity, an intense focus on accountability, and the expectation that operations will achieve a high level of efficiency.

Many reforms, especially those defining health care operations, will continue to play out regardless of what the US Supreme Court decides regarding the constitutionality of the Affordable Care Act. For North Carolina, these changes arrive at a time when its behavioral health system is suffering from highly publicized failures, state budget shortfalls, escalating Medicaid costs, poor quality of care, and abuse of Medicaid services. In order to function effectively under these circumstances, the North Carolina system of care for people who have mental health or substance use problems or intellectual or developmental disabilities needs to be reshaped; its transformation will require leadership and vision.

In response to state budget shortfalls, system instability (including multiple changes in the service array, new requirements for provider staff training, greater utilization control, and rate reductions for certain services), and the expectation that the number of people eligible for Medicaid will increase significantly when ACA criteria go into effect in January 2014, the General Assembly took decisive action in June 2011, passing House Bill 916 [1]. That legislation established a timeline for statewide expansion of the state's section 1915(b)/(c) Medicaid waiver program and defined the framework of the community behavioral health system of the future by requiring a transition to a managed care model

built on Medicaid funding. As part of the waiver expansion, the local management entities (LMEs) that were created by the state's Mental Health Reform Bill of 2001 [2] will merge with one another to form managed care organizations (MCOs). LMEs have long-standing connections to their communities and can build on existing infrastructure. Because the General Assembly wanted to ensure the success of the expansion, House Bill 916 requires that the expansion be implemented in a manner that is faithful to the PBH demonstration model created for the pilot Medicaid waiver program launched in 2005.

Why Managed Care?

The Medicaid managed care contract requires that MCOs develop strategies to address the special needs of Medicaid populations, including inadequate income, disabilities, lack of transportation, substandard housing, illiteracy, poor diet, as well as cultural and language barriers. Regulations governing the operation of Medicaid waivers require education, outreach, and focused intervention activities on the part of the MCO in order to ensure that enrollees are assisted in accessing necessary care. Linkages to primary care are a must. Managed care operates differently in systems that are publicly funded than in commercial systems funded by private insurance, because the people served in the former often require direct outreach and assistance to access care. Without timely and appropriate services, these individuals often seek care in high-cost settings such as emergency departments. It is now well established that if people receive the care they need when they need it, health outcomes are better and the use of high-cost alternatives is reduced.

Managed Care Offers Advantages for States

Advantages of the managed care model include the ability to predict Medicaid expenditures, which allows states to prepare their budgets with greater certainty. States also achieve administrative efficiencies by contracting with one

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Planned Changes in Child/Family/Youth Services at One LME/MCO

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Western Highlands Network (WHN) is a local management entity/managed care organization (LME/MCO) managing state and federal behavioral healthcare funds in Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties. In January 2012, WHN had a general population of 535,492 and a Medicaid-eligible population of 80,297. During that month, the network provided services and supports to 7,785 active consumers through state, grants, and Medicaid funding. Of these, 3,075 were Medicaid funded and less than 21 years old.

The children and young adults we serve, ages birth through 20, have historically been high users of long-term residential placements and psychiatric treatment facility services, which are high in cost and often take these young people far from their families or caregivers. Further, the treatment modality chosen has not always been matched to the underlying diagnosis. Thus treatment success has been hard to predict—results have been uncertain at best and potentially harmful at worst.

The 1915(b)/(c) Medicaid waivers require LME/MCOs to measure how good a job they are doing of adopting evidence-based guidelines and other promising practices, to close the provider network to new providers until an area-services needs assessment has been completed, and to develop methods of assessing provider performance with regard to business operations, service access, expected outcomes and consumer satisfaction.

The waiver is structured to “reward” the LME/MCO for being a good manager of services. One goal is move-

ment from expensive, high-end services of short duration to longer-term, in-home (or at least close to home) services; another is the provision of services that research has shown to be effective. Any savings achieved will be reinvested in expanding the services and supports in the eight county area served by the LME/MCO. The federal Centers for Medicare and Medicaid Services and the North Carolina Department of Health and Human Services clearly expect the LME/MCO to be 100% “at risk.” At risk means that the LME/MCO must operate within the yearly negotiated rates it receives from Medicaid or use its own fund balance to make up any deficit in overspending. Consumers and providers will be the losers if funds go unspent. The goal is to spend wisely on what works for a particular child or family, with the right services and supports at the right time, delivered by the right provider for the right duration and at the right intensity, while monitoring the quality of care.

Coordination of care with primary care physicians is critical for all age groups and disability populations. WHN is a leader in working with the local Community Care of North Carolina network (known as Community Care of Western North Carolina in WHN Counties). With additional waiver funds, the number of integrated care managers will expand from two to four in order to provide coordination of care for consumers whose need of both physical and behavioral health services is great.

Here is the Child/Family/Youth “Blueprint” that WHN plans to implement to achieve the goals of the waivers: (1) Assessments will be performed by competent clinicians,

or more capitated, at-risk MCOs rather than with thousands of fee-for-service providers. Managed care offers states a single point of accountability by making it possible for there to be one designated manager for the entire continuum of services and supports for a specified geographic area. States can hold a single entity responsible for access, quality, and cost. A benefit of managed care for an entity receiving public funding, such as PBH, is that administrative funds are concentrated within the MCO. Currently, Medicaid administrative funds for Medicaid fee-for-services care and for the special Medicaid community waiver program of CAP-MR/DD (Communities Alternative Program for Persons with Mental Retardation/Developmental Disabilities) are dispersed across several organizations, including ValueOptions, HP Enterprise Services, and a few LMEs. Diluting precious administrative resources compromises the capacity of any single entity to develop the infrastructure necessary for waiver operations. The infrastructure requirements include complex information technology, quality oversight systems, and highly qualified staff members to operate these systems and manage for outcomes.

One of the advantages of the managed care Medicaid

waiver program is that there is an option under 1915(b)(3) for states to use savings to reinvest in additional services that are not otherwise available to the state’s Medicaid population. The savings realized are converted to a special per-member, per-month payment that provides funding for the additional services in future years.

Managed care systems create predictable business environments for providers by managing competition through a closed network. A closed network provides choice for consumers, but offers providers the opportunity to have sufficient market share to support investment in their local infrastructure. PBH’s use of evergreen contracts (contracts without an end date) provides additional assurances to providers. The managed care waiver program requires MCOs to ensure that consumers have both access to services and a choice of providers. Low-density populations can result in inadequate numbers of providers and poor access to care in rural areas. The MCOs are responsible for recruiting providers for underserved areas and can use financial incentives such as special rates to bring providers into a specific geographic area.

The MCOs have full authority to ensure quality of ser-

child/adult psychiatrists, and Intellectual/Developmental Disability Care Coordinators. These assessments will be required to address physical needs identified by appropriately trained medical professionals. (2) Coordination of care will be provided for those children and youth with mental health needs who also require social services, are involved with the criminal justice system, have high physical health needs, or have multiple system-related issues (eg, social services, juvenile justice, medical, educational). (3) Referrals will be made to the providers enrolled in WHN who can best meet an individual's needs. (4) Utilization managers and care managers will determine whether WHN providers are providing the right level of care at the right intensity, whether the care is working, and whether the child or youth and his or her family are satisfied with these supports and services. (5) Those planning the care of children, families, and youth will consider when it might be appropriate to titrate them off of supports and services. Life-long planning will begin for children and youth whose intellectual or developmental disabilities suggest that they may need life-long supports and services; criteria for discharge will be determined for the others.

If savings result from implementing the changes listed above, we will use the money to make the following improvements to services and supports for children, youth and families: First, we plan on investing more heavily in prevention, creating a prevention continuum to reach children and youth with trained peer-support specialists (eg, student peer counseling, youth directed mental health advocacy programs). We intend to improve the quality of treatment provided by identifying and offering evidence-based or promising practices for specific conditions or diagnoses. We also plan to expand the array of services

and supports for children with autism spectrum disorder, oppositional defiant disorder, and conduct disorder, and to make a greater variety of specialty providers available. For example, we plan to contract with psychiatric residential treatment facilities in or close to our community to develop specialty services for children and youth with specific diagnoses. We also want to find specialists who can provide therapeutic foster care (ie, families that specialize in taking in youth in crisis as alternatives to inpatient or facility based crisis units). We plan to provide transitional services for adolescents who are aging out of the foster care system and cannot go home, and for those 18 to 20 years of age who have mental health problems, substance abuse disorders, or intellectual or developmental disabilities and lack family support. We also intend to provide facility-based crisis and stabilization services for youths undergoing short, intense crisis episodes by making beds in those facilities available for short-term intensive treatment. NCMJ

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vices. Medicaid regulations establish a framework for quality that is carefully monitored through annual External Quality Review audits. The MCOs have authority to set and enforce quality and performance standards, enroll and discharge providers from the network, and apply sanctions for poor-quality care.

Regulations established by the managed care waiver ensure strong consumer protections, including availability of information and appeal rights. The goal of managed care is to ensure that people needing services are efficiently directed to medically necessary care. The MCOs have the authority to make exceptions in order to meet the unique needs of individuals—by making exceptions for limits on the number of services authorized, for instance, and by setting consumer-specific rates. The PBH demonstration indicates that efficient access to the most appropriate service in combination with other managed care strategies, including a closed provider network, have resulted in overall costs that are significantly lower than in the fee for service Medicaid system in North Carolina.

The managed care model is more structured and organized than a fee-for-service system. There is more over-

sight and management of all aspects of system operations. This will feel restrictive to some stakeholders. However, the advantages of the model far outweigh the disadvantages of any restrictions, whether real or perceived.

States that operate Medicaid fee-for-service systems, as North Carolina has been doing, have few options when they are faced with reducing Medicaid costs. In a fee-for-service Medicaid system, states are limited to system-wide cost-control methods that uniformly impact all providers and all of the people they serve, regardless of needs. The only options the state has are to limit the amount of services available (for instance, by restricting the number of hours per day, per week, or per month that the consumer can receive the service), to reduce provider rates, or to refuse to cover any nonmandatory services.

Basing the Medicaid Waiver Expansion on the PBH Model

PBH began operating a section 1915(b)/(c) waiver in April 2005. The effects of the waiver on the PBH community system have been increasingly positive, and significant overall savings to the Medicaid program have followed

its implementation. Over the years, a number of external evaluations have verified these results. Outcomes affected favorably include the percentage of those in need who are served, compared with the state average, as shown in Table 1. In addition, for individuals with Medicaid coverage, PBH's rate of utilization of services for intellectual or developmental disabilities is much higher than the statewide rate: In the PBH region, 413.2 out of every 10,000 Medicaid enrollees receives such services, compared with the 237.7 out of every 10,000 Medicaid enrollees statewide [3].

PBH has demonstrated that significant savings can be achieved through managed care without compromising quality or access. In 2010, according to an analysis performed by Mercer Government Consulting, PBH's Medicaid costs per member per month using the managed care model were \$132.62, compared with an average Medicaid cost statewide of \$170.96 per member per month (PBH, unpublished data). During the 3-year period from 2008 through 2010, PBH spent a total of \$116,862,770 less than they would have spent if their Medicaid costs per member per month had been the same as the average statewide cost per member per month. For all 6 years of operations since the PBH waiver was implemented (2005-2011), PBH's total Medicaid costs were more than \$200 million lower than they would have been if PBH's costs per member per month had been the same as the average statewide cost over the same period (PBH, unpublished data).

The 1915(b)(3) waiver gives states the opportunity to use Medicaid savings to fund additional services that Medicaid will not pay for outside of the waiver; these are known as (b) (3) services. Services designated for such funding, developed by PBH and approved by the state and CMS, include respite care, supported employment, personal care or individual support, one-time transitional costs, psychosocial rehabilitation and peer supports, physician consultation, and an array of deinstitutionalization services. For example, in the counties served by PBH, those caring for children with Medicaid coverage who have mental health or substance abuse problems or intellectual or developmental disabilities are eligible for respite care services. In the other North Carolina counties, a child must be enrolled in the CAP-MR/DD waiver in order for his caregivers to receive Medicaid-funded respite care. If a CAP-MR/DD slot is not available, the service is not available to that child's caregivers. PBH claims and financial data reveal that from 2008 through 2011, more than \$9.3 million dollars were spent on approved Medicaid alternative services available through the 1915(b)(3) option, and 1,771 people were served (PBH, unpublished data).

Managed care does not mean saying "No." PBH has consistently had a very low denial rate for requests for Medicaid-funded services. PBH data reflect a denial rate that is generally in the range of 0.05% to 1.5% on a monthly basis. In 2010, there were 25,999 requests for services, and the annual denial rate was 1.6%; in 2011, there were 33,931 requests, only 0.85% of which were denied (PBH, unpublished data).

TABLE 1.
Percentage of North Carolinians in Need Receiving Services During State Fiscal Year 2011

Age/Disability Group	In counties served by PBH	State average
Adult/Mental health	80%	53%
Child/Mental health	67%	57%
Adult/ Intellectual or developmental disability	64%	41%
Child/ Intellectual or developmental disability	36%	22%
Adult/Substance abuse	18%	11%
Child/Substance abuse	11%	9%

Note. Persons with multiple disabilities are counted in all applicable rows. Data were initially compiled from PBH claims, Medicaid fee-for-service claims, and state-funded service claims and then published in *The PBH Managed Care Experience: A Comparison to Non-Managed Care Local Management Entities*. North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services; December 1, 2011:1-2. <http://www.ncdhhs.gov/mhddas/statspublications/Reports/DivisionInitiativeReports/LME-MCOPerfReports/PBHExperience2011-12.pdf>. Accessed April 21, 2012.

The Medicaid managed care waiver requires MCOs to focus on consumer satisfaction. PBH conducts an annual consumer survey through a third party to ensure that consumers will feel that it is safe to respond honestly [4]. UNC-Charlotte Urban Institute has conducted the survey for a number of years and provides PBH with an in-depth analysis of survey results. The UNC-Charlotte Urban Institute also conducts an annual provider satisfaction survey to assess the level of provider satisfaction [5]. Data from both satisfaction surveys is widely reviewed within PBH and is used to develop improvement goals and strategies.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse conducts an annual Perception of Care Survey for consumers receiving behavioral health services. The Division also contracts with the Human Services Research Institute to conduct an annual Core Indicators assessment for people with intellectual or developmental disabilities. Tables 2 and 3 show how PBH's performance on these state-sponsored assessments compares with the statewide results.

PBH has also been evaluated a number of times by external organizations with managed care expertise, including Mercer Government Consulting and the Carolina Center for Medical Excellence [6]. Evaluation recommendations have been used to inform improvement plans while at the same time the overall results of these evaluations have been consistently positive, demonstrating that the waivers allow for a higher quality community system at lower cost.

The Managed Care Model Can Work for All of North Carolina

PBH's goals in implementing its managed care model originated with the public input process that defined its 2003 Local Business Plan. The company decided to use the

TABLE 2.
North Carolina Perception of Care Survey Results for Consumers Receiving Mental Health or Substance Abuse Services and Their Families

Domain	Category of consumer	Year	% with a positive perception of domain	
			In counties served by PBH	State average
Access to services	Adults (18 years of age or older)	2009	86%	87%
		2010	85%	88%
	Youth (12 to 17 years of age)	2009	81%	83%
		2010	74%	84%
	Parents of children under 12 years of age	2009	88%	91%
		2010	100%	94%
Outcomes	Adults (18 years of age or older)	2009	67%	73%
		2010	76%	76%
	Youth (12 to 17 years of age)	2009	57%	73%
		2010	87%	71%
	Parents of children under 12 years of age	2009	59%	68%
		2010	50%	73%
Treatment planning	Adults (18 years of age or older)	2009	84%	85%
		2010	82%	87%
	Youth (12 to 17 years of age)	2009	77%	81%
		2010	89%	78%
	Parents of children under 12 years of age	2009	91%	94%
		2010	100%	93%

Note. Data are from The PBH Managed Care Experience: A Comparison to Non-Managed Care Local Management Entities. North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services; December 1, 2011:21-22. <http://www.ncdhhs.gov/mhddsas/statspublications/Reports/DivisionInitiativeReports/LME-MCOPerfReports/PBHExperience2011-12.pdf>. Accessed April 21, 2012.

strength of the model to transform its community system, by focusing on the priorities of consumers and their family members and by making continual adjustments to meet the changing needs and choices of persons with mental health or substance abuse problems or intellectual or developmental disabilities. The values identified at the very beginning of this effort—recovery, self-determination, person-centered planning, and consumer- and family-driven services—continue to be central to PBH's operations.

It was very difficult for PBH to remain focused on these goals during the long waiver start-up period. PBH began waiver operations in April 2005. In March 2006, the Medicaid service array was completely revamped, resulting in a second start-up period for both PBH and our providers. Waivers are difficult to implement because of the myriad of details that must be put into operations through many different individuals within an organization, as well as communicated to external stakeholders. When these details change, the entire system is impacted. The most challenging aspect of operations for PBH during this period was to keep everyone working in tandem. We were presented with problems and questions every hour of every day that had to be addressed. Every decision that had to be made had never been made before. Communicating decisions and change orders on a timely basis was critical. We made many mistakes during start-up. We went down wrong roads, we disagreed about what to do, we were indecisive, and we did not communicate

effectively. We made the best decisions when we remembered what we wanted to achieve through the managed care waivers. A waiver start-up needs strong centralized leadership. There is no room for debate, blame, dissention, or indecision. There is nothing more important than having a strong, committed team. We were also very fortunate to have the good will of our employees, our providers, and the people we served. We learned to be patient, and not to be defensive. We listened to feedback and acted on it. We were lucky that we were not in the spotlight, and when we made mistakes, we learned, made corrections and moved on.

Managed care is a means to an end. It is a strong framework for a cohesive, efficient, organized, responsive, accountable, and quality-driven system. It comes with powerful tools only available through a managed care framework, tools that can be used for the benefit or to the detriment of a community system. This is why having a vision and having values are so essential for success.

North Carolina needs a strong model to take the community system of services for people with mental health or substance use problems or intellectual or developmental disabilities to the next level. The managed care model is the only vehicle currently available that can transform the current system into a world-class operational model of the future. PBH has demonstrated that a publicly managed and privately operated service system can provide balance, accountability, and outcomes that will serve the citizens of

TABLE 3.
Selected National Core Indicator Survey Results for Consumers in North Carolina Receiving Services for Intellectual or Developmental Disabilities

Categories	2008-2009		2009-2010		2010-2011	
	In counties served by PBH	State average	In counties served by PBH	State average	In counties served by PBH	State average
Satisfaction						
The proportion of people who are satisfied with their home staff	100.0%	98.6%	90.9%	95.0%	94.7%	92.2%
The proportion of people who are satisfied with their neighborhood	95.2%	93.3%	81.8%	87.2%	91.3%	87.0%
The proportion of people who are satisfied with their job	100.0%	97.3%	66.7%	90.3%	100.0%	92.5%
The proportion of people who are satisfied with their day activity	100.0%	96.0%	83.3%	91.7%	93.8%	93.5%
The proportion of people who are satisfied with their day activity staff	100.0%	98.9%	100.0%	95.4%	94.4%	94.8%
Service Coordination						
The proportion of people who report that they have met their case manager	100.0%	97.0%	100.0%	93.5%	88.6%	93.5%
The proportion of people who report that service coordinators help them get what they need	100.0%	88.0%	87.5%	87.0%	100.0%	80.7%
The proportion of people who report that their service coordinators asked about their preferences	100.0%	80.8%	75.0%	85.4%	90.0%	82.5%
The proportion of people who report participating in a person-centered plan	78.9%	81.8%	100.0%	86.0%	95.5%	82.0%

Note. Data are from reports titled NCI for Piedmont for each year indicated. These are the results of National Core Indicators Surveys for the years in question. National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute.

North Carolina well.

Nearly all states are expanding their Medicaid managed care programs because of expanding enrollments, diminishing state budgets, and changes driven by the Affordable Care Act. However, North Carolina is the only state pursuing a publicly managed model. We have a unique window of opportunity that will soon close. Success is possible. All the MCOs, including PBH, need the confidence and good will of our system stakeholders. There will not be another chance for the public system in North Carolina. This is it. **NCMJ**

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