

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