

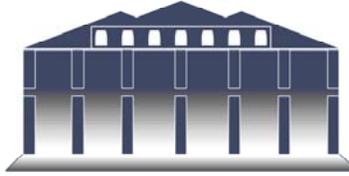
**Compromised Controls and Pace of Change
Hampered Implementation of
Enhanced Mental Health Services**



**Final Report to the Joint Legislative
Program Evaluation Oversight Committee**

Report Number 2008-05-3

July 29, 2008



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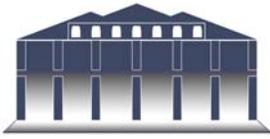
The Program Evaluation Division 2007-2008 Work Plan, approved December 5th, 2007, directed the Program Evaluation Division to conduct a process evaluation of the implementation of the Enhanced Services Package of mental health, developmental disabilities, and substance abuse services. Evaluation findings and recommendations are contained in this report.

I would like to report that the Department cooperated fully with our staff during the evaluation.

Sincerely,

A handwritten signature in black ink, appearing to read "John W. Turcotte".

John W. Turcotte
Director



PROGRAM EVALUATION DIVISION

NORTH CAROLINA GENERAL ASSEMBLY

July 2008

Report No. 2008-05-3

Compromised Controls and Pace of Change Hampered Implementation of Enhanced Mental Health Services

Summary

For the past two years, the NC Department of Health and Human Services has struggled with implementing a new array of mental health services known as the Enhanced Services Package. This new array of services was designed to leverage federal funding and improve the range of mental health, developmental disabilities, and substance abuse services available to citizens with complicated and chronic disabilities. As soon as the new service array was implemented, however, levels of services and expenditures rose rapidly. Subsequent reviews by the department found that in some cases, the services provided were not medically necessary. The Program Evaluation Division's analysis identified several key problems that contributed to utilization and cost overruns.

- **Pace of implementation.** Delays in securing federal approval of the new array of services meant the department had three months to implement the services. As a result, a number of oversight processes either had not matured or were not in place when implementation began. Some providers were thus able to take advantage of the system by delivering an unchecked amount of services.
- **Insufficient forecasting and monitoring.** The department did not adequately forecast costs or utilization. Nor did the department have a baseline against which to measure system performance and assess utilization and expenditures. Once implementation began, the department's tracking of expenditures was not detailed enough to show the underlying pattern of escalating services and costs.
- **Information not organized for decision-making.** Performance goals and measures were not established for the service array at the outset, and the department's current external reports present excessively dense data that are neither synthesized nor interpreted. The lack of useful information limits decision-makers' abilities to understand trends and determine how well the current system is working.

The Program Evaluation Division recommends the department:

- manage data and information so that its executives can readily identify key issues and respond purposively; and
- improve its internal data analysis and policy development processes by continuing to move from data collection and reporting to information synthesis and knowledge management.

Scope

Two years after the introduction of a new array of mental health, developmental disabilities, and substance abuse services concerns about cost overruns and service utilization management prompted the NC General Assembly to question the effectiveness of the implementation of the Enhanced Services Package. Of particular concern were Community Support services, a component of the new service array.¹

As a result, the General Assembly Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to conduct a process evaluation of the implementation of the Enhanced Services Package to determine if the process was efficient and effective.

The Program Evaluation Division collected and analyzed data from many sources including:

- interviews with representatives from the NC Department of Health and Human Services, the Division of Medical Assistance, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services;
- interviews with representatives of the NC Council of Community Programs, the NC Providers Council, and other stakeholders;
- a survey of the 25 Local Management Entity directors;²
- legislation associated with mental health reform and enhanced services implementation; and
- agency documents including policies, directives, communications, and quantitative data.

The Program Evaluation Division's objective was to understand how the department intended to implement the new service array and how implementation actually progressed.

Background

House Bill 381, passed in October 2001, ushered in a major transformation of the state mental health, developmental disabilities, and substance abuse system affecting

- governance/system management,
- infrastructure/organization,
- range and types of services offered,
- types of clients served, and
- service delivery mechanisms.

Legislation, in conjunction with the NC Department of Health and Human Services (DHHS) state plans, laid out a vision for improving the mental health system for consumers, providers, and agencies that participate in

¹ The Enhanced Services Package is an array of new mental health, developmental disabilities, and substance abuse services that was implemented March 20, 2006. It includes 20 services and is designed to provide a range of treatment options across the three disability groups. Community Support is a rehabilitation service that focuses on support needed to assist a person in achieving and maintaining rehabilitative, sobriety, and recovery goals.

² Local Management Entities are the local public health organizations responsible for managing the delivery of mental health care throughout the state.

and are served by the system. Broad reform goals are outlined in Exhibit 1.³

Prior to the passage of House Bill 381, North Carolina’s system for providing mental health, developmental disabilities, and substance abuse services faced major challenges.

- At least one state psychiatric hospital was in danger of losing federal funding.
- Local mental health agencies were being investigated by the Health Care Financing Agency for mismanagement of federal funds.⁴
- Stakeholders criticized the state for lack of access to services and over-utilization of institutional facilities for the care of individuals with mental illness, developmental disabilities, or substance abuse problems.⁵
- A US Supreme Court ruling required states to provide community-based treatment for people with mental disabilities and move away from reliance on state psychiatric hospitals and other institutions. In addition, several national studies recommended states provide mental health services in the community.⁶

Exhibit 1

Mental Health Reform Goals by Stakeholder Category

Consumers	Providers	State
<ul style="list-style-type: none"> • Greater choice • No wrong door • Greater input into system • Community-based services • Services focused on rehabilitation and prevention 	<ul style="list-style-type: none"> • Greater role in shaping the system • System standardization/ state-wide uniformity • Creation of a public-private partnership for service delivery • Training 	<ul style="list-style-type: none"> • System uniformity • Fiscal stability • System-wide accountability • Collaboration among stakeholders • Employment of evidence-based practices • Improved system management

Source: Program Evaluation Division based on State Plan 2001: Blueprint for Change.

³ Every year DHHS releases a state plan detailing the vision, goals, and objectives of the state mental health, developmental disabilities, and substance abuse system. This report was issued every year from 2001 to 2006 and every three years as of 2007. The 2007-2010 State Plan is the Division of Mental Health’s first strategic plan as required by S.L. 2006-142.

⁴ Legacy of Benign Neglect. (1998, August 16). *The Raleigh News and Observer*. The article noted that area authorities (precursors to Local Management Entities) could have to repay as much as \$75 million in federal funds due to insufficient record keeping.

⁵ Public Consulting Group, Inc. (2000, April). *Study of state psychiatric hospitals and area mental health programs* (Final Report). Raleigh, NC: Office of the State Auditor.

⁶ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. (2008, April) *Report to the 2008 Regular Session of the 2007 General Assembly*. Raleigh, NC: General Assembly.

After the passage of HB 381, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance began planning for and implementing mental health reform. Initially, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services focused on developing and articulating a high-level vision for reform, culminating in the publication in November 2001 of the first state plan. In 2002 the department began to develop plans and policies to support reform implementation. The department estimated mental health reform would be implemented over a five-year period beginning in July 2002 and completed in late 2007.⁷ Indeed, between 2002 and the end of 2007 the state mental health, developmental disabilities, and substance abuse services system underwent tremendous changes including

- department reorganization;
- introduction of new services;
- transition from a state-controlled system of care to a public-private partnership where the state and local mental health organizations served as system managers and private providers delivered care; and
- introduction of or changes to various oversight and management processes, including service authorization, provider endorsement and enrollment, and utilization management and review.

One of the most significant changes brought about by reform was transforming Area Programs, the local providers of mental health services under the old system, into Local Management Entities.⁸ Designed to achieve economies of scale and scope, reform legislation called for the consolidation of the 40 Area Programs down to 20 Local Management Entities. The new Local Management Entities, unlike Area Programs, were responsible for developing and monitoring services delivered by a network of private providers. The transition of Area Programs to Local Management Entities began in July of 2003 and the consolidation to 20 Local Management Entities was to be completed by January 2007. To date, there are 25 Local Management Entities operating in the state.⁹

⁷ DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2005, August 3). Reform of the mental health, developmental disabilities and substance abuse services system. Town Hall Meeting briefing. Retrieved from http://www.ncdhhs.gov/MHDDSAS/stateplanimplementation/townmeeting8_3_05.ppt.

⁸ Local Management Entities were established to ensure that accountability for publicly-funded mental health, developmental disabilities, and substance abuse services stays with the public system. The rationale for creating Local Management Entities at the local and regional levels was to separate management functions from provider functions, create local governance with strong county connections, and follow a business plan approved by the state. Original mental health reform legislation assigned Local Management Entities the functions of planning, provider network development, service management, financial management and accountability, service monitoring and oversight, evaluation, and collaboration. Additional legislation passed in July 2006 expanded Local Management Entities responsibilities to include access to core services, provider endorsement and monitoring, and utilization management and review. See 2001 NC Sess. Laws, 2001-437, Section 1.9 and 2006 NC Sess. Laws, 2006-142, Section 4(d).

⁹ In 2001 there were 40 Local Management Entities, by July 2003 there were 33, by July 2006 there were 29. To date consolidation has brought the number down to 25. DHHS continues to pursue options for further consolidation and/or regionalization of Local Management Entities. As of publication the department hoped to achieve additional Local Management Entities reductions by July 2009. See Carpenter, G & Wyman, O. (2008, April 3). *Independent evaluation of the performance of Local Management Entities*. Mercer Government Health and Human Services Consulting. See also Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. (2008, April 17). *2008-2009 Program for MH/DD/SAS, Attachment 3*. Raleigh, NC: NC General Assembly.

In addition to local reorganization, House Bill 381 called for DHHS to reorganize the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Before reform the division was organized by disability groups. As part of the reform effort, the division was reorganized by functional areas to improve management of the new mental health system.¹⁰ The plan proposed reorganization of the division by January 2003; reorganization was completed in April 2003.¹¹

The department, Local Management Entities, and other stakeholders characterize the period between 2003 and 2006 when the bulk of system changes were taking place as a time of instability and reactive decision-making. Stakeholders routinely told the Program Evaluation Division the constant stream of changes (e.g., multiple policy revisions, new processes, new legislation, and new responsibilities) did not afford the opportunity to fully adapt.

Enhanced Evidence-Based Services. North Carolina's broader mental health reform effort sought to strengthen services by adopting evidence-based practices that were clinically proven, science based, and outcome focused. To this end, the department developed and sought approval from the US Centers for Medicare and Medicaid Services (CMS) for a new array of services as seen in Exhibit 2. Each of the services included updated definitions of care, entrance criteria for consumers, staffing requirements, and expected treatment outcomes. Prior to the passage of mental health reform, several studies identified gaps in services across the state. For example, the availability and depth of substance abuse services and crisis services had been identified as lacking across the state.¹² In response, the department designed the new service array to expand participation in Medicaid's rehabilitation option, thereby leveraging federal funding for a wider and more complete range of services.¹³

¹⁰ DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2003, October 21). Reorganization Update. *Communication Bulletin #12*. Retrieved from <http://www.dhhs.state.nc.us/MHDDSAS/announce/commbulletins/commbulletin012.pdf>. Functional divisions included Community Policy Management, State Operated Services, Advocacy and Customer Services, Administrative Support, and Resources and Regulatory Management. Each functional area was further broken down into teams. See Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2003, June 30). *Quarterly Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services April 1, 2003 to June 30, 2003*. Raleigh, NC: NC General Assembly.

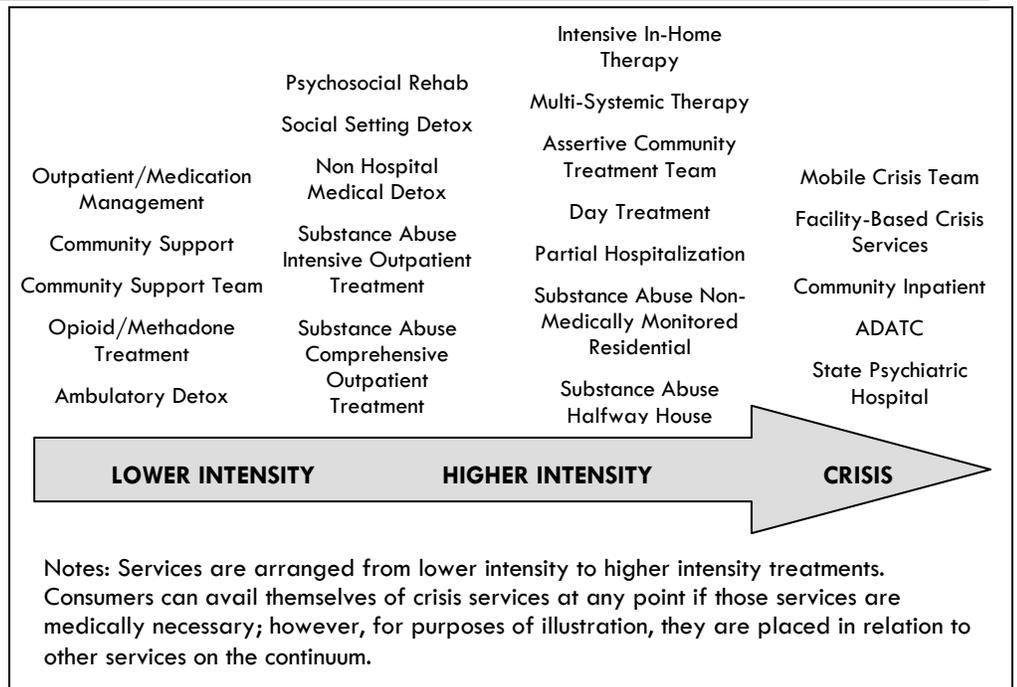
¹¹ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. (2003, June 30). *Quarterly Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services April 1, 2003 to June 30, 2003*. Raleigh, NC: NC General Assembly.

¹² MGT of America. (2001, October). *Study of mental health/substance abuse facilities and their role in North Carolina's system of care*. Presented to Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. Raleigh, NC: NC General Assembly. See also Public Consulting Group, Inc. (2000, April). *Study of state psychiatric hospitals and area mental health programs* (Final Report). Presented to Office of the State Auditor. Raleigh, NC.

¹³ DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2005, February 3). Reform of the mental health, developmental disabilities and substance abuse services system. Town Hall Meeting briefing. Retrieved from http://www.ncdhhs.gov/MHDDSAS/stateplanimplementation/townmeeting2_3_05.ppt.

Exhibit 2

Continuum of New Service Array



Source: Program Evaluation Division in collaboration with Mike Lancaster, Co-Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Aiming for start-up in July 2005, the department began working on the new array of services in 2003 and engaged with CMS in 2004. However, CMS did not approve the service package until December 29, 2005, and the new service array did not go into effect until March 20, 2006.¹⁴

As divestiture of Area Programs progressed, the provider network intended to replace it was not yet fully operational. The department was concerned that until CMS made a final decision, potential providers would be unwilling to commit to delivering a suite of unapproved services and some consumers might be in danger of “falling through the cracks.”¹⁵ Department efforts to ensure continuity of care, allow for greater policy flexibility during the transition period, and mitigate the effects of CMS delays in approving new services produced unintended consequences which are discussed in greater detail later in the report.

Once implemented, utilization of the new services grew quickly. By December 2006, Medicaid expenditures for enhanced services were averaging \$45 million a month. In some cases utilization grew by as much as 200% over a single quarter (April to June, 2006). For example, the average cost of Opioid Treatment, a substance abuse service, went from \$30,972 in the last quarter of Fiscal Year 2005-06 (April-June) to an average of \$103,390 in the first quarter of Fiscal Year 2006-07 (July-September). Although many services grew exponentially during the early days of implementation, simply looking at percentage growth is misleading. When expenditure data by service is considered, the disparity between services is more readily apparent. Monthly expenditures for most

¹⁴ CMS (letter to Alan Dobson, Director, Division of Medical Assistance, December 29, 2005).

¹⁵ Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. (2005, January). Report to the General Assembly of North Carolina. Raleigh, NC: NC General Assembly.

enhanced services stayed well below the million dollar mark, whereas individual Community Support services—for both adults and children—cost over \$10 million within four months of implementation.

Accounting for 90% of expenditures for enhanced services, Community Support services became the main source of alarm.¹⁶ Division of Medical Assistance data show monthly expenditures for children and adolescents grew from \$4.5 million in April 2006 to \$61.8 million in February 2007.¹⁷ Monthly expenditures for adults ballooned from \$1.2 million in April 2006 to \$30.9 million in February 2007.

In the fall of 2006 the DHHS Secretary was notified¹⁸ that the costs of Community Support services continued to surge. This finding prompted the department, beginning in February 2007, to audit 167 Community Support service providers and perform a post-payment clinical review of nearly 12,000 records to determine medical necessity of the type and quantity of services. Reviews found that the program paid providers nearly \$60.8 million for 4.7 million units of Community Support services that were *not* medically necessary.¹⁹

Additionally, the audits and post payment reviews enabled the department to

- identify problems in providers' understanding of Medicaid billing procedures;
- identify problems with providers' understanding and application of the Community Support services definition;
- identify that 36% of previously authorized Community Support services were not medically necessary and another 53% were not authorized at the appropriate level;
- require \$59 million in paybacks from providers who overcharged the system; and
- make policy changes affecting the rate charged for Community Support services and adjust the service definition and authorization process for Community Support services.

¹⁶ Community Support services include Community Support Adults, Community Support Children/Adolescents, Community Support Group, and Community Support Team. However, it should be noted that Community Support Adults and Community Support Children/Adolescents accounted for the majority of Community Support costs.

¹⁷ All expenditure data is based on date of payment.

¹⁸ In fall 2006 several entities became aware of the continuing rise in Community Support expenditures. Although it is not clear who first noticed that Community Support expenditures were getting out of control, it seems that Value Options, the Division of Medical Assistance, and legislative staff all raised questions about Community Support services around the same time. Department officials confirm the Secretary was made aware of the problem sometime between October and November 2006.

¹⁹ According to the Division of Medical Assistance, 4,734,909 units of Community Support services were deemed medically unnecessary. At the current rate of \$12.82 per unit of Community Support service, the value of these units equals \$60,701,533. Units of service for Community Support are measured in 15-minute increments.

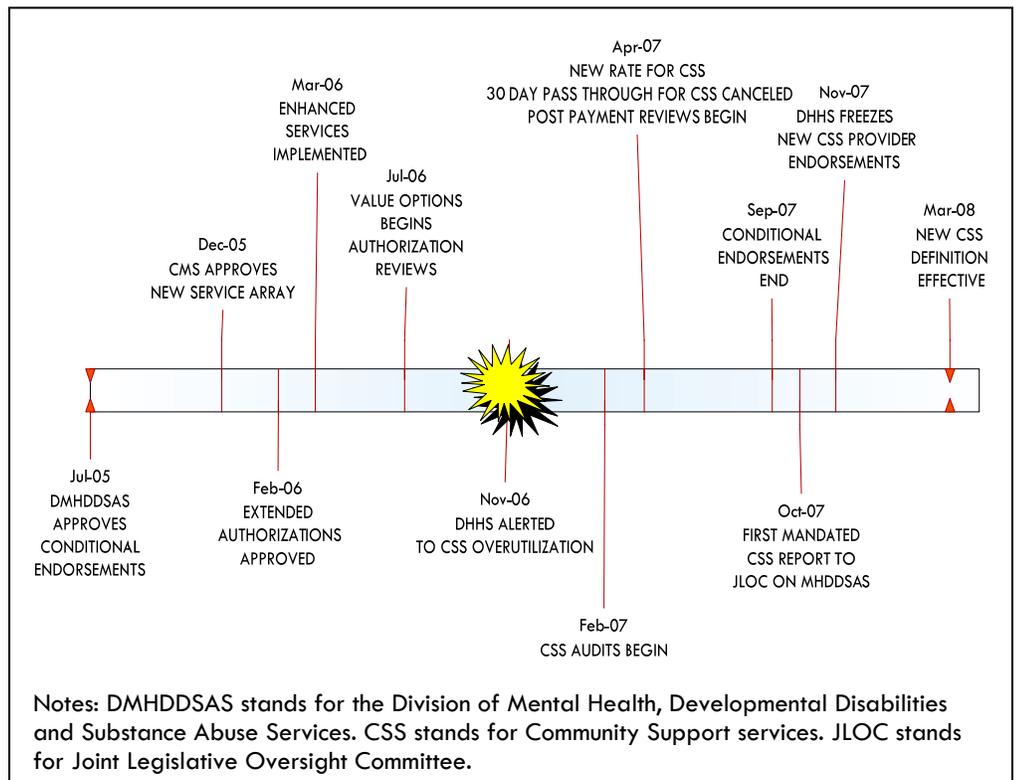
Findings

Finding 1. The pace and scope of implementation facilitated over-utilization and cost overruns.

Once the US Centers for Medicare and Medicaid Services (CMS) approved the new service array, the NC Department of Health and Human Services (DHHS) had a maximum of three months to implement the services.²⁰ This short timeframe put pressure on the department to quickly ramp up the infrastructure necessary to support service delivery. However, a number of oversight processes designed to control system utilization had either not matured or were not in place at the time the new services took effect. Exhibit 3 presents a timeline of key events associated with implementation of the Enhanced Services Package, which are discussed in further detail below.

Exhibit 3

Timeline of Key Events Associated with Enhanced Services Package Implementation



Source: Program Evaluation Division.

Conditional endorsements allowed for a quick ramp up of the provider network, but the process did not guarantee provider quality and has been perceived as administratively cumbersome. The department established an endorsement/enrollment process to verify that incoming providers had the qualifications and capacity to provide services. Providers seeking to deliver enhanced services had to be endorsed by a Local Management Entity before being enrolled by the Division of Medical Assistance and billing Medicaid. Endorsements were site and service

²⁰ According to the department, CMS required the state implement the new services within the first quarter following approval of the new service array. Furthermore, all the services had to be implemented at the same time; CMS would not allow the department to phase in new services over time.

specific. For example, if a provider wished to offer Intensive In-Home services in two different counties, that provider had to be endorsed twice. Endorsements were granted for groups of services in phases. Providers wishing to offer services such as Intensive In-Home, Community Support, and Diagnostic Assessment were eligible to apply for endorsement between September and November 2005. Successive endorsement phases lasted from December 2005 through the end of 2006.²¹

Delays in gaining CMS approval of the Enhanced Services Package and the relatively short time the system had to ramp up once approval was granted created uncertainty about provider network capacity.²² Additionally, providers were hesitant to go through the full endorsement process, especially during the early phases, until final CMS approval was achieved.²³ In order to ensure provider availability and mitigate the effects of CMS delays, the department decided to allow conditional endorsements.²⁴ In order to receive a conditional endorsement, providers had to submit program descriptions for service provisions, hiring plans, policy and procedure documentation, and corporate information. Under conditional endorsement, however, providers were not necessarily required to be fully staffed or to have obtained all required credentials.²⁵

The rationale for allowing conditional endorsements was to ensure an orderly transition from old to new services, address provider capacity concerns, and ensure the continuity of services during the transition. Under conditional endorsement, providers could enroll with the Division of Medical Assistance and bill for services once they became fully staffed. Although initial endorsement and enrollment policy stated a conditional endorsement could be granted for up to six months and renewed for another six, the department extended conditional endorsements for up to 18 months.^{26,27}

²¹ Endorsement for enhanced services was done in eight phases. The endorsement/enrollment processes as well as the endorsement phases are described in DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, *Communication Bulletins #44, #47, and #55*. Retrieved from <http://www.dhhs.state.nc.us/mhddsas/announce/index.htm>. Endorsement for Phase I services was scheduled to take place between September 1, 2005 and November 30, 2005; Phase II between December 1, 2005 and February 28, 2006; Phase III between March 1, 2006 and May 31, 2006; and Phase IV between June 1, 2006 and August 31, 2006. *Communication Bulletin #55* split the last phase into three phases and extended the phases through the end of 2006. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services stipulated the beginning date of each phase represented the earliest date providers could enroll with Medicaid.

²² DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2005, August 31). Provider endorsement transition plan. *Communication Bulletin #47*. Retrieved from <http://www.dhhs.state.nc.us/MHDDSAS/announce/commbulletins/commbulletin047endorsementtransitionplan8-31-05.pdf>.

²³ NC Council of Community Programs. (2006, January 31). New Medicaid Service Definitions Approved—What's Next? *Community News*.

²⁴ DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2005, August 31). Provider endorsement transition plan. *Communication Bulletin #47*. Retrieved from <http://www.dhhs.state.nc.us/MHDDSAS/announce/commbulletins/commbulletin047endorsementtransitionplan8-31-05.pdf>; DHHS, Division of Medical Assistance. (2006, May). Attention: All providers of enhanced benefit mental health/substance abuse services. *NC Medicaid Special Bulletin*. Retrieved from <http://www.ncdhhs.gov/dma/bulletin/Enhancedbenefits0506.pdf>. The department eliminated conditional endorsements in September 2007.

²⁵ It may be helpful to think of a conditional endorsement as a documented intent to provide a given service as well as documentation of how a provider plans to implement service delivery.

²⁶ It should be noted that the endorsement and enrollment policy went through several changes. The draft policy was published in April and June of 2005. During 2007 the policy was amended three times, as documented in DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2007, Sept 10). Full Endorsement of providers of MH-DD-SA services. *Implementation Bulletin #33*. See also DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2007, October & December). Policy and procedures for endorsement of providers of Medicaid reimbursable MHDDSA services. Retrieved from <http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>.

Once conditional endorsement had been granted, Local Management Entities were expected to monitor providers to ensure criteria for full endorsement would be met. At the end of the conditional endorsement period, LMEs were expected to review each provider's readiness to become fully endorsed.

Providers expressed concern to the Program Evaluation Division about the length of time between conditional endorsement and full endorsement reviews, Local Management Entities' inexperience as system managers, and the department's inexperience with the public-private partnership mandated by reform. Some providers believed that verification of provider progression towards full endorsement was not well monitored. Both Local Management Entities and providers expressed concerns that although the spirit of conditional endorsements was well intended, the process could be abused and some providers could deliver inadequate services or not deliver services at all. Furthermore, the lag time between the granting of conditional endorsements and review for full endorsement meant that deficiencies were not readily discerned.

By the summer of 2006, concerns about the number of conditionally endorsed providers who had not yet achieved full endorsement, were not fully staffed, or had not begun to offer services led the department to amend the endorsement policy. The department announced that providers who had been endorsed prior to June 2006 had to become fully staffed and be providing services within 60 days of enrollment with the Division of Medical Assistance or risk withdrawal of endorsement. Those who were conditionally endorsed after June 2006 had to be fully staffed and providing services within 90 days of enrollment with the Division of Medical Assistance.²⁸ Conditional endorsements were discontinued in April 2007. All providers that had been conditionally endorsed as of March 20, 2006 had until September 2007 to complete the full endorsement process.²⁹

Providers also have been critical of the endorsement process in general and the conditional endorsement policy specifically, because some believe the process created undue administrative burdens and delays in service delivery. Providers have noted that it can take as long as 12 weeks to receive a Medicaid number and thus to begin delivering and billing for services. Due to department requirements to have staffing in place and start-up costs, delays in enrollment created significant challenges for providers.

Delays in determining who would provide authorization for services led to a lack of front-end controls to ensure proper system utilization. The authorization process is an important control that allows the department to review service requests. Prior authorization functions as a check on

²⁷ *Communication Bulletin #47*. See footnote 22.

²⁸ DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (2006, June 1). New phases for provider endorsement; Policy amendment for conditional endorsement. *Communication Bulletin #55*. Retrieved from <http://www.ncdhhs.gov/mhddsas/announce/commbulletins/commbulletin055-newphasesproviderendorse6-1-06memo.pdf>. Under conditional or full endorsement, providers could not bill until fully staffed.

²⁹ DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2007, April 12). End of the transition period for provider endorsement and revised documents for the endorsement of community support providers. *Implementation Update #26*. Retrieved from <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/implementationupdate26-4-12-07.pdf>.

diagnostic assessments and plans of care to ensure that the type and amount of service requested is appropriate for patient needs.

Federal regulations allow state Medicaid agencies to limit the amount, duration, and scope of services.³⁰ Prior authorization of services can ensure the right service is being delivered in the appropriate amount and intensity. In North Carolina, however, delays in identifying who would provide authorization and utilization reviews resulted in late implementation of this critical process.

According to department representatives, it was envisioned that several Local Management Entities in cooperation with an outside vendor would collaborate on utilization review responsibilities.³¹ In July 2005, DHHS announced a plan to have Local Management Entities apply to execute utilization review duties. However, no Local Management Entities met the criteria outlined in the Request for Proposal for doing statewide authorizations. As a result, the decision was made in February 2006 to hire Value Options as the sole authorizer of the new Medicaid services. Value Options finalized its contract with the department in April 2006 but was not fully operational until the summer of 2006.

In addition to the late start date, data provided by Value Options show the number of authorization requests received for Community Support services alone equaled the total number of reviews Value Options was projected to perform, based on the Request for Proposal. As Value Options attempted to keep up with the volume of requests, there were no denials or reductions of any of the new services during the initial five months of operations.

Relaxing authorization requirements enabled some providers to deliver an unchecked amount of services. The lack of a formal authorization process and the continuing transition of Local Management Entities from service providers to system managers created concern that consumers might not get necessary care. In mid-February 2006, a joint memo from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance approved the authorization of “both existing and new Medicaid services” for up to six months.³² The memo also stated authorizers could approve extension of services beyond normal limits as well as increase the amount of services as long as justification for the services was documented. Additionally, the department allowed a 30 day “pass through” period without prior authorization for Community Support services. The pass through period allowed for the development of plans of care for patients, or Person Centered Plans, which was a requirement of the new service delivery process. This 30 day period of service did not require prior authorization and remained in effect until June 2007.³³

³⁰ Social Security Act of 1978, 43 C.F.R. 45266 §1102.

³¹ Local Management Entities were already doing utilization review for state-funded services. The department had initially pursued a single vendor option for Medicaid authorization and utilization management in order to meet federal requirements for statewideness.

³² DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (2006, February). Transition services authorizations, service orders, additional crosswalks. *Enhanced Services Implementation Update #4*. Retrieved from <http://www.dhhs.state.nc.us/MHDDSAS/servicedefinitions/servdefupdates/dmadmh2-21-06update4.pdf>.

³³ For more information about department actions in the wake of over-utilization of Community Support services, see DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, April 2007, *Implementation Update #27* and the

When Value Options began operations in the summer of 2006, its information system for tracking authorizations had difficulty transmitting data to the department's claims processing system, managed by Electronic Data Systems. In theory, a claim must be matched with a prior authorization for service before it can be paid. However, due to technical difficulties that resulted in delays in paying providers, the Division of Medical Assistance instructed Electronic Data Systems to turn off certain system audits and edits that matched prior authorizations to claims. The audits and edits were turned off within a month of Value Options operations coming online and were only turned back on for children's services in September 2007. The net effect of this decision essentially rendered prior authorization requirements null and void.

Delays in approval of the new service array and identifying who would carry out authorization and utilization review for Medicaid services translated into a system-wide inability to monitor and track service requests and consumption at the front end of the service delivery system. Department leadership told the Program Evaluation Division their inability to control the "front door" of service access delayed the identification of over-utilization. The department's dependency on paid claims data, which generally has a lag time of four to six weeks, coupled with authorization process issues enabled some providers to take advantage of the system by delivering an unchecked amount of services.

Finding 2. During implementation, the department did not forecast costs, capacity, or utilization.

The rise in utilization and costs associated with Community Support services caught the department by surprise. Department officials said they expected to see an increase in costs as more consumers gained access to services. They did not, however, expect the rate of increase that occurred. It appears that DHHS had outlined broad system transformation goals—statewide uniformity, greater access to services, greater consumer choice, and greater use of evidence-based practices, but the department did not establish a baseline or forecast for system behavior in order to gauge how transformation and implementation of the new service array was progressing towards achieving system objectives. The department maintains that a lack of experience with a public-private model of service delivery and the paradigm shift introduced by mental health reform made forecasting challenging.

The fiscal note used to develop the State Plan Amendment was not intended as a projection of demand for new services. As part of the State Plan Amendment for new services sent to CMS for review and approval, the Division of Medical Assistance created a fiscal note to compare what new services would cost compared to what current services cost.³⁴ The 2005 fiscal note was based on calendar year 2003 data and estimated the fiscal impact to the state after implementation of the new

department's report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (2008, March).

³⁴ The DHHS fiscal note is a budgetary estimate and should not be confused with a fiscal note prepared by the General Assembly's Fiscal Research Division.

service array would be approximately \$1.3 million. The projection of \$1.3 million represents the difference between what the state had been spending on comparable services versus what the new array would cost.³⁵ CMS did not approve the original service array submitted by the department. Developmental Therapies was rejected by CMS and Facility Based Crisis Services and Community Residential Treatment for Substance Abuse were limited to adults.³⁶ The department was not required to update the fiscal note after CMS modified the service array.³⁷

Administrative tracking of expenditures for enhanced services was not detailed enough to reveal an underlying pattern of escalating costs for Community Support services. Medicaid expenditures for services are typically tracked by category of services. Tracking expenditures by category of service provides a high-level view of expenditures for community mental health, developmental disabilities, and substance abuse services because all enhanced services are grouped together and are not tracked individually. When the Enhanced Services Package was implemented, tracking switched from one of these high-level categories of service to another, as providers acquired the ability to bill Medicaid directly rather than billing through the Local Management Entities.

The department expected that as providers switched to billing Medicaid directly, expenditures for services previously billed through Local Management Entities and captured in the original category of services would decline, while expenditures captured in the new category of services would increase. Because the high-level expenditure data behaved as expected, the department had no evidence that a more detailed review of expenditures was needed and continued to monitor only high-level expenditure data. Because the department was not tracking expenditures for individual enhanced services and due to lag time in billing, the fast rise in expenditures was not identified until October 2006 when expenditures for the newly used category of services were increasing faster than expected. At this point, the department began reviewing data at the individual service level and realized that most of the expenditures for enhanced services were for Community Support services.

Problems with data transfer between Division of Medical Assistance contractors prevented the reconciliation of authorization requests with claims information. One way that utilization rates might have been tracked was to use authorization data as a baseline for the type and amount of services requested and compare this baseline against claims activities to determine if actual utilization matched, exceeded, or fell

³⁵ The department has stated the reform effort involved assessments of potential unmet need in the community, but the department believed that any prior assessment would still understate true need. The department further maintains that while it fully expected significant growth, the utilization of services did not decline at the expected targets. However, quantification of these expectations and performance targets were not provided. When Program Evaluation Division staff asked how the department would know that something was wrong, department officials said it was impossible to predict patterns of behavior due to a lack of experience with the new services.

³⁶ As a result, patients who would have been covered by Developmental Therapies were covered by Community Support services until the department could provide a more appropriate alternative to Developmental Therapies. This predicament contributed to the unanticipated growth in Community Support services.

³⁷ It should also be noted that Developmental Therapies is currently a 100% state-funded service. In response to CMS's rejection of the Developmental Therapies from the Enhanced Services Package, the department transitioned many clients that would have been covered by that service to Community Support until more appropriate services could be provided.

below projected utilization.³⁸ Division of Medical Assistance officials, however, said several issues precluded the use of authorization data as a projection tool for enhanced services utilization.

First, Value Options had a short time to ramp up its authorization processes, and in the initial months of operations was overwhelmed by the volume of requests. According to Value Options, duplicate and incomplete requests complicated their ability to review requests and potentially compare their information against claims data.

Second, technical issues between Value Options data system and the state's claims processing system made matching authorizations to provider claims almost impossible. Within a month of Value Options operations coming online, the Division of Medical Assistance decided to disable the audits and edits that check whether claims filed had appropriate prior authorizations and if what was authorized matched what was delivered. These system checks were turned back on for children's services in December 2007. The audits and edits for adult services remain disabled.

Finally, Local Management Entities, as managers of the local mental health system, did not have access to Medicaid claims data until April 2007. The Program Evaluation Division was told these data were not shared with Local Management Entities initially due to the Health Insurance Portability and Accountability Act. After approximately a year of negotiations, the Division of Medical Assistance was given permission by the Attorney General to share Medicaid claims data with Local Management Entities. Local Management Entities were given data retroactively at the time and are to receive Medicaid data on a monthly basis from this point forward. However, at the time, Local Management Entities' lack of access to Medicaid claims data prevented even local level analysis of service utilization.

Finding 3. Despite extensive federal and NC General Assembly reporting requirements, program information about mental health is not communicated clearly or effectively to policymakers.

Since the passage of mental health reform, the General Assembly has codified requirements for performance measures to track progress or unanticipated side effects. More recent legislation has required the department to provide periodic reports detailing system developments as well as corrective actions taken to address legislative concerns.³⁹ However, elected public officials and legislative staff continue to assert that obtaining status information from the department has been a tedious process. Furthermore, Local Management Entities and other stakeholders

³⁸ A prior authorization can approve a service up to a certain amount as defined by the Division of Medical Assistance's service policies. Thus, if authorization data was used to project demand, it could have produced an overestimation of demand. For example, a prior authorization might allow up to 100 units of a given service over a three-month period. However, claims data might only reflect that 50 units were actually received. Thus authorization data might project an estimate of maximum demand as opposed to a precise match to activity seen in claims.

³⁹ House Bill 2077 required the development of mental health system performance measures as well as reports every six months from the DHHS Secretary on the department's progress in associated performance areas. House Bill 1473 requires DHHS to provide regular reports on issues specific to Community Support services on a monthly basis to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services.

told the Program Evaluation Division the department requires too many reports, is unclear about how data is being used, and ignores their suggestions for improving reporting.

DHHS has more than 19,000 employees, a \$14 billion budget, 30 administrative units, and 18 facilities. How such a large organization and its subordinate divisions collect, synthesize, and analyze data and how they disseminate the resulting knowledge can have a profound impact on decision making, understanding of organizational performance, and the agency's ability to identify and respond to emerging problems as well as to recognize success. Identifying the right performance measures, tracking them against defined goals and performance targets, and communicating system performance in a meaningful way to agency leadership as well as to outside stakeholders and the public helps

- improve program management;
- justify programs and costs; and
- demonstrate accountability and stewardship of taxpayer resources.⁴⁰

Although the department is making efforts to meet these objectives, there are several issues, described below, that still need to be addressed.

Appropriate information is not getting to policymakers in a manner that facilitates decision making and oversight. A review of department reports clearly shows the department collects a tremendous amount of data about the mental health system. However, these data may not be communicated to external stakeholders clearly and effectively. Much of the information is presented in numerous stand-alone reports and data are often of a technical or descriptive nature that is not synthesized or interpreted. Policy-makers risk missing key information or misinterpreting data without the benefit of departmental clarification. For example, data from the post payment review process as well as the provider audits done in the wake of Community Support utilization investigations are posted in relatively raw form on the Division of Mental Health, Developmental Disabilities and Substance Abuse Services website. It is impossible to understand from the reports alone the broader impact of the audit and post payment review processes. Not only does this format make it difficult to process the information, but the department is also losing an opportunity to effectively substantiate and communicate system performance and accomplishments.

Due to the tedious process required to glean meaning, legislators have resorted to creating their own summary reports. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services has created its own Core Indicators report—a six-part dashboard quick look at specific system data—since the winter of 2007.

Fragmentation and piecemeal issuance of information, along with reports that no longer meet the needs of current users, cloud rather than inform the issues. The sheer number of reports produced to meet

⁴⁰ Roberts, D. (2006). *Law enforcement tech guide for creating performance measures that work: A guide for executives and managers*. Washington, DC: US Department of Justice.

accountability needs indicates the problem is not a lack of data within the department. Multiple stakeholder demands have contributed to a plethora of information; some of which is valuable yet goes unused, and some of which is of little value to decision makers. Department managers told the Program Evaluation Division some reports mandated by the General Assembly are no longer useful, but the demands placed on staff time and resources curtail their ability to respond to additional requests for information that may ultimately be more informative. While the department concedes that some of their reports are dense and lengthy, department managers reported concern about the lack of feedback they receive from the General Assembly on improving reports.

To be useful, performance data should be analyzed, easily accessible, and used for knowledge-based decision making. The department reports a vast amount of program development data. Efforts to analyze the data and use them to inform program development, however, have been limited. In part, the problem lies in continuous changes in policy direction in recent years, making it difficult to identify and report on current and appropriate indicators. However, without a commitment to knowledge-based decision making to inform future program and policy direction, program information is unlikely to emerge as a tool for policy development. Data reports alone—whether intended as baselines, benchmarks, or performance indicators—do not comprise effective program oversight. Similarly, high-level summations alone are not sufficient without providing users a way to “drill down” to data reports.

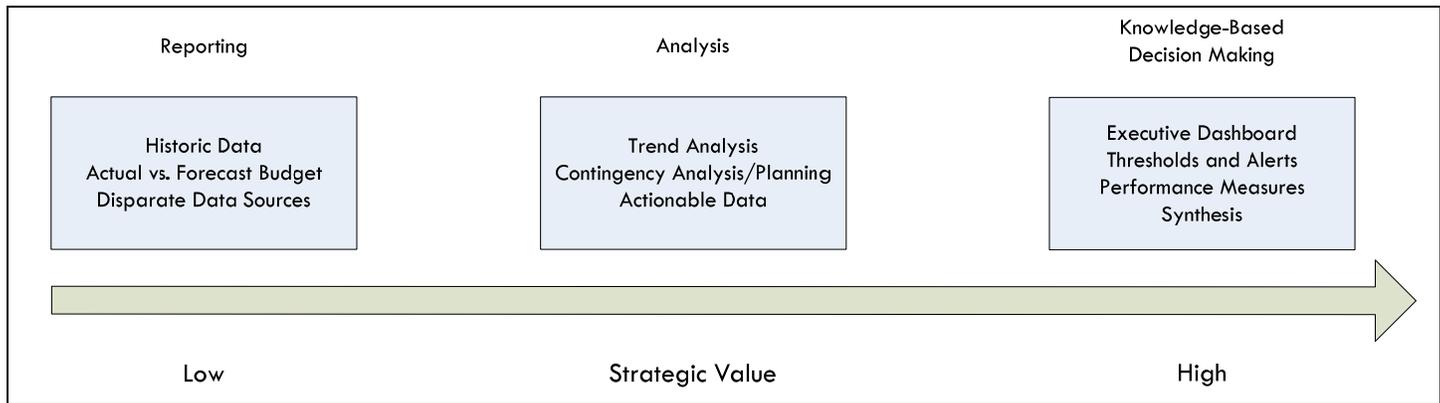
Exhibit 4 displays a conceptual knowledge development framework. The essential difference between reporting data and using information for decision making (i.e., engaging in knowledge management) is that reporting makes critical data available in a timely and consistent manner, whereas knowledge management involves persistent efforts to use available information to identify critical elements for system success.⁴¹ In order for DHHS to progress towards knowledge management, it must be able to place enhanced services data in the context of larger reform goals. Without linking performance measures and associated analysis to larger reform and implementation goals, it is impossible to gauge how well the system is working and how the implementation of the Enhanced Services Package is contributing to achieving reform goals.

It is not unreasonable to expect the department to engage in knowledge management. For example, the Florida Department of Children and Families maintains a Performance Dashboard on its website that reports the department’s performance on external and internal department measures for its various programs.⁴² The dashboard allows the user to view performance at both a statewide and a geographic region level.

⁴¹ Gupta, A., & McDaniel, J. (2002). Creating a competitive advantage by effectively managing knowledge: A framework for knowledge management. *Journal of Knowledge Management Practice*, 3. Retrieved from <http://www.tlinc.com/articl39.htm>.

⁴² Florida Department of Children and Families, Performance Dashboard Application. Retrieved June 23, 2008, from <http://dcfdashboard.dcf.state.fl.us/>.

Exhibit 4: Information Flow and Knowledge Development Framework



Source: Program Evaluation Division adapted from CGI Group Inc.'s (2004) Business Intelligence—Enabling Transparency Across the Enterprise.

Recommendations

Recommendation 1. The NC Department of Health and Human Services should reevaluate current data and reporting processes to focus on the needs of the Secretary and elected officials while assuring linkage and accessibility to supporting data and specialized reports.

The department should review how it presents information about the Enhanced Services Package and other similar broad policy initiatives to ensure that data and analyses address executive and legislative audiences' key questions and concerns about system performance. The department should, in consultation with the NC General Assembly, review the number and format of reports to ensure they provide policy options and impacts of policy choices clearly and effectively.

By January 2009 the department should create a plan that defines

- baseline performance targets for the Enhanced Services Package and for other major initiatives;
- information and data priorities;
- a process that streamlines and focuses data collection and reporting efforts, similar to that supporting the Florida Department of Children and Families Performance Dashboard website;⁴³ and
- a reporting strategy that focuses decision making, alerts department leadership as well as legislative and executive leaders to emerging issues, and facilitates timely and informed responses.

The plan should ensure legislators and other public officials have access to high-level summary analyses through a dashboard system as well as the ability to “drill down” to more detailed information.

⁴³ See footnote 42.

Recommendation 2. The NC General Assembly should require the department to focus its division-wide internal analysis efforts by redirecting the mission of the Quality Management Team within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Although the process described in Recommendation 1 must be a collaborative one, the development of performance targets and performance measures as well as analysis of system performance and identification of policy options should be focused in a single place within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The Quality Management Team should be directed to assume responsibility for this function.

The team is already tasked with development and employment of system-wide performance measures. However, the depth and sophistication of analysis produced needs to improve in order to move the department forward along the knowledge management continuum illustrated in Exhibit 4. Adopting a knowledge-based decision making framework is a challenging but essential step toward managing systemic reform and continual program development.

The Quality Management Team, with input from department leadership and possibly from the staff of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, should

- prioritize which information should be collected and reported;
- develop performance targets and baselines; and
- conduct analyses that inform policy options and recommendations.

By focusing these activities within a single team, the division can ensure

- data consistency;
- strong analytic capacity;
- consistent reporting;
- a fixed and central location of knowledge should questions arise about why the department acted; and
- design and maintenance of a web-based dashboard reporting system.

The Quality Management Team already has some of the skills necessary to perform these functions; however, the General Assembly should consider requiring a review of the composition, responsibilities, and resourcing of the team to ensure it can successfully accomplish its scaled-up mission.⁴⁴

The General Assembly should consider requiring the department to present a plan for redirecting the newly-tasked Quality Management Team by January 2009. The plan should include

⁴⁴ The Quality Management Team is staffed with 10 personnel. In addition to developing performance measures and tracking system development, the team is also responsible for grant writing, management of the federal block grant reporting and applications processes, data management for the NC-Treatment Outcomes and Program Performance System, as well as several other duties. Any review should assess whether the Quality Management Team should continue with these duties. If it is determined the team should not continue with these duties, the department should identify who and what resources are available or required to deal with these responsibilities.

- identification of skills and experience necessary;
- a review of current team personnel and available skills;
- options for realigning personnel and potential impacts;
- training requirements; and
- data access requirements.⁴⁵

DHHS should consider broader application of recommendations. While these recommendations focus on the mental health care system and the two divisions within DHHS charged with delivering that care, the issues raised in this report have broader implications. The problems identified could be repeated by other departmental programs (e.g., public health, Medicaid, child protective services) and then similarly exacerbated by communication problems with elected officials attempting oversight.

The framework recommended here may have broad application across the department as it tries to gauge effectiveness and efficiency of intra-division programs. Indeed, the department may wish to explore how it aggregates and reports department-wide performance from the various quality-management activities at the division levels. Such an effort could enhance the department's ability to communicate department-wide trends, accomplishments, and needs to the Governor, the General Assembly, and the public.

Agency Response

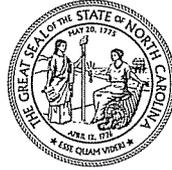
A draft of our report was submitted to the NC Department of Health and Human Services for review and response. Their response is provided below.

PED Contact and Staff Acknowledgements

For more information on this report, please contact the lead evaluator, Yana Ginburg Samberg, at yanas@ncleg.net.

Staff members who made key contributions to this report include E. Kiernan McGorty, Carol H. Ripple, Carol Shaw, and Pamela L. Taylor. John W. Turcotte is director of the Program Evaluation Division.

⁴⁵ Currently there is only one person within the department that has access to claims data from both the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance.



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Michael F. Easley, Governor

Dempsey Benton, Secretary

July 1, 2008

MEMORANDUM

TO: John Turcotte, Director
N.C. General Assembly Program Evaluation Division

FROM: Dempsey Benton 

SUBJECT: Formal Response to the Program Evaluation Division's Review of the Department's Implementation of Enhanced Mental Health and Substance Abuse Services

Thank you for the opportunity to review and discuss with your staff the Program Evaluation Division's report on its review of the Department's implementation of the enhanced mental health and substance abuse services. We believe the final report is a fair assessment of the challenges the Department faced in implementing this major change in the service delivery structure for mental health and substance abuse services.

Outlined below is our formal response to the policy recommendations contained in the final report.

Recommendation 1: The NC Department of Health and Human Services should reevaluate current data and reporting processes to focus on the needs of the Secretary and elected officials while assuring linkage and accessibility to supporting data and specialized reports.

DHHS Response: We agree with this recommendation. DHHS will perform a complete review of all of the reports that it produces relative to mental health, developmental disabilities, and substance abuse services to ensure that the reports continue to be meaningful to various audiences. We intend to review with leadership in the General Assembly a number of legislatively-mandated reports which we believe may no longer be necessary. In addition, we will work with legislative leaders and legislative staff to solicit input on the format and structure of the remaining reports. In reviewing all reports, DHHS will focus on both the content and presentation of the reports to ensure that the data is pertinent and accurate and is communicated in the most effective manner possible.



John Turcotte, Director
July 2, 1008
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Recommendation 2: The NC General Assembly should require the department to focus its division-wide internal analysis efforts by redirecting the mission of the Quality Management Team within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

DHHS Response: We disagree with this recommendation. As the report notes, the Quality Management team in the Division of Mental Health Developmental Disabilities and Substance Abuse Services is already tasked with the “development and employment of system-wide performance measures.” It is reasonable to focus efforts to enhance reporting and knowledge management activities within that team. However, the team is also responsible for a number of other important activities including federally required block grant reporting, grant writing and consumer outcome tracking. The Division does not have other staff available to assume those duties and they cannot be discontinued. It is appropriate for the General Assembly to require the Department to develop certain reports, to perform specific analyses, and to develop and track performance against key performance indicators. However, the way in which the Department organizes itself to fulfill those requirements is a decision for the Executive Branch. If the Department needs to reorganize or adjust personnel internally to accomplish those activities, that should be within the authority of the Department, subject to the approval of the Governor. We disagree with the recommendation that the Division should report to the General Assembly on the individual staff qualifications of the Quality Management Team. The knowledge, skills and abilities required for DHHS staff members are governed by the classification system approved by the State Personnel Commission in accordance with the State Personnel Act. The knowledge, skills and abilities of individual staff are governed by the Department’s ability to recruit and retain a qualified workforce. While management must always work to match the skills and abilities of staff to the requirements necessary to perform vital functions, we believe that a report to the General Assembly on this issue, particularly including any proposals to realign personnel, would be potentially demoralizing and disruptive and would not assist in meeting the goals of Recommendation 1.

Thank you again for the opportunity to review the report. We appreciate the professional manner in which your staff conducted the review.

cc: Dan Stewart
Mike Lancaster, M.D.
Leza Wainwright
William Lawrence, M.D.
Tara Larson
Sharnese Ransome