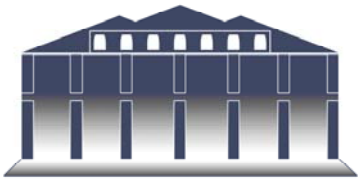
Enhanced Services Package Implementation: Costs, Administrative Decision Making, and Agency Leadership

Final Report to the Joint Legislative Program Evaluation Oversight Committee

Report Number 2009-07-01

July 6, 2009



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John W. Turcotte
Director

July 6, 2009

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Honorable Co-Chairs:

The Program Evaluation Division 2009-10 Work Plan, approved March 23rd, 2009, directed the Program Evaluation Division to evaluate the costs, decisions, and leadership associated with the implementation of the Enhanced Services Package. This evaluation was a follow up to the Division's July 2008 report entitled *Compromised Controls and Pace of Change Hampered Implementation of Enhanced Mental Health Services*.

I am pleased to report the Department of Health and Human Services including the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance cooperated with us fully and were at all times courteous to our staff during the evaluation.

Sincerely,

John W. Turcotte
Director

PROGRAM EVALUATION DIVISION
NORTH CAROLINA GENERAL ASSEMBLY

July 2009 Report No. 2009-07-01

Enhanced Services Package Implementation: Costs, Administrative Decision Making, and Agency Leadership

Summary

At the request of the Joint Legislative Program Evaluation Oversight Committee, the Program Evaluation Division conducted a focused examination of policy and program decisions and agency leadership changes associated with the mental health system's Enhanced Services Package expenditures from April 2006 through February 2009. This report is a follow-up to the Program Evaluation Division's July 2008 report entitled *Compromised Controls and Pace of Change Hampered Implementation of Enhanced Mental Health Services*.

The Enhanced Services Package was designed to expand participation in Medicaid's rehabilitation option, thereby leveraging federal funding for a wider and more complete range of services. In addition to intensive, evidence-based practice models, the Enhanced Services Package included a less-intensive service known as individual Community Support.

The Program Evaluation Division found

- From April 2006 through February 2009, a total of $2.4 billion was spent on enhanced services, $827.2 million of which was North Carolina's share of the costs.
- Total costs began escalating rapidly in October 2006, but key agency cost-controlling decisions were not made until February 2007.
- Assuming that expenditures from September 2008 to February 2009 represent reasonable costs for enhanced services, effective planning and oversight could have avoided costs of $498.5 to $635.3 million, of which $177.4 to $226.2 million would have been North Carolina's share of the avoided costs.
- From April 2006 to March 2007, expenditures for individual Community Support services accounted for 97% of all enhanced services expenditures, whereas the other 18 services accounted for 3% of total expenditures.
- From April 2006 to March 2007, individual Community Support utilization grew by 235%, whereas utilization of all other enhanced services combined grew by 44%.
- There were 10 changes in key agency leadership positions during the three years of Enhanced Services Package implementation. In contrast, a total of six leadership changes occurred in the five years between 2001, when mental health reform began, and March 2006, when the Enhanced Services Package was implemented.

Scope

In December 2008, the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to follow up its July 2008 report entitled *Compromised Controls and Pace of Change Hampered Implementation of Enhanced Mental Health Services* by providing an additional, updated analysis of Enhanced Services Package implementation expenditures.

The Program Evaluation Division conducted a focused examination of policy and program decisions and agency leadership changes associated with enhanced services expenditures from April 2006 through February 2009. Expenditure data were drawn from monthly Medicaid paid claims. Administrators from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and Division of Medical Assistance provided data on key program and policy decisions. Additional service utilization data were provided by Value Options, a private consultant contracted to provide service utilization management of enhanced services for the Division of Medical Assistance.

Background

North Carolina's mental health reform effort was intended to provide a broader range of evidence-based services that were clinically proven, science based, and outcome focused. This array of services would shift the emphasis away from hospitalization and toward treating consumers in their communities. To this end, the North Carolina Department of Health and Human Services developed and sought Medicaid approval of an array of services—the Enhanced Services Package. In addition to introducing stronger community-based service models, the Enhanced Services Package was designed to expand participation in Medicaid's rehabilitation option, thereby leveraging federal funding for a wider and more complete range of services.

Although federal funds cover the majority of expenses for Medicaid services, high utilization of Medicaid services has a significant impact on state resources. Because Medicaid is an entitlement program, the state must pay the non-federal share of Medicaid costs regardless of revenue or appropriations shortfalls. North Carolina's share of Medicaid costs was 36% from Fiscal Years 2005-06 to 2007-08; due to the federal government's American Recovery and Reinvestment Act, North Carolina's share was reduced to 25% for Fiscal Year 2008-09.

Introduced on March 20, 2006, the Enhanced Services Package included not only intensive, evidence-based practice models but also less-intensive services such as individual Community Support services.[1] Individual Community Support services were intended to be a bridge to more intensive, evidence-based services. In addition, individual Community Support services enabled consumers already in the system to maintain stable treatment regimens, preventing more restrictive services or hospitalizations. Services that had been provided by area mental health

[1] There are two types of individual Community Support services, one for adults and one for children. Individual Community Support services are distinct from Community Support Team and Community Support Group services, which are also part of the Enhanced Services Package.

centers before March 2006 were supposed to be available from private providers, shifting the system from a government-operated, institution-centric model to a private-provider, community care-focused model. However, private providers had to become equipped to provide enhanced services, and it took longer for them to set up some services than others. A number of the more intensive enhanced services were not readily available, whereas others such as individual Community Support services were.

The Enhanced Services Package implementation process and related challenges are documented in the Program Evaluation Division's report entitled *Compromised Controls and Pace of Change Hampered Implementation of Enhanced Mental Health Services*. Joint Legislative Program Evaluation Oversight Committee members requested an additional, updated analysis of the data behind the initial report. The Program Evaluation Division conducted a focused examination of policy and program decisions and agency leadership changes associated with enhanced services expenditures from April 2006 through February 2009. This report addresses three central research questions:

1. What was the trajectory of expenditures for the Enhanced Services Package between April 2006 and February 2009?
2. What key policy and program decisions were associated with Enhanced Services Package expenditures?
3. Were ongoing, major leadership changes prevalent during the implementation of the Enhanced Services Package?

Questions and Answers

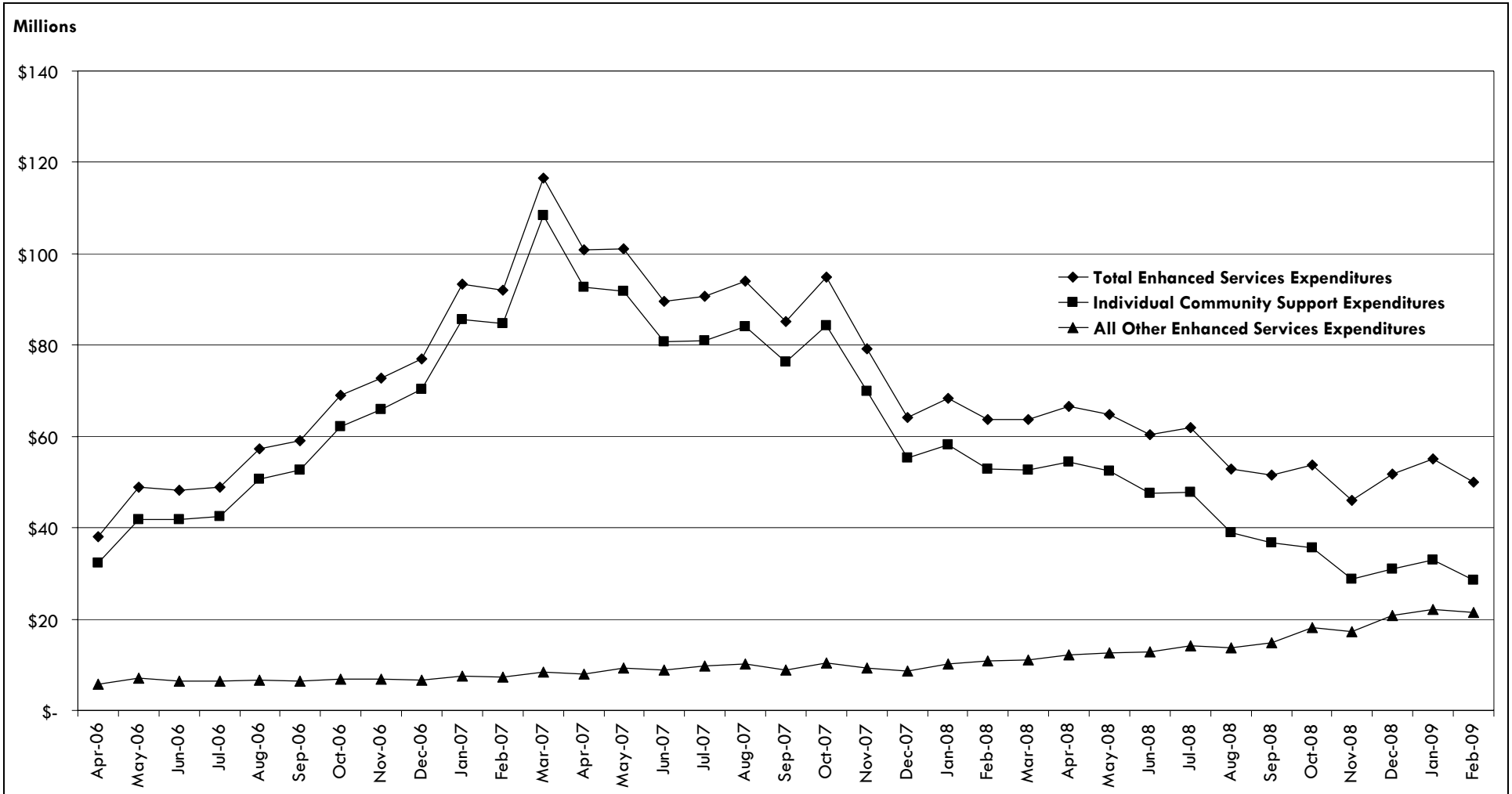
1. What was the trajectory of expenditures for the Enhanced Services Package between April 2006 and February 2009?

A steep increase in costs followed the initial introduction of the Enhanced Services Package. Between April 2006 and March 2007, total monthly expenditures grew by more than $78.6 million or 206%. As shown in Exhibit 1, costs moderated considerably by 2009, but the initial rise was cause for concern among policymakers.

Exhibit 1 also displays expenditures associated with individual Community Support services. According to Division of Mental Health, Developmental Disabilities and Substance Abuse Services management, these services were intended to move individuals receiving care at state facilities into the community as the mental health care system transitioned from a government-operated, institution-centric model to a private-provider, community care-focused model.

As reported to the Program Evaluation Division, division management acknowledged in hindsight that inadequate oversight of individual Community Support services contributed to an unanticipated surge in utilization and expenditures. As shown in Exhibit 1, from April 2006 to March 2007, individual Community Support services accounted for 97% of total monthly enhanced services expenditures, whereas monthly costs of the other 18 services accounted for 3% of the total. The early, sharp increase in total monthly enhanced services expenditures was driven by individual Community Support utilization.

Exhibit 1: Total Monthly Enhanced Services Expenditures (April 2006-February 2009)



Note: Besides individual Community Support services, other enhanced services include Ambulatory Detoxification, Assertive Community Treatment Team, Community Residential Treatment (Medically Monitored), Community Residential Treatment (Non-Medically Monitored), Community Support Team, Community Support Group, Diagnostic Assessment, Day Treatment, Facility Based Crisis Services, Intensive In-Home, Methadone Administration, Mobile Crisis Management, Multi-Systemic Therapy, Partial Hospitalization, Psychosocial Rehabilitation, Substance Abuse Intensive Outpatient Program, and Substance Abuse Comprehensive Outpatient Treatment Program.

Source: Program Evaluation Division based on data from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

From April 2006 to March 2007, monthly individual Community Support utilization grew by 235%, whereas utilization of all other enhanced services combined grew by 44%. Although individual Community Support services were intended to provide initial access to community-based care, persistent and unexpectedly high utilization of individual Community Support services was not in keeping with the ultimate goal of moving consumers into more intensive evidence-based treatments such as Assertive Community Treatment Team and Multi-Systemic Therapy. High utilization of individual Community Support services was a concern not only because of high expenditures but also because of under-utilization of other higher-intensity services.

Monthly Enhanced Services Package expenditures are shown in Exhibit 2. From left to right, the three columns show total monthly expenditures, monthly individual Community Support expenditures, and monthly expenditures for the other 18 enhanced services combined.

As shown in Exhibit 2, enhanced services expenditures can be described as occurring in four distinct phases:

- **Startup (April 2006-September 2006):** Expenditures increased moderately as consumers transitioned to new services. Total monthly Enhanced Services Package expenditures rose from $38.1 million in April to $59.1 million in September 2006.
- **Surge (October 2006-March 2007):** Total monthly Enhanced Services Package expenditures grew from $69.1 million in October 2006 to $116.7 million in March 2007, driven by high individual Community Support expenditures.
- **Transition (April 2007-October 2007):** Although total monthly Enhanced Services Package expenditures remained high, expenditures began to stabilize and decline. In April 2007 total monthly expenditures were $100.8 million, and by October 2007 monthly expenditures were down to $94.8 million.
- **Decline (November 2007-February 2009):** Total Enhanced Services Package expenditures declined, driven in large part by a decline in individual Community Support expenditures. Total monthly Enhanced Services expenditures dropped from $79.2 million to $50 million during this period.

Exhibits 1 and 2 also show the growth of the imbalance between individual Community Support expenditures and all other enhanced services expenditures. In March 2007, at the height of utilization, individual Community Support expenditures totaled $108.3 million and all other enhanced services totaled $8.3 million, a difference of $100 million. As of February 2009, individual Community Support services totaled $28.6 million and all other enhanced services expenditures totaled $21.4 million, a difference of $7.2 million. This reduction in the gap between individual Community Support expenditures and all other enhanced services expenditures suggests providers were offering and consumers were utilizing more of the higher-intensity, evidence-based services as originally intended by the Department of Health and Human Services.

Exhibit 2: Phases and Total Monthly Enhanced Services Expenditures (April 2006-February 2009)

Phase	Month	Individual Community Support Expenditures	All Other Enhanced Services Expenditures	Total Enhanced Services Expenditures
Startup	Apr-06	$ 32,309,347	$ 5,786,040	$ 38,095,387
	May-06	41,742,756	7,127,563	48,870,319
	Jun-06	41,715,755	6,454,553	48,170,308
	Jul-06	42,409,183	6,445,815	48,854,998
	Aug-06	50,602,870	6,651,786	57,254,656
	Sep-06	52,596,937	6,466,772	59,063,709
	Total Startup	**$ 261,376,848**	**$ 38,932,528**	**$ 300,309,376**
Surge	Oct-06	62,143,762	6,961,250	69,105,011
	Nov-06	65,901,988	6,799,499	72,701,487
	Dec-06	70,315,226	6,638,824	76,954,051
	Jan-07	85,692,315	7,629,151	93,321,466
	Feb-07	84,617,683	7,293,006	91,910,689
	Mar-07	108,315,444	8,345,457	116,660,901
	Total Surge	**$ 476,986,418**	**$ 43,667,187**	**$ 520,653,605**
Transition	Apr-07	92,710,964	8,048,019	100,758,984
	May-07	91,752,627	9,341,405	101,094,032
	Jun-07	80,750,428	8,867,470	89,617,899
	Jul-07	80,917,371	9,707,840	90,625,211
	Aug-07	83,962,246	10,130,429	94,092,674
	Sep-07	76,272,483	8,937,074	85,209,557
	Oct-07	84,320,091	10,478,730	94,798,821
	Total Transition	**$ 590,686,209**	**$ 65,510,967**	**$ 656,197,177**
Decline	Nov-07	69,859,829	9,317,499	79,177,328
	Dec-07	55,377,544	8,679,538	64,057,081
	Jan-08	58,187,489	10,260,709	68,448,197
	Feb-08	52,837,280	10,764,918	63,602,198
	Mar-08	52,624,118	10,964,703	63,588,821
	Apr-08	54,308,602	12,200,465	66,509,067
	May-08	52,341,855	12,506,103	64,847,958
	Jun-08	47,589,497	12,870,289	60,459,786
	Jul-08	47,716,538	14,170,678	61,887,216
	Aug-08	38,999,628	13,821,142	52,820,769
	Sep-08	36,801,254	14,786,873	51,588,127
	Oct-08	35,586,982	18,125,028	53,712,009
	Nov-08	28,705,873	17,214,536	45,920,409
	Dec-08	31,033,747	20,699,225	51,732,971
	Jan-09	32,844,751	22,212,593	55,057,344
	Feb-09	28,608,948	21,416,556	50,025,503
	Total Decline	**$ 723,423,934**	**$ 230,010,851**	**$ 953,434,785**
	GRAND TOTAL	**$ 2,052,473,409**	**$ 378,121,534**	**$ 2,430,594,943**

Note: Between Fiscal Years 2005-2006 and 2007-2008, the federal share of Medicaid expenditures was 64% and North Carolina's share was 36%. In Fiscal Year 2008-09, North Carolina's share was reduced to 25% due to the federal government's American Recovery and Reinvestment Act.

Source: Program Evaluation Division based on data from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance.

2. What key policy and program decisions were associated with Enhanced Services Package expenditures?

The Program Evaluation Division requested a list of decisions associated with costs of the Enhanced Services Package from the Department of Health and Human Services. From this information, the Program Evaluation Division identified four decision themes associated with enhanced services costs. Each theme is tracked on one of four gray bars that appear at the top of Exhibit 3:

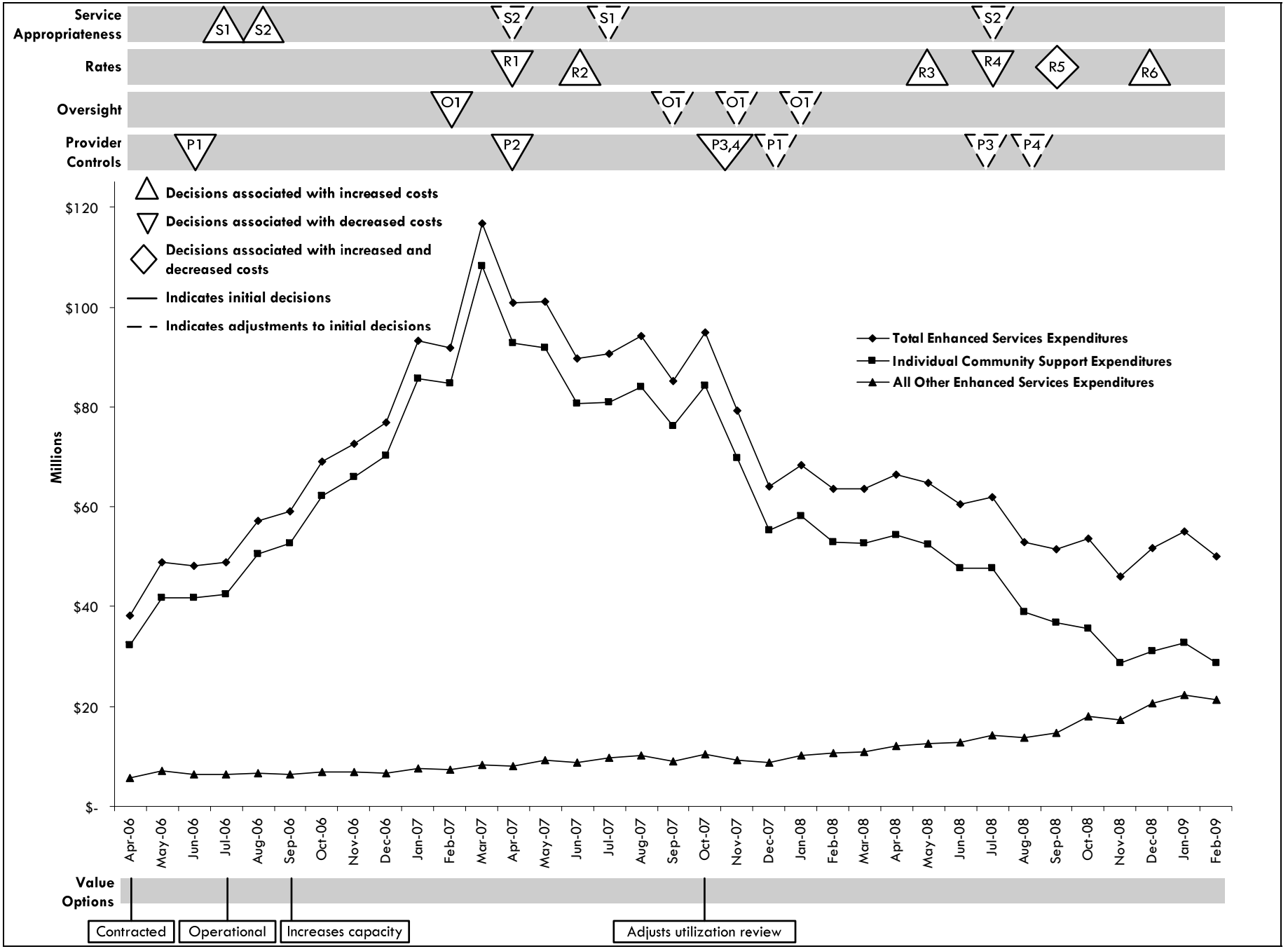
- Decisions about **service appropriateness** are associated with access to services, authorization of services, medical necessity, and amount of services provided. They are noted with an S.
- Decisions about **rates** are associated with how much services cost. These decisions are noted with an R.
- Decisions about **oversight** are associated with efforts to regulate and manage the mental health system. They are noted with an O.
- Decisions about **provider controls** are associated with managing the provider network by controlling who was authorized to provide services. These decisions are noted with a P.

The notes that accompany Exhibit 3 describe each of the key decision points by theme.

The gray bar at the bottom of Exhibit 3 tracks events associated with the implementation of the Value Options contract to provide prior authorization for enhanced services.

As shown in Exhibit 3 and the accompanying notes, even when the Department of Health and Human Services made decisions to act, it took time to implement decisions. Additionally, the department often had to make adjustments that influenced when policy decisions took effect. For example, when the department changed the definition of how individual Community Support services could be delivered, the department could not implement the changes until they were approved by the Centers for Medicare and Medicaid Services, which took six months (see R4).

Exhibit 3: Administrative Decisions and Value Options Implementation Associated with Enhanced Services Expenditures



Note: Bolded dates below correspond to the shapes on the gray bars at the top of Exhibit 3 and indicate initial decisions and adjustments to those decisions.

Service Appropriateness (access to services, authorization of services, medical necessity, and amount of services provided)

S1 – July 2006: Department of Health and Human Services (DHHS) releases access to care flow chart for consumers. Intent is to describe how consumers access new services based on severity of condition and Medicaid eligibility. Goal is to efficiently guide consumers to appropriate services. Unintended consequence is many providers interpret flow chart to mean all new consumers should receive individual Community Support services. Flow chart is revised in **July 2007** to ensure consumers are directed to other services, not just individual Community Support services.

S2 – August 2006: DHHS announces prior authorizations are not required for first 30 days of individual Community Support services. As a result of a "focused review" of individual Community Support utilization that was mandated by the DHHS Secretary, a new individual Community Support definition that limits the number of unmanaged individual Community Support hours for adults and children is announced in **April 2007** and implemented in June 2007. Legislation passes in **July 2008** and is implemented in August 2008 that requires all individual Community Support requests receive prior authorization and increases qualification levels for providers of individual Community Support services.

Oversight (efforts to regulate and manage the mental health system)

O1 – February 2007: DHHS Secretary announces a "focused review" of individual Community Support services. Review includes an audit of the 167 providers with the highest billings of individual Community Support services. Intent is to ensure providers are appropriately providing individual Community Support services. By the end of March 2007, DHHS conducts audit of 167 providers. Provider sanctions include paybacks, additional training, endorsement reviews, and other disciplinary actions. Audits retroactively control costs by making providers pay back individual Community Support claims that are not fully documented. A second round of audits is completed in April 2007. Between August and **September 2007**, DHHS and Local Management Entities conduct Post Payment Reviews to determine whether individual Community Support services were medically necessary and for the appropriate amount. Reviews find providers received more than $60 million for 4.7 million units of individual Community Support services that were not medically necessary. As a result, 63% of reviewed providers are referred to the Division of Medical Assistance's Program Integrity unit for further evaluation. In **November 2007**, DHHS begins withholding payments. Between November 2007 and March 2009, more than $21 million is withheld from individual Community Support providers pending required paybacks and compliance with quality management standards. DHHS announces additional Post Payment Review sanctions in **January 2008.**

Rates (how much services cost)

R1 – April 2007: Rate for individual Community Support services decreases from $60.96/hour (original rate) to $40/hour. Final individual Community Support rate set at $51.28/hour.

R2 – June 2007: Rate for Psychosocial Rehabilitation increases from $2.34/15 minutes to $2.90/15 minutes. Rate becomes effective July 2007.

R3 – May 2008: Intensive In-Home and Multi-Systemic Treatment rates increase from $190 to $258.20/day for Intensive In-Home and $23.54 to $37.32/15 minutes for Multi-Systemic Treatment. Rates become effective June 2008.

R4 – July 2008: Session Law 2008-107 makes multiple adjustments to the provision of mental health care including a hard limit on the number of individual Community Support hours provided to adults (not more than 8 hours). In addition, DHHS is required to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services for tiered rates. Intent is to control who provides individual Community Support services and reduce inappropriate provisions of the service. Tiered rates are implemented in January 2009.

R5 – September 2008: Rates for 14 enhanced services are changed. Rates for 11 services increase, effective October 2008. Rates for three services decrease, effective January 2009.

R6 – December 2008: Day Treatment rate increases from $31.25/hour to $34.75/hour. Rate becomes effective January 2009.

Provider Controls (managing the provider network)

P1 – June 2006: The provider endorsement and enrollment policy originally released in 2005 is amended in June 2006 and September, October, and **December of 2007** to reflect new provider requirements.

P2 – April 2007: DHHS announces conditional endorsement for providers will end by November 2007. Intent is to reduce the number of providers and thereby reduce costs and improve network quality. Conditional endorsements were originally announced in August 2005 and were intended to ensure provider network capacity.

P3 – November 2007: DHHS Secretary freezes endorsement and enrollment of new individual Community Support providers. Intent is to control quality and quantity of providers delivering individual Community Support services and thereby reduce utilization of the service. The freeze on endorsement and enrollment is extended in **July 2008**.

P4 – November 2007: DHHS announces providers, starting in December 2007, must identify who is providing individual Community Support services (i.e., qualified professionals or paraprofessionals). Adjustments and additional requirements are made in June, July, and **August 2008**.

Source: Program Evaluation Division based on data from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance.

As shown in Exhibit 3, although costs accelerated markedly starting in October 2006, the initial cost-controlling decisions were not announced until February 2007. Subsequently, total monthly expenditures leveled off and began to decline. Specifically, individual Community Support expenditures began to decline in early 2007 and continued to decline through February 2009. In keeping with the goals of mental health system reform, expenditures for other enhanced services began to rise towards the end of this time period, reflecting the expansion of services that are, for the most part, more intensive and therefore more costly to deliver.

The steep escalation of expenditures and the time required for the Department of Health and Human Services to react to and make decisions that would moderate those costs has been cause for deep concern among legislators. As described in the previous Program Evaluation Division report, the rampant cost overruns might have been avoided or at least attenuated with better planning and oversight. In order to estimate how much of the cost of Enhanced Services Package implementation might have been avoided, the Program Evaluation Division analyzed two hypothetical scenarios:

- Scenario A: Appropriate planning, cost controls, and oversight mechanisms were in place *before* full implementation so that costs remained relatively constant and excessive expenditures were avoided.
- Scenario B: Planning and cost controls were not in place before full implementation, but appropriate oversight mechanisms were in place that triggered *earlier* attention to and action on escalating costs.

In each scenario, the Program Evaluation Division assumes the relatively stable period from August 2008 to February 2009 represents reasonable total monthly enhanced services expenditures, at $51.6 million per month.

Results of these analyses suggest that in Scenario A, $635.3 million in total Enhanced Services Package expenditures might have been avoided—$226.2 million of which would have been North Carolina's share of avoided costs—if the Department of Health and Human Services had implemented appropriate planning, cost controls, and oversight mechanisms before new services were rolled out. In Scenario B, assuming appropriate oversight mechanisms alerted agency management to escalating expenditures in October 2006 and appropriate controls were implemented soon thereafter, $498.5 million in total Enhanced Services Package expenditures might have been avoided—$177.4 million of which would have been North Carolina's share of the avoided costs.

When the Program Evaluation Division asked agency administrators about influences on Enhanced Services Package expenditures in addition to agency policy decisions, they reported the stabilization of Value Options' operations was critical. The timeline at the bottom of Exhibit 3 shows key events during Value Options' implementation of the prior authorization process. After being awarded the contract for the prior authorization process in April 2006, Value Options began operations in July 2006. However, the high volume of authorization review requests received for individual Community Support services, insufficient staff, technical difficulties, and shifting authorization policies affected Value Options'

ability to provide effective front-end control of enhanced services utilization. During its first six months of operations, Value Options denied or reduced only 217 authorization requests (7 of which were individual Community Support requests).

In September 2006, Value Options added staff, office capacity, and information technology capabilities to accommodate the volume of authorization requests. In October 2007, Value Options stabilized operations and implemented new utilization review activities. According to the Division of Medical Assistance, these changes enabled Value Options to reduce the number of authorized units of individual Community Support services—which declined 72%—and increase utilization of other enhanced services. These utilization changes were achieved through approval/denial decisions and recommendations provided by Value Options' clinical staff for more appropriate services for recipients.

3. Were ongoing, major leadership changes prevalent during the implementation of the Enhanced Services Package?

There were 10 changes in key leadership positions throughout the implementation of the Enhanced Services Package. As shown in Exhibit 4, the Secretary of the Department of Health and Human Services changed three times, the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services changed three times, and the Director of the Division of Medical Assistance changed four times during the three-year time period between April 2006 and February 2009. In contrast, a total of six leadership changes occurred at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance during the five-year time period between 2001, when mental health reform began, and March 2006, when the Enhanced Services Package was implemented. Whereas changes occur as a matter of course in any organization, turnover in leadership among these three entities was lower during the period preceding the implementation of the Enhanced Services Package.

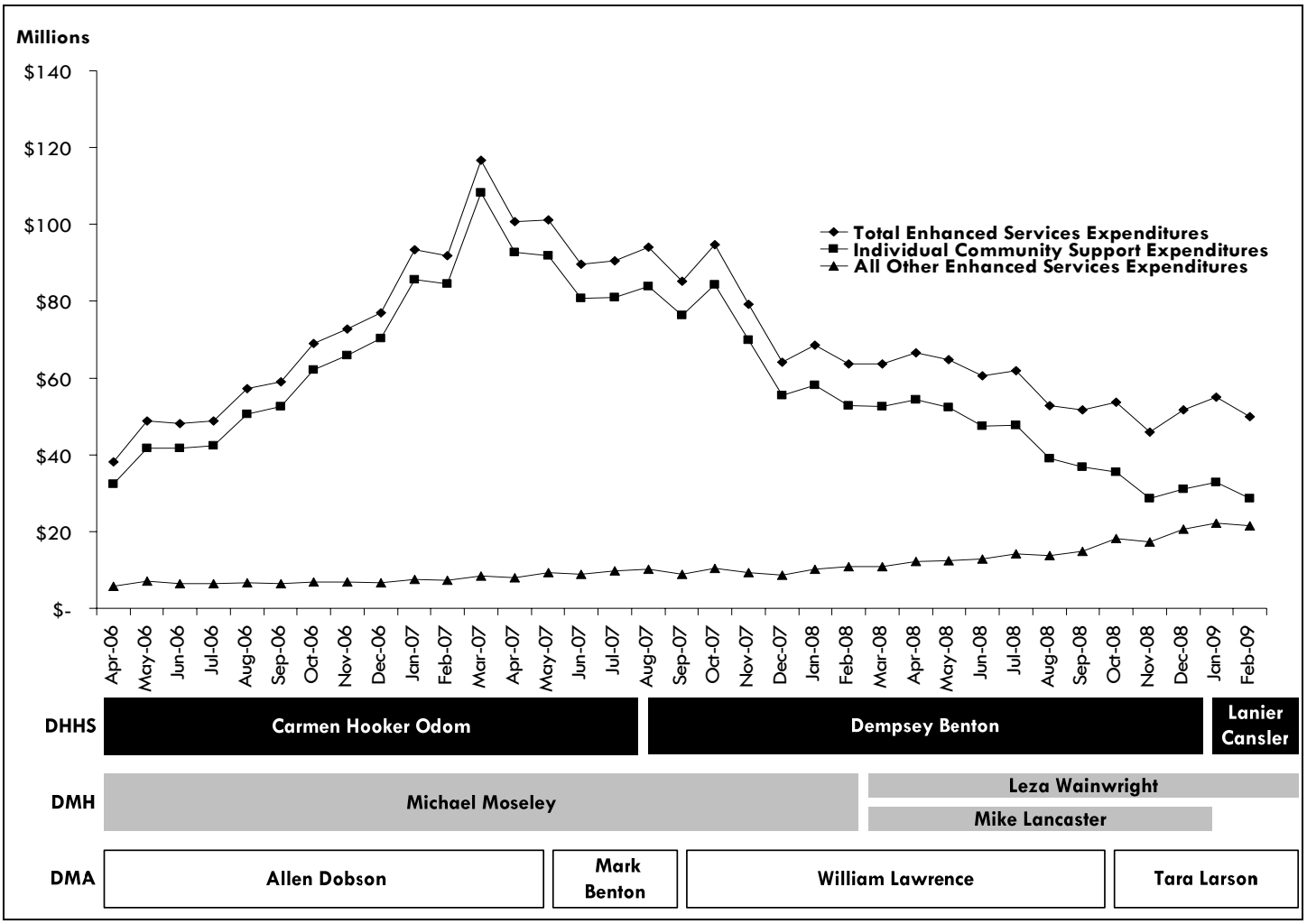
Exhibit 4: Changes in Agency Leadership (April 2006-February 2009)

Agency Leadership	Appointment	Departure	Reason for Departure
Department of Health and Human Services (Secretary)			
Carmen Hooker Odom	January 2001	August 2007	Resigned
Dempsey Benton	August 2007	January 2009	Resigned
Lanier Cansler	January 2009	Current Secretary	Currently serving
Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Director)			
Mike Moseley	March 2004	February 2008	Resigned
Michael Lancaster (co-director)	March 2008	January 2009	Returned to Chief of Clinical Policy position
Leza Wainwright (co-director)	March 2008	Current Director	Currently serving
Division of Medical Assistance (Director)			
Allen Dobson	July 2005	May 2007	Resigned
Mark Benton	May 2007	September 2007	Resigned
William Lawrence (acting)	September 2007	October 2008	Resigned
Tara Larson (acting)	October 2008	April 2009	Returned to Chief Clinical Operations Officer position
Note: Craigan Gray became director of the Division of Medical Assistance in April 2009.			

Source: Program Evaluation Division.

The Division of Medical Assistance has had the least stability in leadership. Since the departure of Allen Dobson in 2007, all three successors have served as interim or acting directors. These interim and acting directors also held significant other positions. For example, Tara Larson was serving as director and chief clinical operations officer. Before her, William Lawrence served as both the acting director and the chief financial officer.

Exhibit 5: Changes in Agency Leadership Associated with Enhanced Services Expenditures



Source: Program Evaluation Division.

In sum, analyses conducted for this report show total costs began escalating rapidly in October 2006, but key agency cost-controlling decisions were not made until February 2007. Subsequently, total monthly expenditures leveled off and began to decline. Specifically, individual Community Support expenditures began to decline in early 2007 and continued to decline through February 2009. In keeping with the goals of mental health system reform, expenditures for other enhanced services began to rise toward the end of this time period. The initial, steep escalation of expenditures and the time required for the Department of Health and Human Services to react to and make decisions that would moderate those costs have been cause for deep concern among legislators.

The cost overruns might have been avoided or at least attenuated with better planning and oversight. Analyses conducted by the Program Evaluation Division suggest that, assuming expenditures from September 2008 to February 2009 represent reasonable costs for enhanced services, effective planning and oversight could have avoided costs of $498.5 to $635.3 million, $177.4 to $226.2 million of which would have been North Carolina's share of the savings.

Agency Response

A draft of our report was submitted to the North Carolina Department of Health and Human Services to review and respond. Their response is provided at the end of the report.

PED Contact and Staff Acknowledgments

For more information on this report, please contact Carol H. Ripple at carol.ripple@ncleg.net.

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

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Lanier M. Cansler, Secretary

May 28, 2009

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Dear Mr. Turcotte:

Thank you for the opportunity to comment upon the Program Evaluation Division's latest review of the implementation of new mental health and substance abuse services by the Department of Health and Human Services. The report, entitled "Enhanced Services Package Implementation: Costs, Administrative Decision Making, and Agency Leadership," documents the rapid growth in one particular service implemented in March, 2006, Community Support Service (CSS), and the actions that the Department subsequently took to control that growth.

We find the report to be an accurate description of the events and actions that have occurred following the implementation of the new services three years ago. As the report clearly demonstrates, the Department of Health and Human Services has focused a great deal of attention on reducing the expenditures on CSS, while at the same time encouraging the use of other more rigorous and evidence-based practices, and has been successful in those efforts.

We believe, however, that some additional explanation of the state and federal rules and regulations governing the Medicaid program that have constrained the Department from acting even more quickly to reduce expenditures is warranted. We offer three examples:

1. Service Definition Changes which do not require approval by the Centers for Medicare and Medicaid Services (CMS). In the fall of 2007, the Department began rewriting the CSS service definition to increase the clinical effectiveness and control the growth of less clinically competent providers. One of the changes made to the service definition was a limitation on how much of the service could be delivered by paraprofessional staff, both at an individual consumer level and for the entire provider agency. In accordance with NC requirements, that change in clinical policy was subject to review by the Physicians Advisory Group (PAG), a process that takes at least thirty (30) days. Also, in accordance with federal regulations, the revised definition was subject to a forty-five (45) day public posting period. The input from the public posting convinced the Department that limiting the amount of paraprofessional time at the individual recipient level could have unintended consequences and that the agency –level limitation only would accomplish the goals of the change. However, since the definition was modified, based upon the required public comment period, it then had to be published, in accordance with federal regulations, for another fifteen (15) day public

comment period. As a result, a change that was envisioned in October, 2007 was not implemented until March, 2008.

2. Maintenance of Service (MOS). Federal regulations require Medicaid recipients to be given due process when a decision is made to reduce, terminate, suspend, or deny a service. If the Medicaid recipient has been receiving the service at a certain level when the decision is made to reduce the level or terminate the service, federal regulations require that the recipient must continue to receive the service for at least ten (10) days in order to give the recipient time to decide whether or not to appeal the reduction or termination. In 2008, the NC General Assembly extended that time to at least thirty (30) days. If the recipient decides to appeal, they may elect to continue to receive the service during the pendency of the appeal. Therefore, recipients often continue to receive services at a higher level for many months after a decision has been made to reduce or terminate the service. As a result, overall expenditures for the service remain high while the lengthy appeals process runs its course. At one point, nearly $100 million in CSS service expenditures in any given month related to MOS.
3. Service Definition and Fiscal Changes which require CMS approval. In June, 2008, the Department of Health and Human Services submitted a State Plan Amendment (SPA) to CMS to make changes in the CSS service definition which required CMS approval and to change the payment methodology of the service from a single rate to a range of rates based upon the actual qualifications of the worker delivering the service (known as "tiered rates.") Those changes could not be implemented without CMS approval. The SPA finally received CMS approval, with very minor substantive changes, in December, 2008 and the changes were implemented effective January, 2009.

We believe these examples help to illustrate the complexities of the Medicaid program and put into context the challenges the Department faces in managing the expenditures in this entitlement program.

Thank you again for the opportunity to comment and for the professionalism of your staff in conducting this review.

Sincerely,

Lanier M. Cansler

cc: Allen Feezor
Craigan Gray, MD
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