NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Administration and Community Services

March 27, 2019

Discussion Guide

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3. NC Behavioral Health System Structure
4. NC Behavioral Health Strategic Plan
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People

Public System	Received Behavioral Health Services CY 2018
2.2 million people have Medicaid	**285,000** Medicaid beneficiaries
1 million people are uninsured	**97,000** uninsured

10 million residents, 2.2 million have Medicaid, 1 million uninsured, 6.8 million have private insurance

Prevalence

- **1 in 20** people are living with a **serious mental illness**
- **1 in 20** people are living with an **opioid use or heroin** use disorder (**2nd highest increase in death rate in the nation from opioid misuse as of CY 2017)**
- **Over 1400** people died by **suicide** in CY2017. **Five per week were Veterans**.
- **1 in 58** children has **autism spectrum disorder**
- There are **128,000 adults and children** in NC with an **Intellectual Developmental Disability**
  - **Only 12,738** have a slot on the Innovations waiver
- **Nearly 80,000** people sustained a **traumatic brain injury** last year
- Over **16,000 kids** in **foster care**
- **25,000** people were **re-entered society** from prison last year – 44% of jail inmates and 31% of prisoners have a history of mental health treatment
- **9,000** people **experiencing homelessness**; over **800 are veterans**

**Various documented sources*

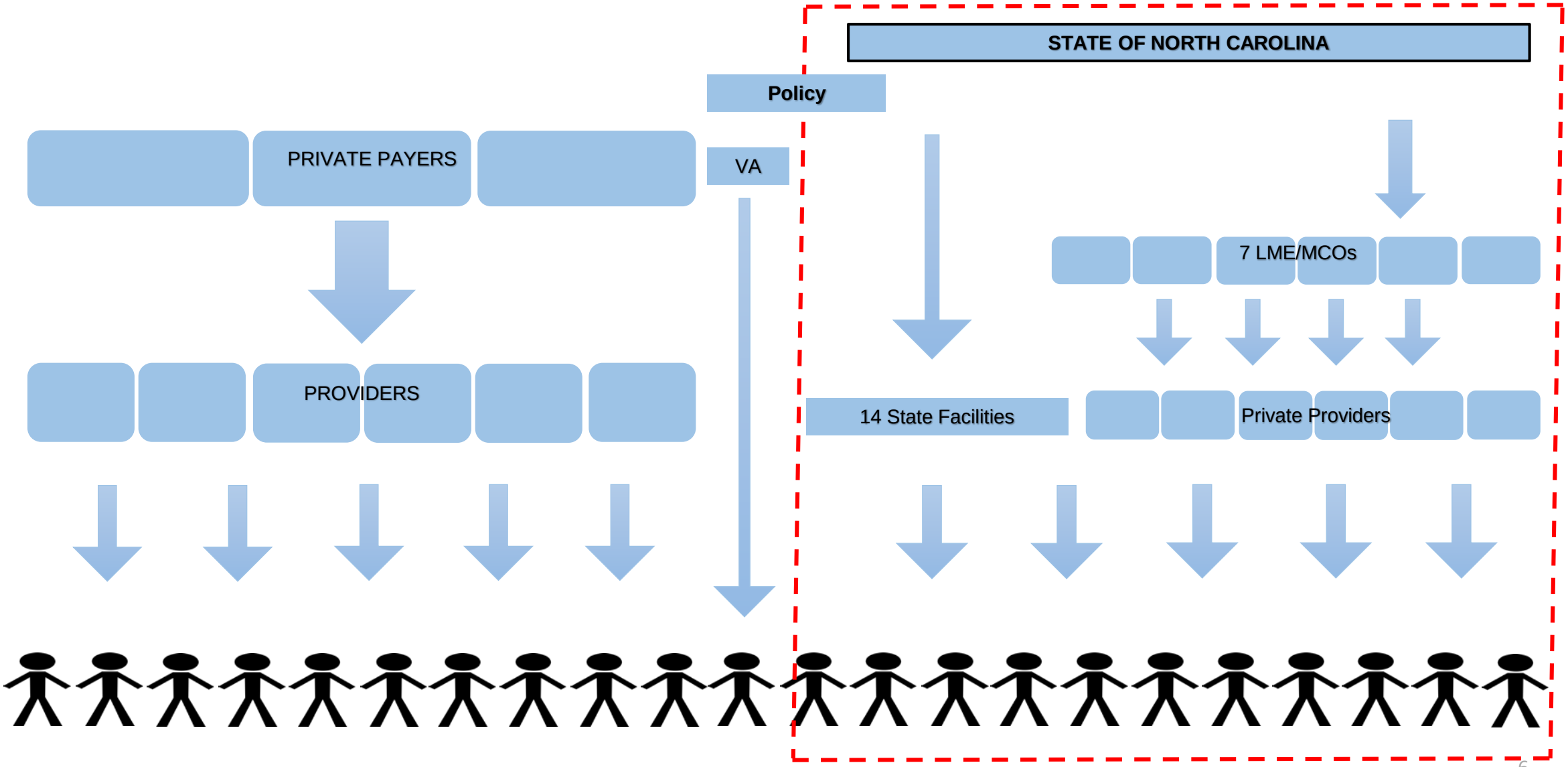
Behavioral health conditions, like physical health, vary in complexities and do treatment strategies, locations, and cost.

Mild	Moderate	Severe
Mental Health Condition		
Condition: Mild Depression Treatment: Medication treatment and brief counseling by primary care provider Cost: Individual able to work with minimal disruption to productivity or family responsibilities	Condition: Moderate Depression Treatment: Medication treatment by a psychiatrist and weekly individual counseling Cost: Individual maintains employment, but misses days of work and not always able to meet family responsibilities	Condition: Severe Depression Treatment: Inpatient psychiatric hospitalization followed by outpatient day programming Cost: Individual unable to maintain employment or meet family responsibilities for several months
Physical Health Condition		
Condition: Mild Diabetes Treatment: Medication treatment and nutritional counseling by primary care provider Cost: Individual able to work with minimal disruption to productivity or family responsibilities	Condition: Moderate Diabetes Treatment: Insulin treatment by an endocrinologist and ongoing counseling with a nutritionist Cost: Individual maintains employment, but misses days of work and not always able to meet family responsibilities	Condition: Severe Diabetes Treatment: Inpatient medical hospitalization followed by home health and physical therapy Cost: Individual unable to maintain employment or meet family responsibilities for several months

Examples of diagnoses, services, and supports in key domains of our behavioral health system (sampling).

Mental Health	Intellectual and Developmental Disability, Traumatic Brain Injury	Substance Use Disorder
Diagnosis		
- Mild Depression -Major Depression Disorder -Bipolar Disorder -Post traumatic stress disorder -Serious Emotional Disorder -Serious Mental Illness -Psychotic Disorders	-Autism Spectrum Disorder -Fetal alcohol syndrome -Developmental Disability -Down Syndrome -Fragile X -Traumatic Brain Injury with Behavioral	-Opioid or heroin use disorder -Alcohol use disorder, DWI -Cocaine use - Benzodiazepine use disorder - Polysubstance use disorder - Problem Gambling -Tobacco use, underage smoking
Treatment: No stigma, evidenced-based, high quality, community based, accessible		
-Outpatient Therapy -Supportive Employment -Intensive outpatient -Peer supports -In-patient residential treatment programs -Inpatient hospitalization	-Innovations Waiver -Natural supports, respite -Supportive employment -Intermediate care facility -Traumatic Brain Injury Demonstration Waiver -Home and Community Based Care	-Prevention -Medication assisted treatment -Intensive outpatient -Intensive residential treatment -Medical detox

Continuum: The state sets policy, manages health-care finance for the public system, and providers direct security-net care.



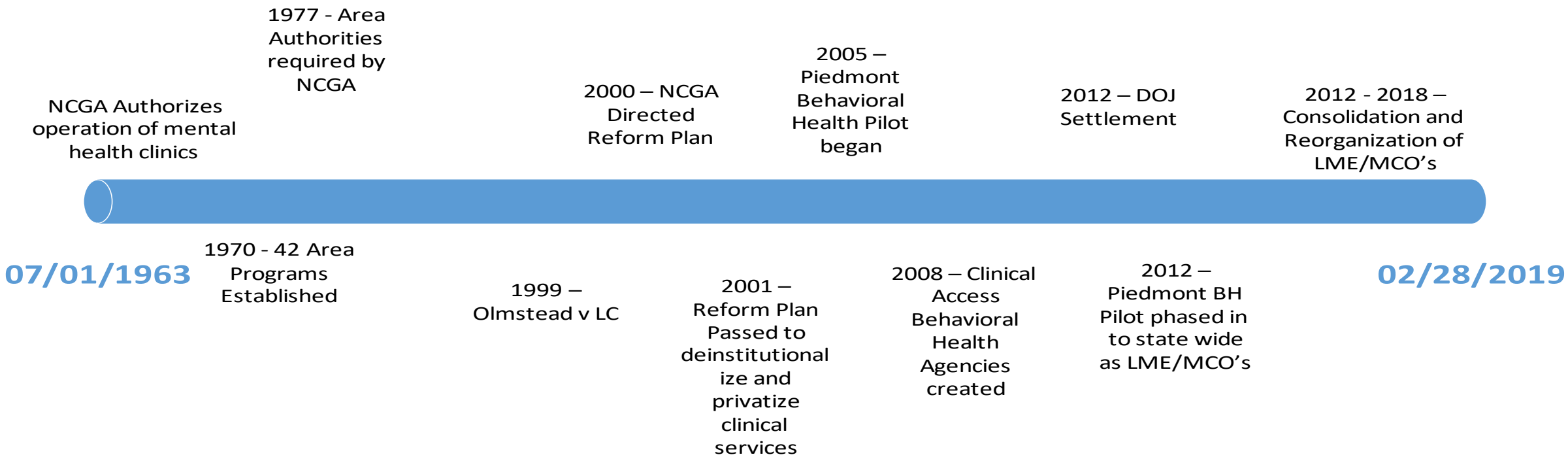
Organizational Overview

- Mental Health, Developmental Disabilities and Substance Abuse Services
  - *Administrative – general admin and reserves/transfers*
  - *Community Behavioral Health Services – single stream, prevention, community MH,SA,DD and crisis services*
  - *State Operated Facilities – inpatient (892 beds), neuro-medical (577 beds), ADATC (196 beds), developmental centers (1,195 beds) and schools (42 resident capacity)*
- State Staffing

	FTE's
Administration	208.0
Community Services	27.0
State Operated Facilities	11,078.8

Behavioral Health System History

Evolution of State System

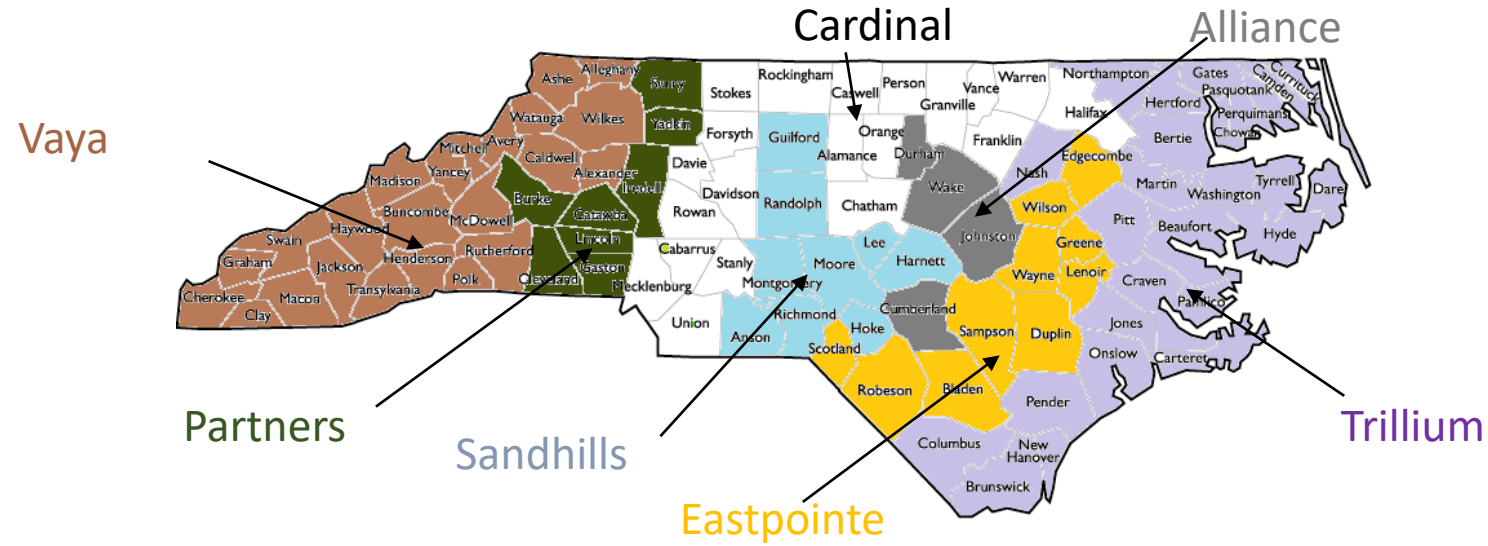


The state funded behavioral health system has evolved from a collaboration with counties to offer services to overseeing and coordinating agreements to manage the services for populations covered under either an at-risk capitation agreement or an annual allotment

https://www.ncleg.gov/documentsites/committees/JLOCHHS-MHSub/Meeting%20Folder/September%2010,%202012/HISTORY%20OF%20NORTH%20CAROLINAS%20BEHAVIORAL%20HEALTH%20DELIVERY%20SYSTEM-J.%20Paul%20-%20Attach.%20No.%203.pdf

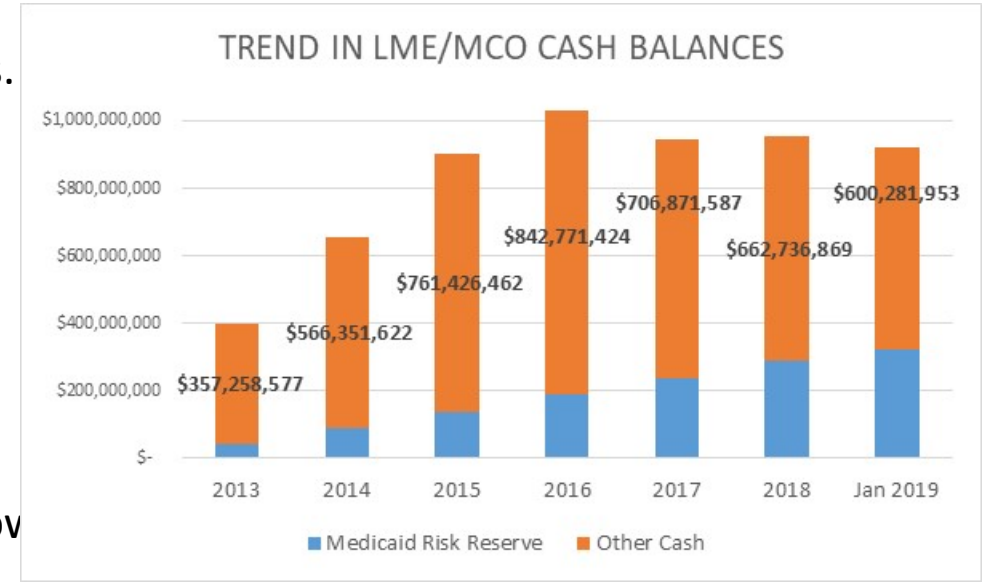
NC Behavioral Health System Structure

- 7 Local Management Entity/Managed Care Organizations currently manage the services for the State's covered populations across the State
- LME/MCO's manage services for both the uninsured and Medicaid



NC Behavioral Health System Structure

- LME/MCO's are funded by State, Local, Federal and Medicaid receipts.
- Medicaid represents 84% of the total funding LME/MCO's receive.
- Any surplus from Medicaid is the property of the LME/MCO and CMS prohibits the State from directing hov



- In FY 2018-19 the General Assembly found that a viable system is critical to meet the needs of the covered populations. The budget recognized the need for and established a range of acceptable cash balances that represented solvency standards – ***shift the conversation from cash balances to performance and outcome measures***.

LME/MCO Solvency

SL 2018-5 Section 11F.10

- Incurred but unreported claims
- Net Operating Liabilities
- Catastrophic or Extraordinary Items
- 24 Months Mandated Intergovernmental Transfers
- 24 Month Forecasted Net Operating Loss
- 36 Month Reinvestment Plans

First DHHS Quarterly Report Findings

- Alliance - within range
- Cardinal – over upper range
- Eastpointe – over upper range
- Partners – within range
- Sandhills – within range
- Trillium – under lower range
- Vaya – over upper range

Corrective action plans in process for LME/MCO 5% over or under ranges

Strategy: Vision, Mission, and Goals

In February 2017, the Department issued a behavioral health strategic plan, identifying two broad areas for strengthening the system: (1) integration and (2) access.

Vision for Behavioral Health in North Carolina: *North Carolinians will have access to integrated behavioral, developmental, and physical health services across their lifespan. We will increase the quality and capacity of services and supports in partnership with providers, clients, family members, and communities to promote hope and resilience and achieve wellness and recovery.*

The strategic plan grounds our efforts in data and key indicators of performance across our system.

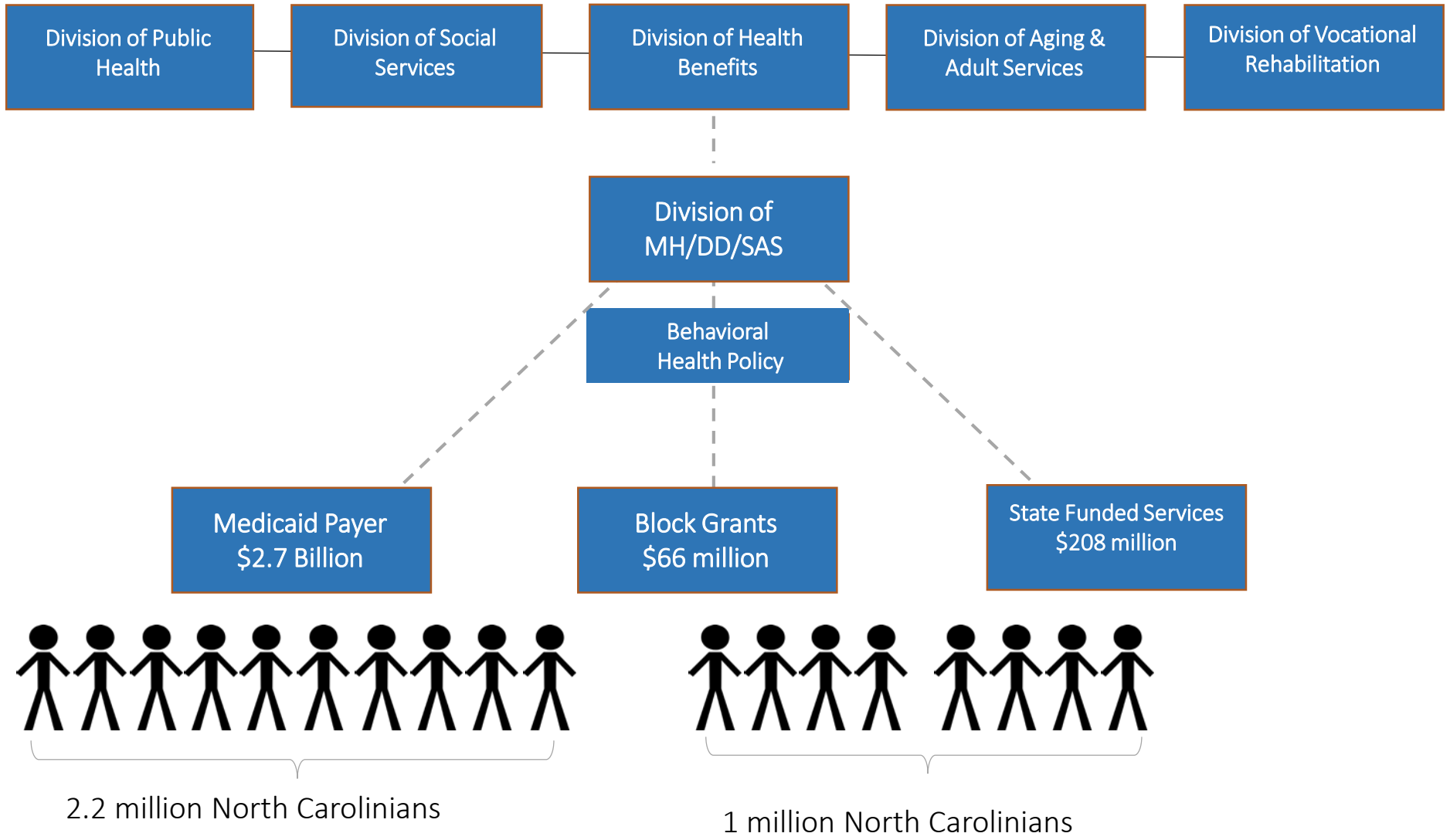
DMH/DD/SAS Mission: *Through the lens of behavioral health, we aim to lead with our ideas to identify gaps, invest in promising interventions, and efficiently scale a system that promotes health and wellness for all North Carolinians across all payers, providers, and points of care.*

1. Access: Increase overall access to high-quality behavioral health services and IDD supports; right-care, right-time, and right-setting.
2. Integration: Integrate behavioral healthcare into routine primary care
3. Transformation: Radically realign the behavioral healthcare system to maximize access and integration of services
4. Operational excellence: Strive for operational excellence and continuous improvement in our internal operations and regulatory functions.
5. Maximize impact: Advance policies and narratives that reinforce the Division as competent thought leaders and service-oriented partners

Key system gaps and initiatives were outlined in the Behavioral Health Strategic Plan – work is underway implementing these efforts.

	Gaps	Initiatives
ACCESS	• Coverage gap – one million people in NC have no routine access to care; • Geographic imbalance to services, providers and inpatient beds • Emergency room "boarding" • Service-array imbalance or lack of evidence to services provided • Workforce - variations in provider capacities, training, and skills. • Service navigation and supports • Opioid treatment, especially in rural communities	• 1115 waiver as part of transformation – SUD amendment • Telehealth and telepsychiatry policy; UNC ECHO • Home and Community Based Services • Community collaboratives • Behavioral Health Crisis Referral System (BH-CRSys) • Peer Support • Step-down services; respite; pre/post inpatient care
INTEGRATION	• Physical and Behavioral Health • Continuum of Service • Criminal Justice System • Schools Services • Social Determinants of Health (healthy food, safe housing, transportation, etc.)	• Medicaid transformation • Transitions focused team • Jail-based MAT; ED-Induction; Jail Diversion/Re-Entry • School based interventions, training, CALM • Healthy Opportunities: NC Care 360 • Routine Screening of Children and Adults • Transitions to Community Living (TCLI) • Awareness, training • Robust communication between providers

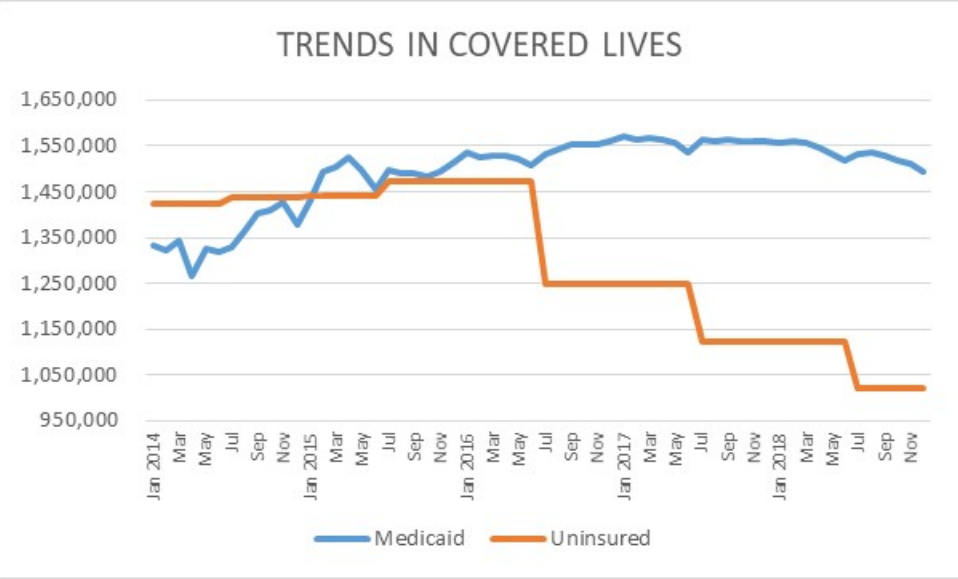
DMH/DD/SAS works collaboratively across divisions to create well-informed-policy that drives whole-person wellness.



DMH/DD/SAS works closely with external stakeholders to make sure state-wide policy is informed by on-the-ground needs.

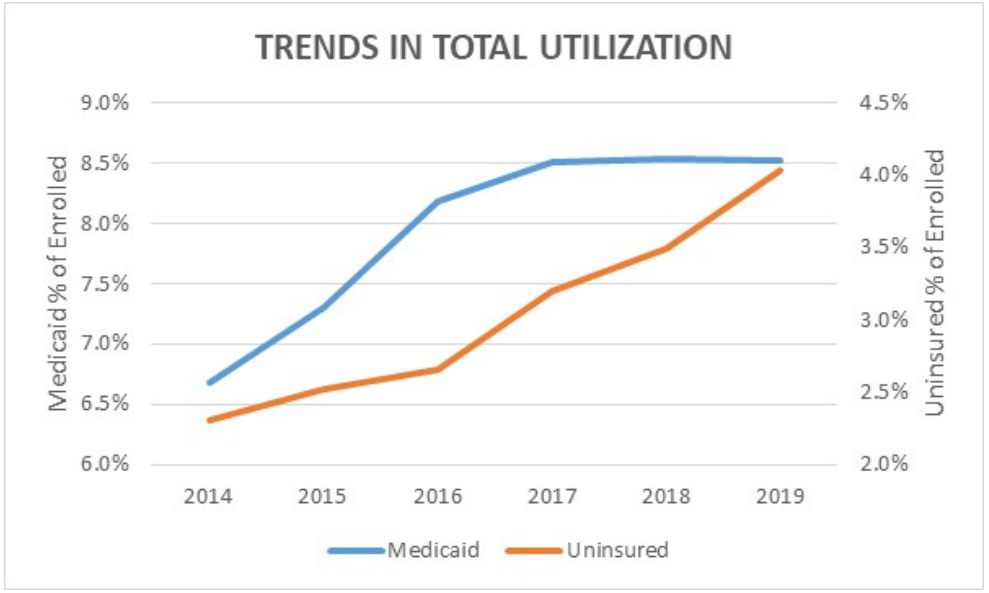
Trends in Uninsured Population

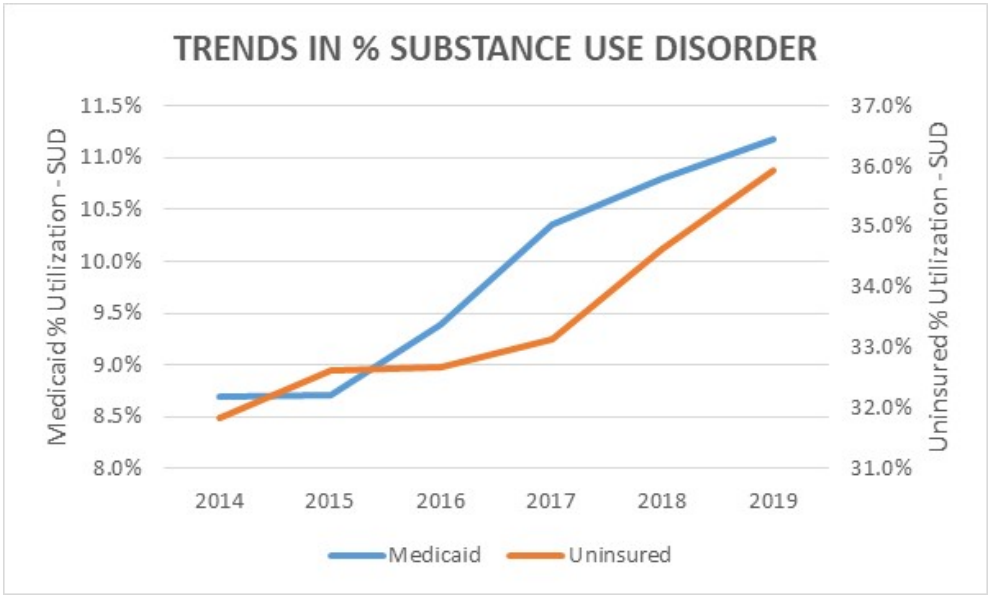
The declines in the uninsured population don't translate into an expectation of less services funded; because non-Medicaid funding is a fixed annual allotment with the requirement to provide

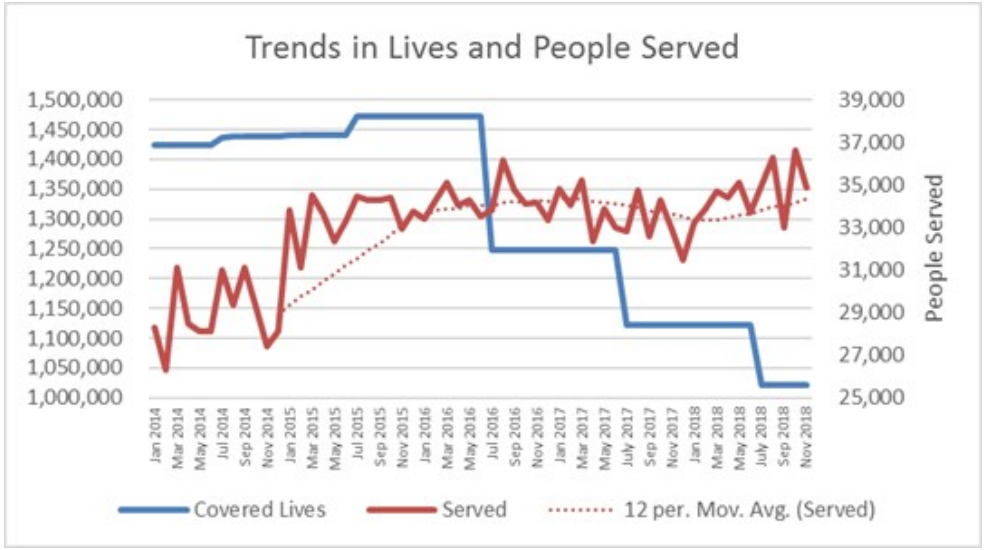


core services within available resources. There is always unmet need or the service that are provided are to those with the most need, which do not change with changes in the State's uninsured population.

Utilization and Performance Measures

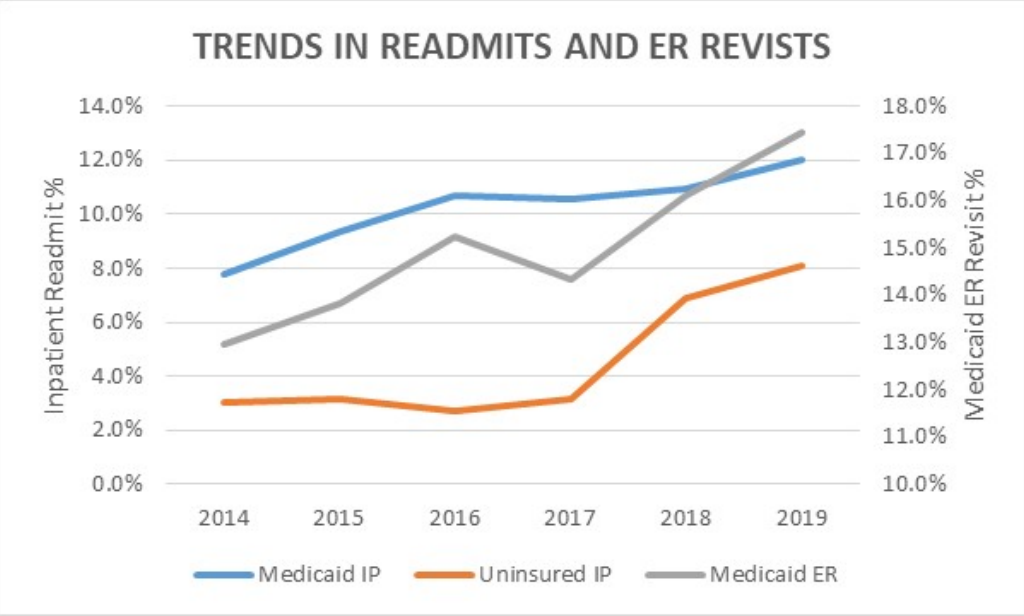


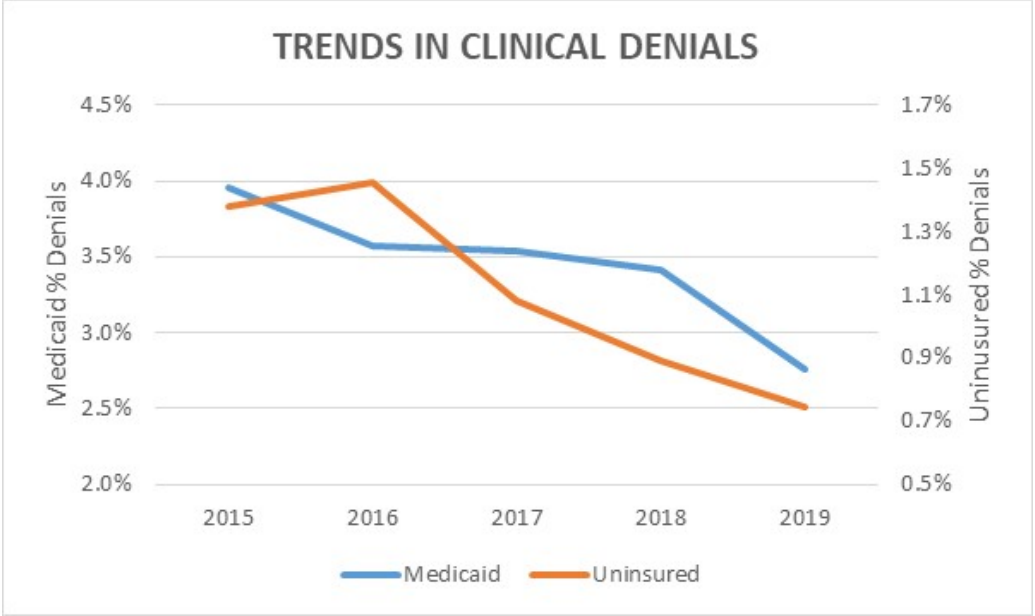




- Growth in the % of uninsured population accessing services is a function of declining total uninsured, the absolute people served has remained relatively the same in recent years.
- Both Medicaid and Uninsured utilization is increasingly represented by individuals with a substance use disorder.

Utilization and Performance Measures





- One measure of a systems effectiveness or access is the % of people admitted to inpatient services or using an hospital emergency room that return within 30 days
- These measures have been consistently increasing for Medicaid and beginning in 2017 the uninsured readmissions have increased dramatically

Untreated behavioral health needs often put pressure on other community resources and government services.

- **Employment:** Untreated mental illness or untreated substance use disorder challenge individuals ability to maintain gainful employment. A failed on-the-job drug test often results in the loss of a job and therefore loss of health insurance. Without insurance to cover chronic treatment for substance use disorder – individuals in these situations struggle to regain employment.
- **Homelessness:** Untreated serious mental illness and other behavioral health needs often prevent individuals from working and maintaining functional housing. Even with housing, some individuals present behaviors that can disrupt their community and threaten housing. **About 25% of those experiencing homelessness have a serious mental illness compared to 5% in the general population**.
- **Criminal Justice**: Untreated mental illness and substance use disorder drive individuals to behaviors that often disrupt community in ways ranging from small disruptions to violating public nuisance laws and more serious crimes such as theft or harm to others. As such – these individuals often find themselves in jail or prison with high rates of recidivism. **44% of jail inmates have a previously diagnosed mental illness – whereas only 18.5% of the population at large has a mental illness in a given year.**
- **School**: The educational system is the primary community and provider of care for school-aged-children. Behavioral health or developmental disabilities are often first screened and addressed in the school system. Early interventions are key to successful learning and long-term life success.
- **Family systems:** Mental illness and intellectual and developmental disabilities impact families in a variety of ways. Parents struggling with substance use disorder often become engaged with the social service system and without treatment, loss of custody of children. Families without adequate supports suffer trauma driving increased behavioral health needs for other members and future generations.
- **Death: People with severe mental illness die up to 25 years earlier than the general population.**

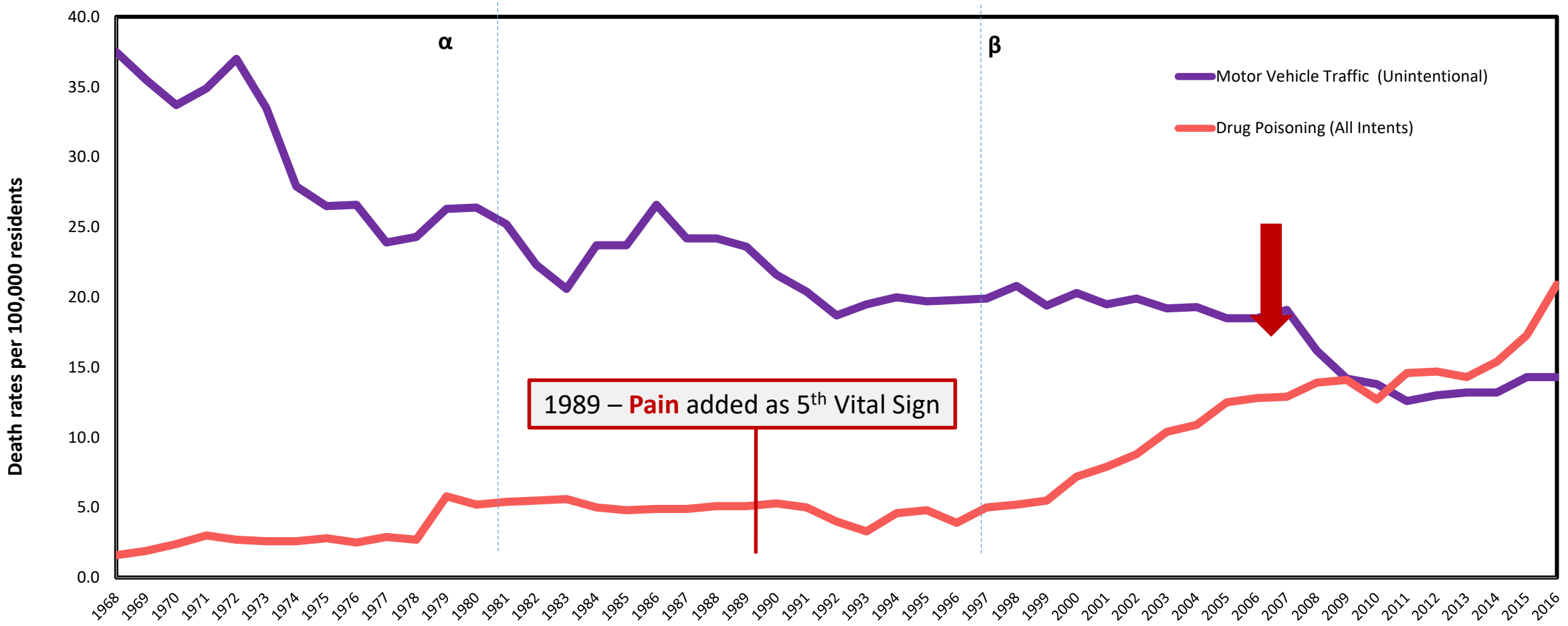
Deep Dive: North Carolina's Opioid Action Plan

1. Coordinate the state's infrastructure to tackle opioid crisis.
2. Reduce the oversupply of prescription opioids.
3. Reduce diversion of prescription drugs and flow of illicit drugs.
4. Increase community awareness and prevention.
5. Make naloxone widely available.
6. Expand treatment and recovery systems of care.
7. Measure effectiveness of these strategies based on results.

- **1 in 20** people are living with an **opioid use or heroin** use disorder – about 450,000 people.
- **North Carolina has 2nd highest death rate in the nation from opioid misuse as of CY 2017**

- https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/north-carolinas-opioid-action-plan

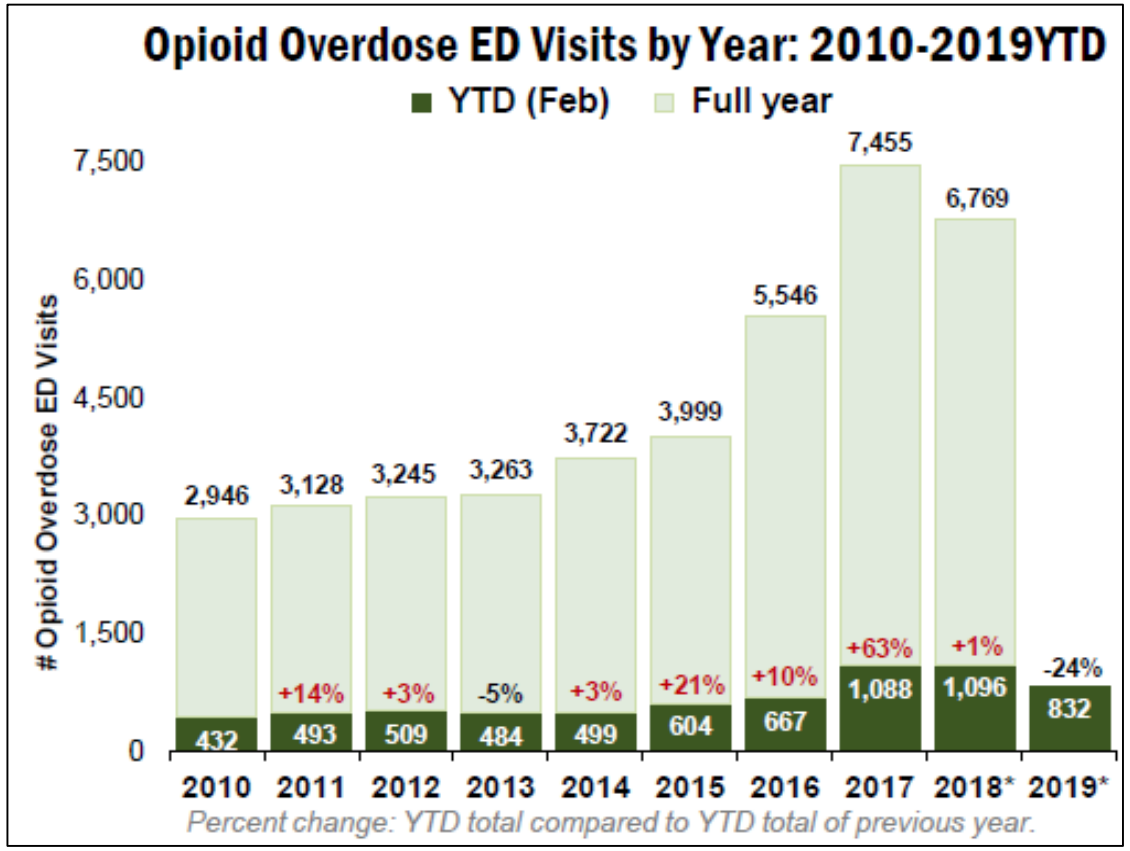
Poisoning death rates are higher than traffic crash death rates in North Carolina



α - Transition from ICD-8 to ICD-9
β – Transition from ICD-9 to ICD-10

Technical Notes: Rates are per 100,000 residents, age-adjusted to the 2000 U.S. Standard Population
Source: Death files, 1968-2016, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit

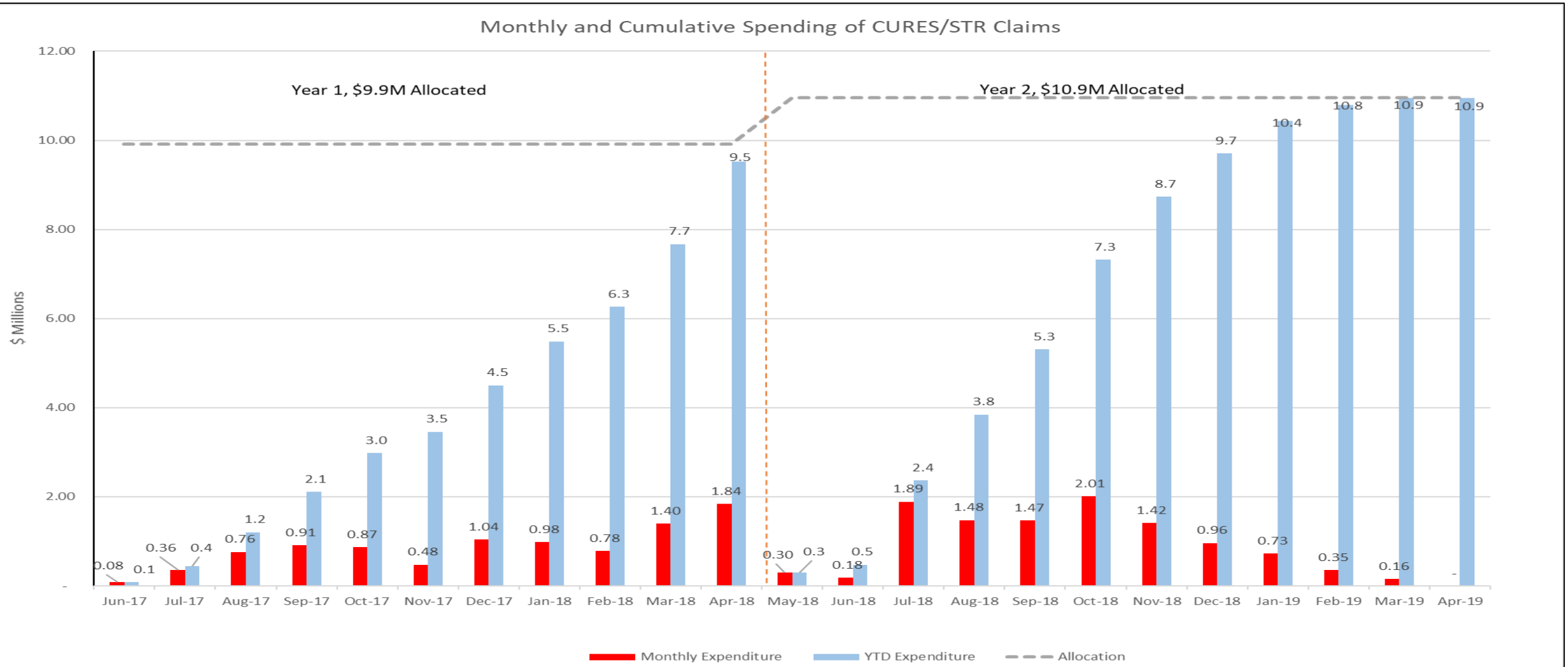
Opioid Overdose Emergency Department Visits: 2010-2019 year to date, as of February 2019 – nearly half are uninsured.



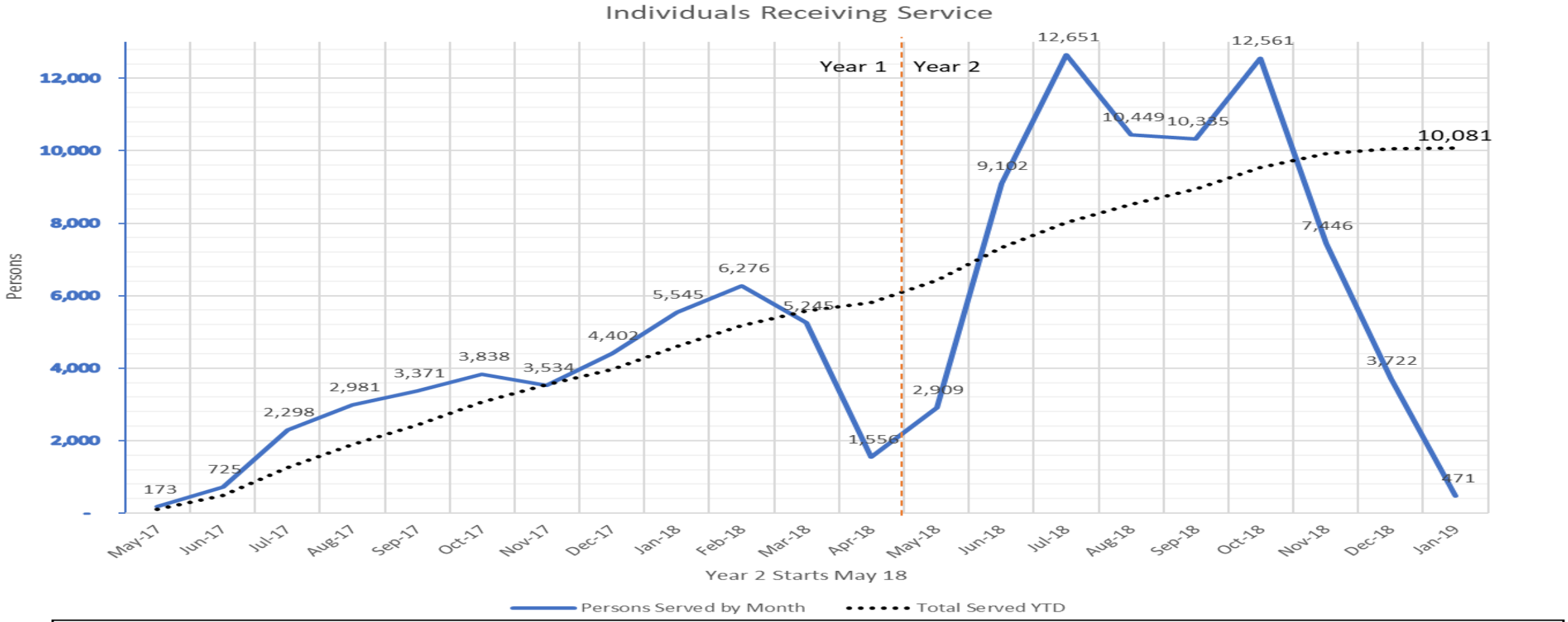
Insurance Coverage: 2019 YTD	
Private insurance	14%
Medicaid or Medicare	29%
Uninsured/Self-pay	46%
Other/Unknown	11%

Data Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT), 2010-2019;
*2018-2019 data are provisional and subject to change; Data as of February 2019
Analysis by Injury Epidemiology and Surveillance Unit

The 2 year CURES/STR federal funding has been quickly expended to support treatment.

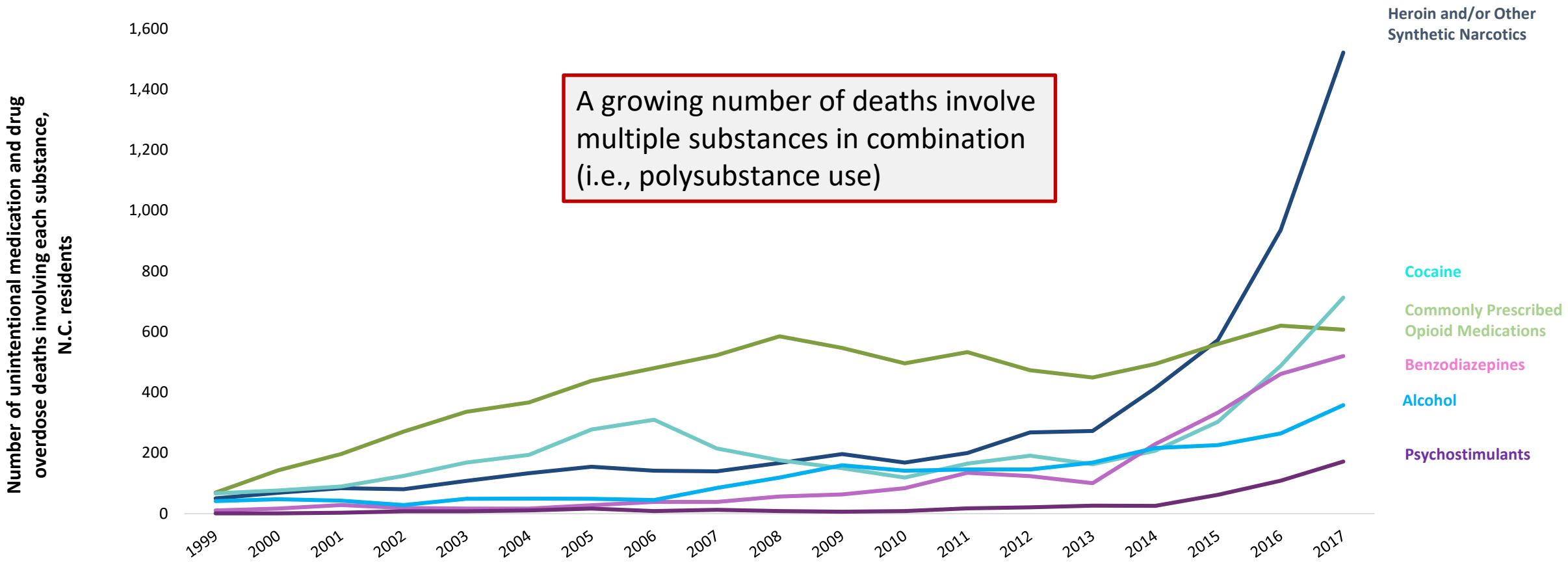


The 2 year CURES/STR federal provided services to 10,081 individuals – many of whom will require ongoing care.



Between May 1, 2017 and April 30, 2018, 33,234 individuals with an opioid use disorder received publicly-funded (Medicaid, state, federal) treatment services. Of these, 10,081 individuals received services through Cures/STR funds. 2,279 of these individuals received services in Year 1 and Year 2 of the Cures/STR grant.

Broader: Unintentional overdose deaths involving illicit opioids* have drastically increased since 2013



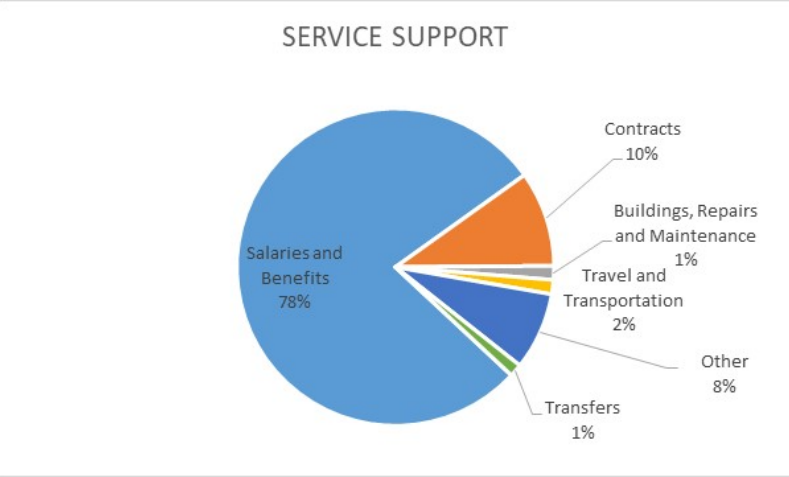
*Heroin and/or Other Synthetic Narcotics (mainly illicitly manufactured fentanyl and fentanyl analogues)

Technical Notes: These counts are not mutually exclusive; If the death involved multiple substances it can be counted on multiple lines; Unintentional medication, drug, alcohol poisoning: X40-X45 with any mention of specific T-codes by drug type; limited to N.C. residents

Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 1999-2017
Analysis by Injury Epidemiology and Surveillance Unit

Administrative Budget Overview

ADMINISTRATION		Actual 2017-18	Certified 2018-19	Authorized 2018-19	Inc\Dec 2019-20	Total 2019-20	Inc\Dec 2020-21	Total 2020-21
1110	Service Support	$ 23,619,378	$ 26,385,167	$ 26,447,502	$ (550,000)	$ 25,897,502	$ (550,000)	$ 25,897,502
1910	Reserves and Transfers	25,437,667	23,885,556	23,885,556	(10,604,732)	13,280,824	(10,604,732)	13,280,824
1991	Reserve - Indirect Cost	-	-	-	-	-	-	-
1993	Prior Year - Refunds and Carry Forwards	247,629	-	-	-	-	-	-
Total Requirements		**$ 49,304,674**	**$ 50,270,723**	**$ 50,333,058**	**$ (11,154,732)**	**$ 39,178,326**	**$ (11,154,732)**	**$ 39,178,326**
1110	Service Support	$ 7,485,733	$ 8,087,053	$ 8,131,778	$ -	$ 8,131,778	$ -	$ 8,131,778
1810	Revenue - Clearing Account	(1,437,490)	-	-	-	-	-	-
1910	Reserves and Transfers	14,535,169	-	-	-	-	-	-
1991	Reserve - Indirect Cost	462,871	-	-	-	-	-	-
1992	Prior Year - Earned Revenue	563,878	-	-	-	-	-	-
1993	Prior Year - Refunds and Carry Forwards	498,051	-	-	-	-	-	-
Total Receipts		**$ 22,108,213**	**$ 8,087,053**	**$ 8,131,778**	**$ -**	**$ 8,131,778**	**$ -**	**$ 8,131,778**
Net Appropriation		**$ 27,196,461**	**$ 42,183,670**	**$ 42,201,280**	**$ (11,154,732)**	**$ 31,046,548**	**$ (11,154,732)**	**$ 31,046,548**



Decrease in base budget reflects removal of non-recurring items in prior years budget for state retirement contributions, facilities and special funds

Community Services Budget Overview

COMMUNITY SERVICES		Actual 2017-18	Certified 2018-19	Authorized 2018-19	Inc\Dec 2019-20	Total 2019-20	Inc\Dec 2020-21	Total 2020-21
1160	MH/DD/SA Workforce Development	$ 1,399,301	$ 1,470,837	$ 1,470,837	$ -	$ 1,470,837	$ -	$ 1,470,837
1262	Enforce Underage Drinking Laws	372,843	360,000	360,000	-	360,000	-	360,000
1271	General SA Prevention - Quality Improvement	7,022,173	9,312,034	8,948,341	-	8,948,341	-	8,948,341
1332	Targeted Substance Abuse Prevention	682,545	352,692	352,692	-	352,692	-	352,692
1422	Community Services - Single Stream Funding	364,357,339	242,959,093	228,033,936	71,189,458	299,223,394	71,189,458	299,223,394
1442	Community Substance Abuse Services - Child	2,330,495	3,986,024	3,218,544	-	3,218,544	-	3,218,544
1443	Community Services - Riddle Center - FIPP	1,913,010	2,173,738	2,185,797	-	2,185,797	-	2,185,797
1444	Community Mental Health Services - Child	10,492,198	10,351,088	9,455,371	-	9,455,371	-	9,455,371
1445	Community Developmental Disability Services - Child	5,581,686	155,034	155,034	(50,000)	105,034	(50,000)	105,034
1451	Community Services - Traumatic Brain Injury	1,100,202	1,156,202	3,170,070	(550,000)	2,620,070	(550,000)	2,620,070
1452	Path Homelessness	855,145	1,379,000	1,379,000	-	1,379,000	-	1,379,000
1461	Community Mental Health Services - Adult	11,897,661	19,518,859	19,320,686	(35,000)	19,285,686	(35,000)	19,285,686
1462	Community Developmental Disability Services - Adult	5,331,530	2,782,743	6,294,768	(625,000)	5,669,768	(625,000)	5,669,768
1463	Community Substance Abuse Services - Adult	60,913,125	81,970,050	86,725,122	(6,440,000)	80,285,122	(6,440,000)	80,285,122
1464	Community Crisis Services	44,219,917	44,146,644	44,516,644	(1,400,000)	43,116,644	(1,400,000)	43,116,644
Total Requirements		**$ 518,469,168**	**$ 422,074,038**	**$ 415,586,842**	**$ 62,089,458**	**$ 477,676,300**	**$ 62,089,458**	**$ 477,676,300**
1160	MH/DD/SA Workforce Development	$ 1,324,584	$ 1,265,692	$ 1,265,692	$ -	$ 1,265,692	$ -	$ 1,265,692
1262	Enforce Underage Drinking Laws	372,843	360,000	360,000	-	360,000	-	360,000
1271	General SA Prevention - Quality Improvement	6,694,581	8,749,311	8,482,532	-	8,482,532	-	8,482,532
1332	Targeted Substance Abuse Prevention	813,805	337,692	337,692	-	337,692	-	337,692
1422	Community Services - Single Stream Funding	66,213,836	262,728	262,728	-	262,728	-	262,728
1442	Community Substance Abuse Services - Child	2,330,495	3,986,024	3,218,544	-	3,218,544	-	3,218,544
1443	Community Services - Riddle Center - FIPP	305,704	2,188,889	2,200,948	-	2,200,948	-	2,200,948
1444	Community Mental Health Services - Child	7,957,727	8,172,679	7,500,891	-	7,500,891	-	7,500,891
1445	Community Developmental Disability Services - Child	6,003,949	-	-	-	-	-	-
1451	Community Services - Traumatic Brain Injury	240,977	246,984	246,984	-	246,984	-	246,984
1452	Path Homelessness	855,145	1,379,000	1,379,000	-	1,379,000	-	1,379,000
1461	Community Mental Health Services - Adult	9,026,791	18,761,088	18,776,922	-	18,776,922	-	18,776,922
1462	Community Developmental Disability Services - Adult	3,539,673	1,599,589	4,286,742	-	4,286,742	-	4,286,742
1463	Community Substance Abuse Services - Adult	56,157,103	35,852,338	36,065,951	-	36,065,951	-	36,065,951
1464	Community Crisis Services	1,813,107	1,395,000	1,395,000	-	1,395,000	-	1,395,000
Total Receipts		**$ 163,650,319**	**$ 84,557,014**	**$ 85,779,626**	**$ -**	**$ 85,779,626**	**$ -**	**$ 85,779,626**
Net Appropriation		**$ 354,818,849**	**$ 337,517,024**	**$ 329,807,216**	**$ 62,089,458**	**$ 391,896,674**	**$ 62,089,458**	**$ 391,896,674**

The most significant action in the base budget was the restoration of the non-recurring single stream reduction

Community Services Budget Overview

§ 122C-2. Policy.

The **policy of the State is to assist individuals with needs for mental health, developmental disabilities, and substance abuse services** in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens. **Within available resources** it is the obligation of State and local government to provide mental health, developmental disabilities, and substance abuse services through a delivery system designed to meet the needs of clients in the least restrictive, therapeutically most appropriate setting available and to maximize their quality of life. It is further the obligation of State and local government to provide community-based services when such services are appropriate, unopposed by the affected individuals, and can be reasonably accommodated within available resources and taking into account the needs of other persons for mental health, developmental disabilities, and substance abuse services.

State and local governments shall **develop and maintain a unified system of services** centered in area authorities or county programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector. **Within available resources**, State and local government shall ensure that the **following core services are available**:

(1) Screening, assessment, and referral.

(2) Emergency services.

(3) Service coordination.

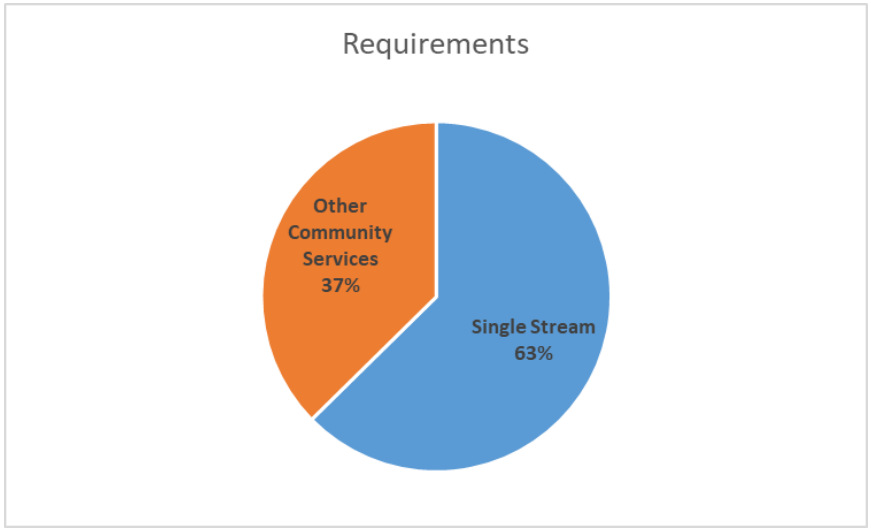
(4) Consultation, prevention, and education.

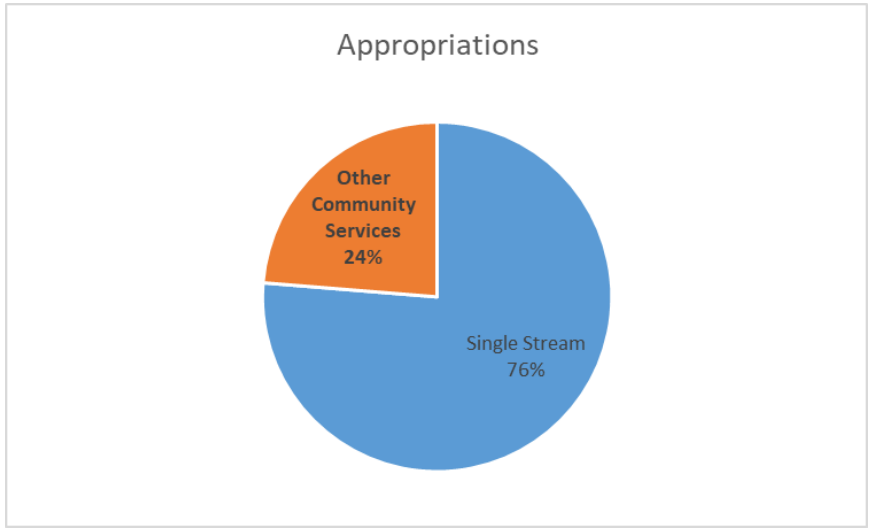
Within available resources, the State shall provide funding to support services to targeted populations, except that the State and counties shall provide matching funds for entitlement program services as required by law.

As used in this Chapter, the phrase "within available resources" means State funds appropriated and non-State funds and other resources appropriated, allocated or otherwise made available for mental health, developmental disabilities, and substance abuse services.

The furnishing of services to implement the policy of this section requires the cooperation and financial assistance of counties, the State, and the federal government. (1977, c. 568, s. 1; 1979, c. 358, s. 1; 1983, c. 383, s. 1; 1985, c. 589, s. 2; c. 771; 1989, c. 625, s. 2; 2001-437, s. 1.1.)

Community Services Budget Overview





- The largest item is the $299 million of funding to the LME/MCO's for single stream services, which reflects a $71 million restoration of a non-recurring reduction in FY 2018-19
- Core Services – screening, assessment, emergency, triage, prevention, education and consultation

Prior Year's Legislative Actions

- 2017-57 Single Stream 11F.2 – *recurring and non-recurring reductions, with a requirement to continue utilization at the same level as FY 2014-15*
- 2017-57 BH Strategic Plan Additions 11F.6 – *changes to the requirement in SL 2016-94 to develop a behavioral health strategic plan that identified a lead agency, developed a statewide needs assessment, established specific measurable outcomes and a specific solvency standard*
- 2017-57 MH/SA Central Assessment and Navigation 11F.7 – *pilot in New Hanover county to assess and navigate people to appropriate community based services to reduce hospital ER utilization*
- 2017-57 TBI Funding 11F.8 – *to assist families in accessing the continuum of care, educational programs and support residential programs designed to support people with TBI*

Prior Year's Legislative Actions

- 2018-5 Single Stream Funding 11F.1 – *Increased single stream recurring and non-recurring reductions; 12/1/18 DHHS can modify distribution; maintain single stream utilization at FY 2014-15 – TROSA, Wilkes County Crisis – HISTORICALLY WHERE DHHS BUDGET BALANCED*
- 2018-5 LME/MCO Solvency 11F.10 – *Viable state funded system critical to meet needs of population and achieve desired outcomes. Short and intermediate term standards to provide a uniform analysis of each LME/MCO's financial position and provide a mechanism for ongoing assessment of viability. Quarterly review, with corrective action plans required.*

QUESTIONS AND DISCUSSION

- Kody Kinsley, *Division of Mental Health, Developmental Disabilities and Substance Abuse Services*
- Steve Owen, *Fiscal Research Division*

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly