NUTS AND BOLTS TRAINING FOR LEGISLATORS:

FUNDING FOR COMMUNITY MENTAL HEALTH, SUBSTANCE USE DISORDER AND INTELLECTUAL OR OTHER DEVELOPMENTAL DISABILITIES

LEZA WAINWRIGHT, CEO

TRILLIUM HEALTH RESOURCES

I2I CENTER BOARD MEMBER

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Topics to be covered

- How are community behavioral health and I/DD services funded?
- Who delivers the services and who manages public BH and I/DD funding?
- What are the requirements for
  - Management?
  - Funding by type?
- How are public funds distributed across the State?
- How much public money is there for community services?
- Breakdown of funding by disability and persons served.
- Changes on the horizon.

How are community services funded?

Under the control of the NC General Assembly:

- Medicaid (must follow federal requirements)
- State General Fund appropriations
- Non-Medicaid federal funds (must follow federal requirements)

Outside General Assembly control:

- Medicare
- TriCare
- Commercial Insurance
- Patient self-pay

Partially controlled by General Assembly:

- Counties
- ABC Boards

Service delivery and management

- All community services are delivered by public and private providers: hospitals, for-profit and non-profit agencies, individual practitioners (psychiatrists, LCSWs, psychologists, etc.) under contract with LME/MCOs.
- Management of community services by Local Management Entities/Managed Care Organizations (LME/MCOs) under contract to DHHS.
- LME/MCOs do perform care coordination for members and have clinicians that respond telephonically 24/7 to crisis calls, but other than that, do not provide direct services.

Requirements for LME/MCO fiscal operations

- As entities of local government
  - GS 159, Local Government Budget & Fiscal Control Act
    - Oversight by Local Government Commission
    - Minimum fund balance requirements – 8%
    - Annual independent audit, under rules of LGC
    - Basis of accounting
  - Governmental Accounting Standards Board (GASB) requirements
    - Audit requirements
- Unique to LME/MCOs
  - GS 122C-124.2 Effective Management of Behavioral Health Services under 1915(b)/(c) Waiver
    - Provisions against fiscal insolvency
    - Requirement to pay at least 90% of clean claims in 30 days
    - Semi-annual certification of compliance by Secretary of DHHS

Funding Requirements - Medicaid

- Enrollees are entitled to all services in the Medicaid State Plan if they are medically necessary.
- Enrollees are entitled to all medically necessary (b)(3) services, up to the level of federally approved funding.
- Enrollees are not entitled to an Innovations Waiver slot, but once they have a slot they are entitled to all medically necessary services available through that Waiver.
  - General Assembly and CMS approve the number of slots available.
- DMA clinical policy outlines staff credential requirements, entrance, exit and continued stay criteria, and any restrictions applicable to each service. Services must be delivered in compliance with clinical coverage policies.

Funding Requirements - State

- General Assembly determines the amount of funding available each year.
- There is no entitlement to State-funded services.
- Priority given to
  - Core Services (GS 122C-2): screening, assessment and referral; emergency services; service coordination; and consultation, prevention and education.
  - “Targeted populations” – those most severely in need clinically and financially or otherwise deemed a State priority, e.g. veterans and their families.
- If the service is also covered by Medicaid, the requirements for service delivery are the same.
- Services not covered by Medicaid –residential services for adults with all disabilities, employment and day activities services, habilitation services for people with I/DD not on Innovations – must follow services definitions published by DHHS.

Funding Requirements - Other

- Non-Medicaid federal funds
  - Annual Block Grant plans must be approved by General Assembly
  - No entitlement to services
  - Federal agencies establish priority services and populations
  - Service definitions follow Medicaid clinical coverage policies or State requirements
- County funds
  - Counties must provide **some level of funding**, per GS 122C-115, but no formula stipulated or amount specified
- ABC funds
  - 1₵ and 5₵ surcharges on bottles (under/over 50 ML) must be spent on treatment, education or research on alcoholism or substance use (GS 18B-805)

Distribution and Payment - Medicaid

- Each LME/MCO has individual per member per month rates from DHHS.
- Rates are negotiated annually, must be approved by CMS
- Rates must be actuarially sound and are based upon past utilization, trend analysis, program changes mandated by State or federal government.
- Rates vary by Medicaid category of aid and are paid monthly to LMEs based upon the number of Medicaid enrollees aged 3 or over by category of aid.
- LME/MCOs must submit encounter claims to NC Tracks detailing how funds have been used – by provider, service and individual served.
- Insurance model – LME/MCOs receive funding for every eligible, even though most will never require BH or I/DD services.

Distribution & payment – State and other federal

- Primarily distributed on an historical basis going back more than 40 years.
- Funding not adjusted for population growth or inflation.
- General Assembly typically prescribes distribution method for any expansion funding
- Recurring federal funds also generally distributed on historical basis
- Non-recurring and federal grants for special projects may be distributed based upon RFPs or applications.
- Most State funds are paid to LME/MCOs in 1/12th increments with encounter reporting to NC Tracks like Medicaid.
- Some State and federal funds are paid only after LME/MCOs submit expenditure reports showing funds have been expended.
- Federal funds paid on a claims basis are only reimbursed after claims have been submitted to NC Tracks.

How much money is there?

- Medicaid - $2.6 billion (includes LME/MCO administration)
- State
  - Crisis services - $43.9M (includes $40M for 3-way hospital beds)
  - TBI - $1.1M
  - General services - $292.8M (includes $37.3M from ADATCs, LME/MCO non-Medicaid administration, funding to address DOJ settlement, etc.)
  - This year, per General Assembly, LME/MCOs must spend $86.9M in fund balance to replace State funding reductions.
- Federal - $53M (includes Cures opioid grant)
- County (including ABC) ≈ $70M (varies widely by county)
- Total ≈ $3.15B

Persons Served - January 2018 Snapshot

- Persons Served
  - Mental Illness - 91,527
  - I/DD - 23,195
  - SUD - 19,557
- Percentage Persons Served
  - Mental Illness - 68%
  - I/DD - 17%
  - SUD - 15%
- Percentage dollars spent by disability (annual estimate)
  - Mental Illness - 34%
  - I/DD - 58%
  - SUD - 8%

On the horizon….

- Behavioral health and I/DD services have been under managed care statewide since 2013. LME/MCOs have been managed care operators
- Physical health, vision, dental and pharmacy services currently under fee for service directly with DMA.
- Beginning as early as July 2019, most physical healthcare, vision and pharmacy services will be managed through commercial managed care companies or provider led entities.
- Current state law says that LME/MCOs will continue to manage all behavioral health and I/DD services for 4 years after managed care "goes live" for physical health.
- Proposal pending General Assembly approval to modify that by creating "Standard Plans" and "Tailored Plans."
  - Standard Plans would be integrated plans covering most of the Medicaid population for physical health, vison, pharmacy and mild to moderate behavioral health services.
    - Capitation for Standard Plans will still follow insurance model – payment for everyone in plan with understanding that not all will access services.
  - Tailored Plans would be integrated Plans covering physical health, vision, pharmacy and behavioral health services for the Medicaid population with serious mental illness, addictions, traumatic brain injury and I/DD.
    - Capitation will no longer be an insurance model but will change to a "disease" model, since everyone in plan will be expected to access services.
    - Tailored Plans, as proposed, would also manage State and non-Medicaid federal funds for behavioral health and I/DD services.

QUESTIONS?

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