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Organizational Review

North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

MERCER

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Introduction

The Department of Health and Human Services (DHHS) Division of Mental Health (DMH), Developmental Disabilities (DD) and Substance Abuse Services (SAS) [Division] engaged Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to conduct an organizational review of its oversight of Medicaid behavioral health programs. The Division is the lead agency for mental health, developmental disabilities and substance abuse policy, standards and quality and manages the state general and federal block grant funds that support services managed by North Carolina's local management entities (LMEs). The Division of Medical Assistance (DMA), also a DHHS Division, is responsible for oversight of Medicaid services in collaboration with the Division. DMA and the Division collaborate on policy direction and oversight of the management and quality of behavioral health services financed through Medicaid. The Division wants to enhance its quality monitoring skills related to oversight of the behavioral health Medicaid services provided through the LMEs under Centers for Medicare and Medicaid (CMS) authorities. Mercer conducted the organizational review to identify the best structure, staffing, methods and strategies for collaborative oversight of Medicaid behavioral health programs.

Background

Medicaid financing of behavioral health services

Most Medicaid behavioral health services in North Carolina are reimbursed through fee-for-services (FFS). In 2005, a Section 1915(b)(c) waiver to operate a prepaid inpatient health plan (PIHP) was implemented by PBH – the LME serving Cabarrus, Davidson, Rowan, Stanly and Union counties. This managed care initiative is effective in improving quality and access to services and in managing costs when compared to fee-for-service Medicaid programs. As a result, DHHS decided to expand the Section 1915 (b)(c) program statewide by phasing in LMEs that are prepared to operate a PIHP. Mecklenburg County LME, which was recently selected through a Request for Application (RFA) process to operate a PIHP, will begin waiver operations in 2011.

Historically, the Division has focused most of its resources and attention on the non-waiver entity LMEs. PBH was one of 24 to 26 LMEs during its implementation and ongoing operations.[1] Thus, the Division focused most of its finite resources and attention on the remaining LME operations, providing oversight of all state general funds and federal grant services. The LMEs also provided utilization management of the FFS Medicaid program in the early 2000s; however, due to increasing costs of the FFS Medicaid program, the DMA procured a statewide behavioral health managed care vendor to conduct utilization management for Medicaid services for all LMEs, except PBH. Thus, the Division has not had a lead role with Medicaid behavioral health programs until recently when, in collaboration with DMA, its staff had an instrumental role in expanding the 1915(b)(c) waiver and RFA.

In recent years, the involvement of Division staff in waiver activities included the LME Systems Performance Team Chief and the staff liaison to PBH since its inception in 2005. Division staff that represents the Quality Management (QM) team, and the Resource and Regulatory Management Section, also participates on the Intradepartmental Monitoring Team (IMT) jointly established by DMA and the Division to oversee PBH. These staff and two others also represented the Division in the 2009 – 2010 1915(b)(c) waiver/RFA development and selection process, and other staff participated in a Waiver Advisory Group. The involvement of additional Division staff in waiver activities has been limited due to workload rather than lack of interest.

Expansion of the Medicaid managed care program will require additional Division oversight. The Division's leadership team identified the need for staff training in Medicaid managed care to be prepared for statewide expansion of the waiver programs. Furthermore, they want to organize their staffing to address quality management oversight responsibilities.

With the expansion of Medicaid and national healthcare reform, where Medicaid will cover persons up to 133% of the federal poverty level (FPL), including single adults, Medicaid financing of behavioral health services will likely increase. The Division wants to be prepared to meet current and future responsibilities related to behavioral policy, standards and quality oversight and, consequently, requested Mercer to conduct the organizational review.

Previous reorganization of the Division

The Division reorganized in 2003 to a matrix organization, deemphasizing condition specific functions (i.e., mental health, developmental disabilities and substance abuse) and moving to a cross-condition management structure that includes sections and teams. This change was significant, and managers and staff had to learn new ways of operating to address the Division's mandate.

[1] Consolidation of some LMEs occurred during the start up and full implementation of PBH.

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Approach

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this organizational review process, Mercer chose a specifically designated team with a variety of specialties and talents that could meet the needs of the Division. The team included individuals who are specialists in the areas listed below, which will address CMS Medicaid requirements for managed care:

Financial management/risk management strategies
Clinical management policies and protocols (e.g. , access, utilization management, care management)
Provider network management requirements
Quality management
Information technology, including clinical, financial and claims management systems
Reporting and monitoring
Managed care organizations contracting/performance requirements

The methodology used by Mercer during this review process was organized into five critical phases presented in the following diagram:

Documents request

Mercer completed a documents request based upon the specialists' knowledge regarding what is needed by an organization to be able to effectively manage a managed care entity. Mercer submitted the documents request to the Division on March 30, 2010, with responses due on April 27, 2010. Information was requested for the purpose of

understanding the current reporting and oversight responsibilities done by the Division in order to prepare for the on-site interviews.

Desk review

Mercer received information from the Division on April 26, 2010 via email, as well as an organizational chart received on April 16, 2010. The information submitted consisted of a grid outlining the positions within the department, which included job descriptions and number of FTEs assigned to the task. Information also centered around the Division's data dictionary, as well as a link to the NC-TOPPS data, where a large portion of the data warehousing and reporting is located.

Mercer reviewed all documents submitted by the Division in order to assist in the development of the on-site interview guides, as well as selecting the appropriate people to be interviewed while onsite. Based on the desk reviews, tailored interview guides were established for each interviewee based on job descriptions and position within the department.

On-site interviews and follow-up interviews

On-site interviews were conducted on May 25 – 27, 2010, for a total of two and a half days at the Division's office in Raleigh. Four interviewers were onsite, with an additional interviewer available by phone for certain interviews. The interviewers were separated into two teams, with the Division's participants selected to be interviewed by team based on area of expertise. Mercer conducted interviews using the previously developed guides. Follow-up telephone interviews were conducted after the on-site to capture any information from the Division's staff members that were not able to participate in the on-site review or to clarify information.

Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. Results of the review comprise this report and include Mercer's recommendations on the steps necessary to provide quality oversight of a managed behavioral health program.

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Findings

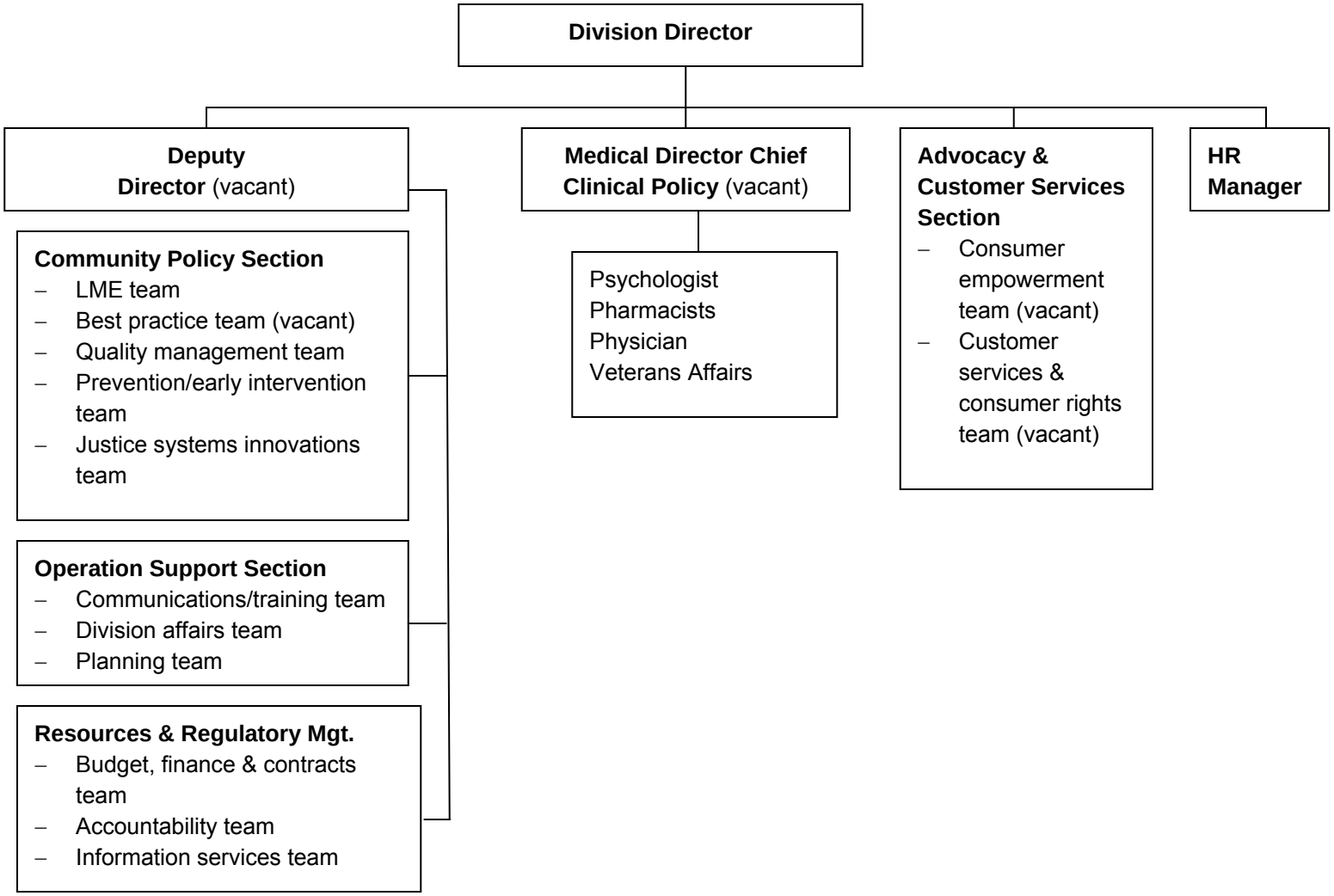
This section of the report discusses Mercer's findings from the desk review of materials provided by the Division and interviews of staff and managers. Division chiefs, team leaders and staff were open and enthusiastic throughout the interview process. They consistently expressed a strong level of support and interest in the Division's monitoring of waiver entities. They also identified several process and data issues viewed as critical to the Division's success. These issues will be highlighted in the discussion below.

Overall management structure

The organization chart of the Division, as of June 2010, is displayed on the following page as Figure 1. As noted on the chart, there are three executive level managers of the Division: the Director, the Deputy Director and the Medical Director/Chief of Clinical Policy. At the time of the review, two key positions were vacant, the Deputy Director position and the Medical Director/Chief of Clinical Policy. These positions represent a significant gap in leadership, limiting the availability of senior leadership guidance to coordinate the work across the Division's sections. This gap in leadership contributes to the communications and coordination challenges that are identified in this report. Furthermore, due to a variety of extenuating circumstances, the Medical Director role, only recently vacant, was diverted from a focus on clinical quality of community-based services funded through the LMEs. For example, this position, when filled, had significant responsibilities related to the state-operated psychiatric facilities for an extensive period of time.

During the review, Mercer also learned that the Division Director will be retiring in August 2010. The absence of this position, along with the Deputy and Medical Director positions, creates a significant challenge to the stability of the Division's day-to-day operations. While there are existing staff members that can operate the Division on a short-term basis, it will be important to quickly hire the three Division leadership staff members to manage the behavioral health program under its mandate.

Figure 1: Division of Mental Health, Developmental Disabilities and Substance Abuse Services Organization – June 2010



Organizational findings

This part of the report will highlight the findings from interviews with the various sections and teams reporting to the director and the deputy director positions. While the findings are organized by sections, the narrative may include information from interviews of staff throughout the Division, rather than comments from staff that are solely part of a team or section. Prior to the discussion on organizational findings, a description of the roles of the Division and DMA pertaining to Medicaid is below to provide a context for all findings.

Responsibilities for Medicaid

The Division's quality monitoring and oversight of the behavioral health Medicaid services provided through the LMEs must address the requirements outlined in North Carolina's Centers for Medicare and Medicaid (CMS) authorities. The following discussion highlights these requirements in relation to the roles of the Division and DMA.

Each State has a contract with the Federal Government regarding the administration and oversight of the Medicaid program. That contract, called the State Plan, outlines the State's procedures for submitting changes and exceptions to the contract. Per 42 CFR 430.12, only the Medicaid agency (DMA) may submit State Plan Amendments. In the case of the Division's Medicaid funded programs, the State Plan, a 1915(b) and a 1915(c) waiver outline the administration and oversight requirements. As outlined in the 1915(c) waiver, DMA is the State Operating Agency with assistance from the Division. North Carolina's functions and activities are already explicitly outlined and may not change without waiver amendment. The waiver specifically outlines all functions required and how DMA with the assistance of the Division will perform those functions including: evaluations, plans of care, quality review, monitoring, payment, the Intradepartmental Monitoring Team (IMT) process and other functions. If North Carolina would like change the performance of those functions, it may submit a waiver amendment. However, the Medicaid agency would still be required to retain oversight of the program and certain required functions such as submitting State Plan Amendments and waivers and communications with CMS. Within the Division, accountability for the waiver should reference the functions outlined in these CMS authorities.

Sections/managers reporting to the director

The Medical Director/Chief of Clinical Policy: This position serves as the Division's premier clinical expert, focusing on the development of sound clinical community systems and models of practice. This position was vacant at the time of the review. The responsibility for oversight of QM across the Division, including chairing a QM committee and developing an annual QM plan, were not identified job functions of the Medical Director and are gaps.

Advocacy and customer services sector

The Advocacy and consumer services section includes staff that report to the acting section chief, as well as two teams: the Consumer Services and Consumer Rights team and the Consumer Empowerment team.

Consumer Services and Consumer Rights team: The staff of this team stated they work seamlessly with PBH and the other LMEs and expect this to continue under the waiver expansion, expecting minimal impact on current processes. Staff highlighted their active role in educating consumers and family regarding consumer rights and recovery/self-determination and encouraging their participation in advisory and advocacy activities. Team staff also manage a call center for responding to consumer concerns and complaints, many of which are referred to the LMEs for action. As a direct resource to consumers, providers and LMEs, the customer service staff wants to be actively involved in workgroups established to address community education. They recommended the Division sponsor regional training for consumers, families and advocates related to the access to waiver services and consumer rights. There were vacancies on this team, and the staff person filling the Chief position was in an acting role. This team also includes licensed clinicians.

Consumer Empowerment team: This team consists of a team leader position and five staff located regionally in five field offices across the state. This is different from the Division's other defined "regions", which are based on the location of the state's three institutions. Regional definitions appear to be fluid and driven by staff location or other factors and are not consistently defined across work teams. This may be an area for increased efficiency as the movement of LMEs into consolidated waiver entities continues to evolve across the state.

Human Resources: There are significant issues related to hiring new personnel, salary and staff retention. All job descriptions are generic and do not match actual functional responsibilities within the Division or the necessary skill sets. A good example is the personnel that maintain the Division's Website. The posting for these positions often require degrees related to social services rather than the technical skills necessary to perform the job functions. This requires reposting the position many times, resulting in a very lengthy hiring period. Additionally, salaries do not tie to the required skill set. There are a limited number of knowledgeable staff regarding data repositories, reporting and extraction for analytical purposes. IT staff in general are stretched very thin and often are working on immediate fixes rather than long range initiatives. Often, there is a lack of critical position backups, and loss of critical personnel would leave a significant gap.

Furthermore, staff and leadership report that there are limited senior clinical positions in the Division. The availability of senior clinical positions to guide clinical policy and quality management is critical to the success of a public behavioral health and developmental disabilities agency. This gap is serious and impedes clinical quality.

Sections reporting to the Deputy Director

The Deputy Director position (vacant) oversees the Community Policy Management section, the Operations Support section and the Resource and Regulatory Management section. Each of these sections and associated teams are discussed below.

Community Policy Management section

The Community Policy Management section includes staff that reports to the section Chief, as well as the following teams: the Best Practice team, LME Systems Performance team, the Quality Management team, the Prevention/Early Intervention team and the Justice System Innovations team.

Best Practice team: The purpose of this team is to identify best practices and innovations in services and treatment as well as manage policy and program development for services and supports in the community. The team also manages grant support programs. This team leader position was vacant at the time of the review.

LME Performance Team: Each member of the team is assigned to one to four LMEs, usually in the same region of the state. (These regions are different from the consumer empowerment regions, which may not be efficient.) Functioning as the Division's local presence, the staff is responsible for LME contract development and monitoring. The LME Performance staff are also responsible for the Critical Access Behavioral Health Agencies (CABHA) design and implementation; the1915(b)(c) waiver design and implementation; the coordination of LME site visits when there is evidence of problems with specific areas of best practice or outcomes; responding to provider questions regarding new policy; and participating in committees.
While the teams are actively involved with the LMEs, they do not have a standard set of policies and procedures for oversight that encompass the different management responsibilities of the LMEs. For example, all the LMEs are responsible for managing state general funds and federal and other grants. The LMEs operating the PIHP waiver programs (PBH and soon to be Mecklenburg) manage all Medicaid services. A few LMEs will take on utilization management of Medicaid services operated under the state's fee-for- service (FFS) program in the future, pending statewide expansion of the PIHP waiver program. All LMEs will manage CABHAs, which have another set of Medicaid state plan requirements. It will be necessary to develop guidance for the LME performance teams in providing technical assistance and oversight to the LMEs managing these various programs.

Also, the LME teams reported they do not have adequate staffing to conduct regular quality reviews of the LMEs, other than participation on the Intradepartmental Monitoring Team with the DMA that reviews PBH. This is a gap that will need to be addressed.

Quality Management team: The primary purpose of the Division's QM team is to establish the standards of quality and the performance measures required of facilities, LMEs and providers. They also have the responsibility to identify performance measures with specifications, develop the methodology for data collection and manage reporting

and use of data and information. However, it appears the focus of the QM team is on collecting data and reporting information. Since about 2005, the QM team has been viewed within the Division as the “go to” place for the numerous report requests from constituents. Due to the volume of reports requested by constituents, the team has little time to evaluate the request to determine: 1) if the report is the most effective/efficient response; 2) if an existing report will address the need; or 3) if the report will provide value to DHHS.

While staff agreed there is a lot of data available to the Division, they differ on the value of the data collected. Some report the data is not used efficiently and is not measured or analyzed correctly. Others find value in the reports, but acknowledge they must improve the reports because many people do not understand them.

Even when the Division is able to collect useful performance data, outdated information technology at the Division hampers timely provision of information that can be used to identify quality management issues and trends. While there are efforts to examine performance data, the volume of ad hoc reporting and the outdated systems also hamper establishing benchmark performance data.

The QM team does not provide regular quality review of the LMEs, except when they participate on the IMT reviews of PBH. Typically, quality reviews fall under a QM function in an organization.

The Division’s organizational chart does not indicate any relationship of QM to the Medical Director/Chief of Clinical Policy, which was confirmed by QM staff. Quality management functions typically are the responsibility a senior licensed clinician, often the Medical Director/Chief of Clinical Policy position within an organization.

Prevention/Early Intervention team: This team has the responsibility for monitoring that prevention services are actually provided by the LMEs/PHIPs, as well as the types of prevention offered when an LME operates under single stream funding. Staff expressed the concern that DMA may view prevention as a service outside the system, due to its not being a Medicaid funded service. They view prevention as a critical need that can be funded through state general funds and block grants. For this reason, the team would like to be more integrated into Division operations to promote the importance of these functions.

In Mercer’s experience, it is not unusual for prevention services and staff to report concerns about isolation of funds. This may be due to the separate nature of the funding streams for prevention services. Fuller integration of these staff into the day-to-day operations of the Division would be useful. Prevention and early intervention are essential to reducing long-term reliance on service systems, as well as reducing stigma associated with mental illness and substance use conditions. Monitoring compliance with prevention and early intervention funding allocations may be better addressed through the Accountability Team, freeing up these staff to work on programmatic issues.

Justice System Team: This team presented as strong advocates for assisting people in the justice system to obtain treatment. Staff also displayed an understanding of managed care programs. They report that coordination with DMA has been effective in addressing Medicaid eligibility of people leaving correctional facilities. The team would like the opportunity to impact quality through active participation on quality initiatives rather than hearing second hand about issues from a probation officer or court counselors.

As Medicaid coverage becomes more accessible to single adults under the Patient Protection and Affordable Care Act (Pub.L. 111-148) (PPACA) of 2011, it will be important to obtain Medicaid reimbursement for justice involved individuals that are on probation or parole or using medical facilities when they are eligible for Medicaid reimbursement. It is essential to review CMS policies in these areas in order to finance services for individuals with mental illness and substance use conditions that are reentering communities from jails and prisons. Thus, more active involvement of the Justice System team staff in strategic planning, QM and oversight of the LMEs would be useful.

Operations Support section and Resource and Regulatory Management section

The Operations Support section includes the Division Affairs team, the Planning team and the Communications and Training team. The Resource Management section includes the Budget, Finance and Contracts team, the Accountability team and the Information Services team. Each of these teams has responsibilities for the business operations of the Division. The team leaders and staff interviewed shared similar perspectives.

The Budget, Finance and Contract team, the Division Affairs team and the Planning team: These teams provide business and planning operational support for the Division. Staff noted that the business requirements and responsibilities for implementation and ongoing monitoring of waiver programs have not been documented and agreed upon by the business areas within the Division and DMA. Further, the finance staff are interested in becoming more sophisticated in fiscal matters relating to Medicaid waivers, which would lead to anticipating and preventing adverse conditions.

Lessons learned from the PBH waiver program provide a good example of items that should be incorporated into the waiver expansion requirements as they are developed. Yet, discussions revealed that many areas within the Division have individual components of waiver oversight but that there doesn't appear to be an overall plan that is understood throughout the organization. There are also conflicting opinions about waiver oversight and whether this requires more focused day-to-day management of the LMEs rather than monitoring activities through the use of analytical tools, audits and documented policies and procedures.

Teams within this section and throughout the Division have significant questions about the waiver expansion and their responsibilities. Involvement of the varied business teams in ongoing discussions regarding the waiver program would help broaden their

knowledge of waiver requirements and establish ownership among the teams. Communication regarding specific and detailed information about the wavier program – what it is, who it applies to, what the LMEs are responsible for and how oversight will be performed – has not occurred.

The LMEs also need similar communication to broaden agreement and understanding of the waiver requirements. Discussions also suggest there is a lack of communication about business decisions both internally and externally. Accountability for decision-making has not been clearly documented, including resolving the specific roles and responsibilities of the LME, DMA and the Division.

During discussions with staff, it was evident that there are heavy workloads in all areas. This places an emphasis on inter-Divisional (DMA and DMH/DD/SAS) collaboration and partnering, which is critical in order to monitor the financial and operational solvency of the LMEs. It is important to coordinate with DMA and the LMEs in order to streamline business efforts. Collaboration at all levels is important to streamline work efforts and reduce overhead and redundancy. There is a lack of collaboration between the areas within the Division and an inconsistent understanding regarding the level of support the Division will provide for waiver oversight.

Furthermore, only a few staff members have the knowledge about the waiver requirements and expansion. A core group of staff work very hard and do a majority of the waiver work, but other staff would like to learn and participate in these efforts. Recognizing that it is the Division's goal to transfer knowledge from those that were involved in the PBH waiver development and oversight, and the recent PIHP waiver procurement, it is essential to establish a plan to train other staff on the lessons learned.

Specific findings related to the Operations Support and Resource & Regulatory Management sections are below.

Communication and Training team: Their responsibilities include increasing stakeholder awareness of the Division's efforts, development and dissemination of information and communications and development of a comprehensive training plan. Staff described Division communications as being reactive rather than proactive. They are not aware of a communication strategy or communication plan driven.

Division staff does not have access to training that would enable them to develop skills necessary for waiver program oversight or that could develop their management skills. Discussions revealed that if training were available current workloads across sections would likely prevent staff from having the time to complete training. Training programs have not been developed that both assess the needs for current staff, including management and curriculums to support those needs. It was pointed out that inconsistencies exist between what the Division expects from LMEs regarding requirements for provider training versus what the Division staff receives for training, yet Division staff is expected to oversee the LMEs' performance. Also, there are no resources for staff to participate in training offered outside the Division.

Accountability team: This team performs compliance monitoring, conducts single audits and monitors corrective actions related Medicaid programs. It has the responsibility to ensure Medicaid and overall fiscal integrity within the Division.

In addition, it is important to note that the compliance activities are specific to regulatory and contract specifications and do not address overall quality of care, except through staff participation on the IMT that performs quality reviews of PBH. The addition of licensed clinicians to the team is critical to ensuring that potential quality of care issues are identified during compliance monitoring and audits, with subsequent referral to QM for further review and action.

Contract compliance for waiver entities involves extensive Medicaid regulation as well as consistency with the monitoring requirements specified in North Carolina's Medicaid authorities (State Plan and waivers). The Accountability team functions should include documenting policies and procedures for program monitoring of services funded by Medicaid and other sources. The goal is to develop accountability protocols that will enhance LME performance and provide ongoing viability measurement of the waiver program. Collaboration with other sections across the Division and with DMA to document clear reporting and data submission requirements for the waiver entities is essential.

Furthermore, it will be important to not only gather information, but also provide reports that spread that knowledge to other LMEs and increase their sophistication about Medicaid waiver requirements.

Information Systems team: This team supports the information technology for the Division. Staff reported and Mercer verified that systems and technology that supports reporting tools and efficient business functions are not in place. In some cases data is missing, located in disparate locations or access to the information isn't available.

The Information Technology (IT) infrastructure is archaic, and knowledgeable staff are worried that significant component failure could occur at any time. In order to perform waiver oversight, the IT system needs to be able to produce accurate and timely reporting. Problems currently exist with the completeness of the data, as well as the timeliness of data availability. The ability of existing infrastructure to support data storage and additional processing and reporting requirements that are needed under waiver expansion has not been measured. Onsite discussions revealed that staff anticipates they will have access to data online once additional LMEs are up and running under the waiver program; however, there is no plan for achieving this goal. Often the LMEs' IT is more advanced than the Division's. Currently, technological guidance is not provided to the LMEs with the result that LMEs are operating independent IT solutions. Other examples of IT challenges include:

- State facilities do not comply with HIPAA EDI claims formats, which will be an issue for LMEs expanding under the waiver program.

- Diagnostic and service information supplied by the rendering provider are not included on the claims submitted to the State. This is a gap that needs to be addressed during waiver expansion to ensure that the clinical information is retained throughout the entire process.

Service bureau operations for the Division of State Operated Health Facilities: The Division of State Operated Health Facilities (DSOHF) was established as a separate entity in 2009; however, the Division continues to provide IT, HR and budget supports for DSOHF's daily operations. . While it is possible for the Division to provide a service bureau function for the facilities, clarification of roles and responsibilities is necessary through a clear Memorandum of Agreement and by assigning the appropriate staff resources to carry out the work. Alternatively, DSOHF could assume operations of their own business management functions.

Summary of findings

Organizational summary

Staff and managers appear motivated and want to improve their expertise with oversight of Medicaid waiver entity programs. Furthermore, they demonstrated the capacity to learn about Medicaid as evidenced by the participation of a small group of staff involved in oversight of PBH and the recent development of the waiver and procurement to expand PIHP programs throughout the state. This is an important strength that should be recognized.

The need for substantial reorganization within the Division is not necessary or desirable at this time, due to the reorganization in 2003, and strategies that can be implemented to improve operations under the existing organization.

The Division and the LMEs and provider community have accomplished positive results and outcomes, for example, reduction in use of restrictive residential placements for children in the System of Care, but this accomplishment and others need to be better communicated to stakeholders.

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Vacancies of the Deputy Director and the Medicaid Director positions impede the effectiveness of Division. There is an absence of executive management positions to provide oversight of the sections and manage cross-cutting goals and tasks, which may contribute to duplicative activities and difficulty in setting priorities. This places extra burden on the section chiefs and team leaders to establish priorities, which then may be set independently from other parts of the organization.

It is a positive finding that QM functions are performed by staff throughout the Division, yet there is no centralized leadership of QM. Central oversight requires the leadership of the Medical Director/Chief Clinical Policy of the organization, a QM Committee and an annual QM plan that outlines quality goals and tasks.

There is an absence of senior licensed clinicians to help guide policies and procedures and quality management, reportedly due to not having the appropriate position classifications that would enable hiring of experience clinicians.

The Customer Services team is staffed by clinicians that could be utilized in other areas. The Prevention/Early Intervention team could be more integrated into the operation of other teams and the portion of their functions related to tracking correct utilization of prevention funds could be moved to the Accountability team.

There is a significant lack of IT tools and a limited number of technical staff to support efficient business operations and reporting requirements. The IT system: a) is archaic, with the potential for imminent and significant component failure; b) is non-compliant with regards to HIPAA; c) has significant gaps in the completeness in data; and d) does not provide timely information for management. Also, the position classifications assigned to the Division are not based on IT competencies, and thus, it is difficult to recruit and pay for the skill-sets required.

The provision of administrative support for the DSOHF draws from already limited resources of the Division and contributes to poor staff morale due to having two Division directors setting priorities that current staffing cannot support.

Regional boundaries for staff assignments are not consistent and may lead to inefficiencies.

Division staff does not receive training, which would enable them to develop skills necessary for waiver program oversight or which could develop their management skills. Furthermore, they believe, if training were available, current workloads would prevent them from participation.

Clear policies and protocols for all teams within the Division for monitoring LMEs are necessary, specifically for managing: a) state general funds, b) block grants and other grants; c) Medicaid programs for individuals with developmental disabilities, and d) the behavioral health Medicaid FFS and PIHP waiver programs. Implementation of additional waiver entities, without standardization of policies and procedures, will result in ineffective and inefficient oversight.

The inability to focus finite resources on LME and PIHP oversight stems from multiple assignment to special projects, typically data collection, often requiring extensive information gathering on outdated information technology that impedes queries. There has been limited training on managed care and CMS regulations, which limits staff's ability to understand their role in monitoring and providing technical assistance. The working relationship between the Division and DMA was described as positive, yet there remains tension about roles and responsibilities. A clear vision and articulation of the roles of the Division and DMA, as well as the specific staff responsibilities of each entity, are critical to define. Improved clarity will promote successful collaborative

oversight of PIHP waiver programs while minimizing overlapping, redundant and inefficient processes.

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Recommendations

To address the finding of the organization review, Mercer recommends implementation of the following strategies:

1. **Fill vacancies of executive leadership:** Recruit the executive leadership of the Division, including the Director, Deputy Director and Medical Director immediately. Review the adequacy of the position classifications and salaries. Consider engaging a recruitment firm to assist with the selection. Hiring these three executive leadership positions is essential to effective operations of the Division.

2. **Develop a communication plan:** Develop a communication plan with DHHS that outlines strategy to proactively inform staff and stakeholders of the Division's vision and actions relative to the management and oversight of the LMEs/PIHPs, including planned communications that specifically address the concerns of each population (MH, SA, DD). Also, review of the Communication and Training team job descriptions is necessary to ensure the expertise needed to develop a strong communication strategy and plan are included in position requirements, including strong written and verbal communication skills that go beyond the technical skills of contract writing.

3. **Establish a QM section under the Medical Director/Chief of Clinical Policy.** Include a Director of QM that is a senior licensed clinician reporting directly to the Medical Director. Institute a cross-Division QM committee and develop an annual QM plan for the Division. The QM committee should meet monthly to: a) develop the QM plan goals, b) review QM and monitoring reports related to LME operations and internal Division QM functions (i.e., NC TOPPs, other outcome data, consumer complaints, consumer/family satisfaction); c) identify the need for special studies, and d) review reports, such as consumer complaints, and service outcomes. The QM committee should also monitor the PIHP's utilization management practices and reports on their utilization, as well as other clinical performance measures contained in the PIHP contracts..

4. **Assess Accountability Team Staffing.** The Division should consider adding licensed clinicians to this team. While Accountability is responsible for compliance monitoring and audits, it is important that the team be vigilant for quality of care issues during all monitoring activities. Clinical staff will help ensure potential quality of care issues are identified and presented to QM for review and action.

5. **Establish a LME/PIHP Implementation Committee.** This committee would normally fall under the oversight of the Deputy Director, with input from the Medical Director.
   - During the interim period, until a Deputy position is hired, designate a lead (preferably a staff person that has participated in the PBH and more recent waiver expansion activities).
   - Establish an implementation committee that cuts across all sections
   - Develop an interim LME/PIHP implementation plan to include the tasks outlined below. Specific tasks can be assigned to one sector or team, but the implementation committee should spearhead these assignments.

   - Establish a vision, guidelines and policies and procedures for monitoring new waiver entities, so that reporting requirements are clearly understood. These vision, guidelines and policies and procedures will become the Division's "Quality Management and Monitoring Program". To ensure success, it should be developed through a collaborative effort of the Division and DMA. The Implementation Plan should be a written document that addresses key tasks, time frames and responsible parties. The Implementation Plan should:
     - Incorporate information learned during the PBH waiver rollout.
     - Decide and articulate how and at what level monitoring will be performed.
     - Explain how the various areas that perform oversight tie together to create an overall monitoring program.
     - Clearly define PIHP performance standards and desired outcomes (based upon the waiver and procurement contract language)
     - Document clear reporting and data submission requirements for staff and LME use that results in accurate performance and ongoing financial viability measurement.
     - Emphasize the use of data on performance and outcomes to assess compliance and quality.
     - Develop an internal and external communication plan, with the Communications and Training team incorporating steps for disseminating information related to the waiver expansion, as well as communicating information related to performance monitoring. Initial communication steps should be included for establishing clear roles and responsibilities for both Division and LME staff.
     - Document Division staff roles and responsibilities for waiver implementation and monitoring activities.
     - Communicate how staff within DMA and DMH will collaborate on waiver-related work to ensure that interactions between LME and state staff are transparent to the LMEs, and instances of department separateness are reduced or eliminated. Staff should be included as early as possible in the

waiver expansion, so that they have time to learn and train in specific functions of responsibility.

6. **Address the inadequacies of the current HR processes** to timely hire staff, with the appropriate experience levels to perform the necessary work requirements of the Division. Identify key IT and clinical job classifications that require immediate action and request assistance from DHHS and the Office of State Personnel (OSP). Identify a list of positions that require review and develop a long-term strategy with DHHS and OSP to update job classifications.

7. **Review the existing PIHP (Waiver) quality management strategy (QMS) with DMA to identify areas for inclusion of additional Division staff in the monitoring and oversight of existing and future PIHPs via the IMT**. The QMS defines reporting requirements for PBH and Mecklenburg County LME as waiver entities and requires the submission of data to DHHS/IMT on a quarterly and annual basis. Representatives from all sections should be involved in monitoring the QMS and other CMS requirements.

   - Ensuring the reporting of industry-standard performance measures is essential. The IMT, with Division representation, must design statewide reporting requirements that comply with CMS requirements, as well as the requirements for state general funds and federal block grants, and other relevant funding. Where possible, reporting requirements should be standardized across PIHPs and LMEs to streamline monitoring and oversight and simplify processes. Standardization of this information will also help the Division respond to requests from stakeholders about statewide system performance.

   - Assessing provider management requirements as detailed in the North Carolina QMS, each PIHP is responsible for development of a comprehensive provider network in which provider services are appropriately managed and available to all members needing services. The PIHP must establish policies and procedures (P&Ps) to monitor the adequacy, accessibility and availability of its provider network. The state will review and approve all PIPH provider network P&Ps and monitor compliance with the established access standards through quarterly and annual reporting to the IMT.
     - Network providers may serve more than one PIHP across regions, thus standardization of P&Ps will minimize provider confusion and duplication of effort. A standard process for reporting geographic network access by location, service, population and other dimensions will enable the Division to roll-up and report network access to stakeholders by PIHP, region and state. Existing reporting requirements across programs (PIHP, FFS, grant funded) should be reviewed for consolidation and streamlining. Through collaboration with DMA, standardize the reporting of network access across all programs for consolidation and streamlining.

- Develop a specific implementation plan for the Mecklenburg LME, modeled after the implementation plans required in the PIHP procurement.

8. **Perform an IT assessment of the current system**. A system assessment is critically needed to measure the capabilities for data storage and to determine whether the current system can handle the additional processing and reporting requirements that would be needed under waiver expansion. This assessment should ensure data completeness, accuracy and the system's ability to support the expansion of the waiver program.

9. **Perform a systematic review of existing reports and reporting requirements**. The review is necessary to identify information that is important to collect and to eliminate measures that are redundant or do not reflect performance areas targeted by the Division. A small group representing the current QM team, Budget, Finance and Contracts team, and the Accountability team, at a minimum, should be involved in an initial review, and they should develop recommendations for broader review within the Division. Following the review and recommendations report, a representative of the Implementation committee (see recommendation # 5) should collaborate with DMA on data collection strategies.

10. **Develop a training plan on CMS requirements for the operations of PIHP and management of FFS programs.** The training plan should be developed in collaboration with DMA to focus on key elements of Medicaid requirements, including a "Medicaid 101" overview, with the goals of a) ensuring transfer of knowledge between staff to expand the available resources within the Division to monitor and expand the waiver program; and b) ensuring Division staff are adequately trained to monitor and review the required functions of the LMEs.

11. **Establish consistent regional boundaries**. The Division should establish consistent regional boundaries for all Division staff work teams to avoid duplicative efforts and promote efficiency and clarity for the LMEs, other state agencies and the public at large.

12. **Assess customer services staffing credentials**. The Division should consider the reassignment of clinicians on this team to more programmatic functions and rely on bachelor level staff and/or certified peer specialists to answer customer services calls. A licensed clinician should provide supervision of the team.

13. **Integrate Prevention/Early Intervention staff into other Division operations.** The Division should consider assigning the responsibility for monitoring compliance with funding use to the Accountability team. This would allow further integration of the Prevention/Early intervention team into the Divisions day to day operations to better promote prevention and early intervention strategies.

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