



The stated goal of North Carolina's public mental health, intellectual and developmental disabilities (I/DD), and substance use (MHDDSU) services system is to "meet the needs of clients in the least restrictive, therapeutically most appropriate setting available and to maximize quality of life."<sup>a</sup> North Carolina's MHDDSU services system comprises a complex web of state and local government agencies, public LME/MCOs, providers, and various funding streams. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), a division of the Department of Health and Human Services (DHHS), is the primary state agency charged with overseeing the administration of publicly-funded care for individuals with I/DD, mental health and/or substance use disorders who are uninsured, underinsured, or Medicaid beneficiaries.<sup>b</sup> However, the Division of Medical Assistance (DMA) is the primary funder of the public MHDDSU system, as Medicaid dollars pay for the majority of MHDDSU services provided through the system.<sup>1</sup>

Public MHDDSU services are primarily provided through the regional LME/MCOs, but can also be provided through, or in partnership with, other agencies such as the Division of Public Health, Division of Social Services, the Department of Public Safety, and the Department of Public Instruction.<sup>2</sup> Another DHHS division, the Division of State Operated Healthcare Facilities, oversees the administration of inpatient services at 14 state-operated healthcare facilities that treat children and adults with mental illness, developmental disabilities, substance use disorders, and neuro-medical needs.<sup>3</sup> While multiple agencies are involved in the administration of MHDDSU services, state agencies largely do not provide direct services to individuals, other than those delivered in state-operated facilities.

In North Carolina's public MHDDSU system, services are paid for and managed through a partnership between state and local government and the seven regional local

management entity/managed care organizations (LME/MCOs).<sup>c</sup> LME/MCOs are "local political subdivision[s] of the State"<sup>d</sup> whose authority, organization and governance are detailed in statute. As public entities that receive state and federal funds to manage MHDDSU services for individuals in their regions, LME/MCOs are required to "plan, develop, implement and monitor services...to ensure expected outcomes for consumers within available resources."<sup>e</sup> LME/MCOs are funded through annual contracts with DMH/DD/SAS and DMA that outline requirements for expenditures, management, performance, and reporting. Through statute and their contracts with DMH/DD/SAS and DMA, LME/MCOs are responsible for the administration of public MHDDSU services at the local level including:<sup>f</sup>

- connecting consumers to core services, including "(1) screening, assessment, and referral, (2) emergency services, (3) service coordination, (4) consultation, prevention, and education."<sup>g</sup>
- developing a provider network and ensuring quality service delivery;
- managing services to ensure consumers are receiving the appropriate services;
- coordinating care during transitions (e.g. discharge from the hospital);
- collaborating with the communities they serve and consumer affairs;
- ensuring financial management and accountability; and
- authorizing utilization of State facilities for MHDDSU.

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<sup>c</sup> LME/MCOs evolved from a prior system of local management entities (LMEs) that moved towards managed care organizations (MCOs). Pursuant to G.S. 122C-3, they are now known as LME/MCOs.

<sup>d</sup> A political subdivision is a separate legal entity of a State which has specific governmental functions. Legally they are part of State government.

<sup>e</sup> G.S. 122C

<sup>f</sup> G.S. 122C

<sup>g</sup> G.S. 122C

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<sup>b</sup> Individuals are underinsured if their insurance does not cover a service they need but cannot afford.

## Publicly-Funded Services

The public system involves a wide array of services, designed to meet varying levels of need. These include services such as:

- clinical assessments, psychotherapy, and medication management;
- support services such as supported employment, transitional living/recovery supportive housing, and peer or individual support;
- enhanced services designed to meet more complex needs with both therapeutic and case-management components;
- residential services;
- and crisis and in-patient services to address acute symptoms, including detoxification needs.<sup>4,5</sup>

Eligibility for and coverage of these services differs depending on an individual's needs and insurance status. To be eligible for state-funded services, individuals must be uninsured or underinsured and meet priority population criteria,<sup>h</sup> which are established by the General Assembly and prioritize treating those with the most severe needs due to limited funding.<sup>5</sup> Additionally, uninsured individuals receiving state-funded services may be subject to a sliding-fee scale, meaning they may need to pay a portion of the cost, and if funding is not available at the time they are seeking services, they may be placed on a waitlist.<sup>6</sup> Eligibility for Medicaid-funded services is less prescriptive; any individual enrolled in Medicaid in need of a medically necessary service is entitled to receive such care. However, in order to be covered by Medicaid, the service must be included in the state's benefit plan for Medicaid-reimbursable services, as determined by DMA.<sup>7</sup> As a result, Medicaid beneficiaries may receive services administered with state appropriations or federal block grant dollars if Medicaid does not cover the service.

## Funding Streams for the Mental Health, I/DD, and Substance Abuse System

North Carolina's LME/MCOs are managed care organizations, which means that they receive a "capitated" or set amount of funding to meet the

MHDDSU needs of the population they serve.<sup>i</sup> Currently, LME/MCOs receive a per month, per member<sup>j</sup> (PMPM) allotment of state and federal Medicaid funds to meet the needs of all Medicaid beneficiaries in their catchment area.<sup>k,l</sup> Although the LME/MCO receives a PMPM allotment, to receive services, Medicaid beneficiaries must enroll with the LME/MCO.<sup>4</sup> Through contracts with the LME/MCOs, DMA governs the use of state and federal Medicaid dollars by these organizations for the provision of services for Medicaid beneficiaries. Resources are distributed consistent with 2011 Medicaid reform legislation and the resultant 1915(b)/(c) Medicaid waiver in efforts to control the growth of Medicaid costs.<sup>m,1</sup>

Similarly, the LME/MCOs receive county, state, and federal funds to provide services for uninsured individuals in their catchment area who meet specific eligibility criteria. Counties are required to appropriate funds to the LME/MCO serving their respective catchment area, which typically makes up the smallest portion of LME/MCO funding.<sup>1</sup> The majority of the funding comes from the state general fund, although the amount of state appropriations has been decreasing over time. The General Assembly appropriates a set amount of single-stream funding for community-based services that is then allocated through DMH/DD/SAS to the LME/MCOs based on the needs of the catchment area they serve. In SFY 2017, the General Assembly appropriated over \$217 million of single stream funding.<sup>8</sup>

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<sup>i</sup> The MCO capitated model is in contrast to a fee-for-service model where services are provided and billed without a set limit on total spending.

<sup>j</sup> Based on the number of Medicaid eligible in the LME/MCO region.

<sup>k</sup> The PMPM was originally calculated by DMA based on historical MHDDAS Medicaid funding for the LME/MCOs region under the prior fee-for-service model, with some adjustments, divided over 12 monthly installments. The PMPM rate can be updated based on actual expenditures and other factors.

([https://www.ncleg.net/fiscalresearch/fiscal\\_briefs/Fiscal\\_Briefs\\_PD\\_Fs/Payment%20Primer%20Fiscal%20Brief.pdf](https://www.ncleg.net/fiscalresearch/fiscal_briefs/Fiscal_Briefs_PD_Fs/Payment%20Primer%20Fiscal%20Brief.pdf))

<sup>l</sup> The PMPM covers physician and non-physician services, hospital services, Client Assistance Program (CAP), and Intermediate Care Facilities for Individuals with Developmental Disabilities. The PMPM does not cover prescription medication, which are billed on the fee-for-service model.

<sup>m</sup> S.L. 2011-264

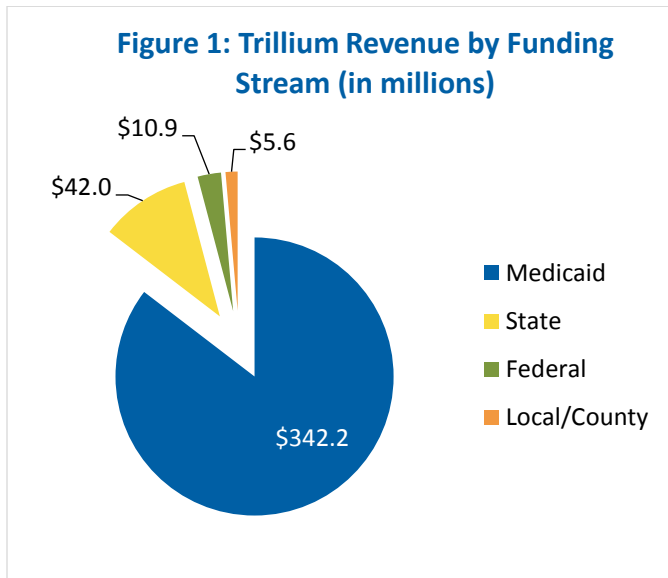
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<sup>h</sup> Full list of eligibility criteria available online at <https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/Benefit%20Plan%20Eligibility.pdf>

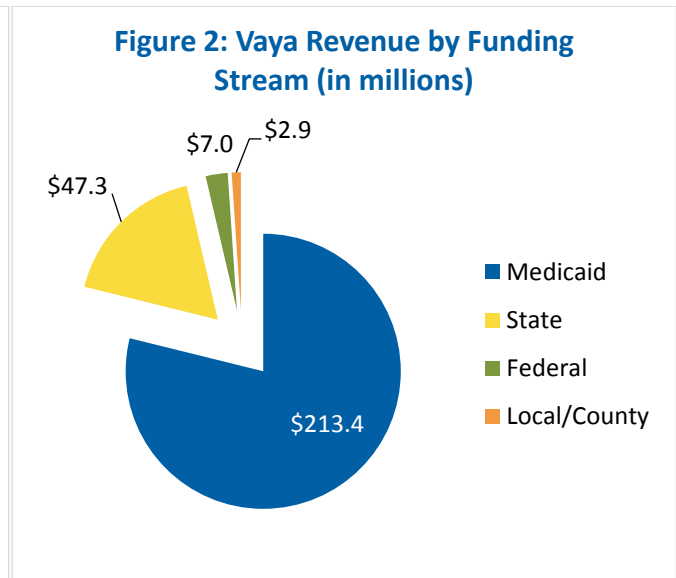
Federal funds for community-based services are largely provided through annual block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), for which DMH/DD/SAS is the administrative state agency. The Substance Abuse Prevention and Treatment block grant and the Community Mental Health Services block grant offer funding to states to develop prevention, treatment and support services for individuals without insurance.<sup>9</sup>

In FY 2017, North Carolina received over \$91 million in block grant and other funding from SAMHSA.<sup>10</sup> As state dollars do not pay for prevention services, federal grants address a critical gap in North Carolina’s MHDDSU service system.<sup>11</sup> Through contracts with the LME/MCOs, DMH/DD/SAS governs the use of state and federal dollars by these organizations for the provision of services for individuals who are uninsured or underinsured.<sup>2</sup>

Figures 1 and 2 reflect the revenue reported by two of the LME/MCOs for SFY 2017.



Data from: Trillium Health Resources. Financial Statement and Compliance Reports, Fiscal Year 2017. Greenville, NC. <https://www.trilliumhealthresources.org/sites/default/files/docs/About-Us/Financial-Statement/2017-Single-Audit-THR.pdf>. Accessed January 17, 2018.

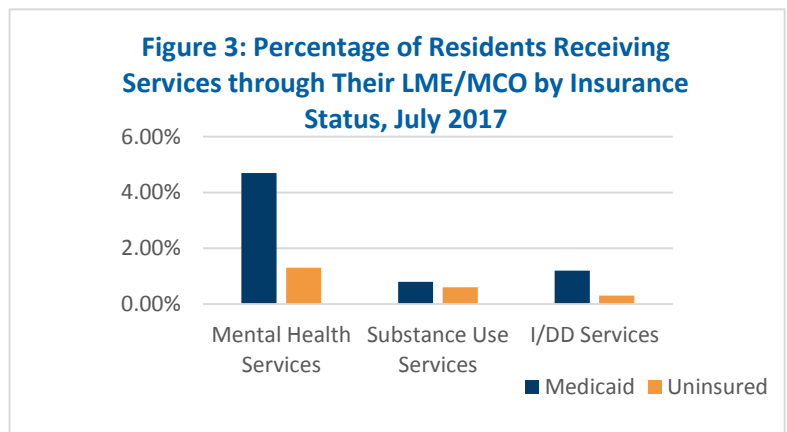


Data from: Vaya Health. Smoky Mountain LME/MCO Proposed Revenue Budget FY 16-17. Asheville, NC. <http://vayahealth.com/about-us/financial-information/>. Accessed January 17, 2018.

### Impact and Challenges

It is estimated that about 17% of adults in North Carolina have mental health and/or substance use disorders, and about 4% have serious mental health and/or substance use disorders per year.<sup>2</sup> However, many individuals, particularly low-income and uninsured individuals, do not have access to necessary services. Data from the LME/MCOs in 2017 shown in Figure 1 indicate that uninsured individuals are less likely overall to receive MH/DD/SU services through their LME/MCO than individuals enrolled in Medicaid.<sup>12</sup>

Underinsured individuals may be eligible to receive medically-necessary services through their LME/MCO, as high deductibles for private insurance



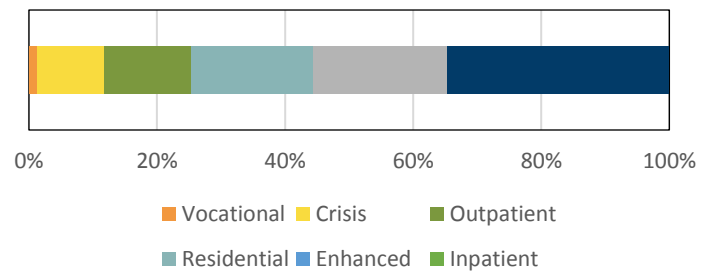
Data from: North Carolina Council of Community Programs. July 2017 LME/MCO Monthly Monitoring Report. NC Council of Community Programs website. <http://www.nc-council.org/advocacy/medicaid/lmemco-monthly-monitoring-reports-by-state/>. Published October 4, 2017. Accessed November 1, 2017.

or plans with limited coverage for mental health, substance abuse, or I/DD services may make services unaffordable. However, as they must meet the eligibility criteria, these individuals may only qualify for services when they are in crisis, and only if the LME/MCO has funding available. State funds are primarily reserved for individuals with the most urgent needs, leading to disproportionate state investment in inpatient and crisis services, as shown in Figure 2, as well as increased emergency room utilization by individuals requiring mental health, I/DD, or substance use treatment.<sup>2</sup>

Geographic barriers prevent both Medicaid beneficiaries and uninsured individuals from accessing services. Across North Carolina, there is inconsistency in the distribution of providers specializing in treating mental health and substance use disorders. Rural areas are particularly underserved, and as of 2016, 32 counties do not have a psychiatrist in their local provider workforce.<sup>13</sup>

In August of 2017, DHHS released its proposed changes to the state Medicaid program to establish a managed care model as mandated by the General Assembly in Session Law 2015-45. This shift aims to promote whole-person care, integrating physical and behavioral health,

**Figure 4: SFY15 DMH/DD/SAS Expenditures by Service Type\***



Data from: NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. NC Department of Health and Human Services. NC Mental Health and Substance Use Array Survey. Raleigh, NC. [https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/NCServiceArraySurvey-DMH\\_2015-10-15.pdf](https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/NCServiceArraySurvey-DMH_2015-10-15.pdf). Published October 15, 2015. Accessed August 1, 2017.

\*Includes services for both children and adults.

which will likely lead to changes in the methods of delivery of care within the public mental health, substance use, and I/DD system. As the system for serving these populations evolves, meeting the needs of those with mental health disorders, substance use disorders, and developmental and intellectual disabilities will continue to be a critical aspect of health care in North Carolina.

## References

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<sup>11</sup> NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services. NC Department of Health and Human Services. NC Mental Health and Substance Use Service Array Survey. Raleigh, NC. [https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/NCServiceArraySurvey-DMH\\_2015-10-15.pdf](https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/NCServiceArraySurvey-DMH_2015-10-15.pdf). Published October 15, 2015. Accessed August 1, 2017.

<sup>12</sup>North Carolina Council of Community Programs. July 2017 LME/MCO Monthly Monitoring Report. NC Council of Community Programs website. <http://www.nc-council.org/advocacy/medicaid/lmemco-monthly-monitoring-reports-by-state/>. Published October 4, 2017. Accessed November 1, 2017.

<sup>13</sup> North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. <https://nchealthworkforce.sirs.unc.edu/>. Accessed November 1 2017.