

Chapter Two: Overview of Prevention, Treatment, and Recovery Systems

Effective treatments for mental health and substance use disorders can help individuals with mental health and substance use disorders live, work, learn, and participate fully in their communities.¹ These services, when managed and implemented effectively, can minimize long-term costs to individuals, families, businesses, and governments.² Effective prevention, treatment, and recovery are the foundation of today's publicly funded mental health and substance use system. However for many North Carolinians, mental health and substance use services remain fragmented, disconnected, and often inadequate. The fragmentation of the mental health and substance use service systems contributes to unnecessary and avoidable disability, school failure, homelessness, and incarceration.² Fragmentation and disarray are primarily driven by payment policies that create huge disparities in access to high-quality and effective prevention, treatment, and recovery services; lack of integration between mental health services, substance use services, and physical health services; and the nearly constant changes over the past 15 years to North Carolina's public mental health and substance use system. Access to services and supports for individuals with mental health and substance use disorders also varies based on other factors, including specific type of mental health or substance use disorder, geographic location, and age. This chapter reviews North Carolina's mental health and substance use prevention, treatment, and recovery systems and payers and includes recommendations from the Task Force to improve access to effective, high-quality services.

Prevention, Treatment, and Recovery

Ongoing care and treatment are required for individuals to regain health and maintain recovery from mental health and substance use disorders. Although some mental disorders may be precipitated in response to disruptive life events, most mental health and substance use disorders are chronic or recurrent conditions that, like other chronic illnesses, require ongoing care and treatment. As with any chronic disease, prevention, identification, treatment, and recovery services and supports are essential to ensuring positive health outcomes. Therapy, medication, behavior change, and other treatments can often lead to great improvements in symptoms, however the underlying mental health and substance use disorders are still present and may persist to varying degrees over an individual's lifespan.

The prevention, diagnosis, and treatment of mental health and substance abuse disorders are difficult for several reasons. One reason for such difficulty is that **there is no single system for mental health and substance use services.** The "system" includes a variety of fragmented providers and services and various agencies that provide funding and oversight. Payment for mental health and substance use treatment services comes from federal, state, and local agencies including the Centers for Medicare and Medicaid Services; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Division of Medical Assistance; the Division of Social Services; state and federal criminal justice systems; private insurance companies; school systems; housing agencies; and others.³ Each funding source has its own objectives, requirements, and restrictions. This creates a financing approach to mental health and substance use treatment that is complex, fragmented, and inconsistent in coverage.² The result is not a system, but rather a fragmented set of financing mechanisms and service providers. **This fragmentation creates significant systemic barriers to delivering needed prevention, treatment, and recovery services.**

In addition to the systemic barriers to accessing effective treatment, many individuals do not recognize that they have a mental health or substance use disorder, do not seek treatment, or do not have access to affordable and/or evidence-based treatment. Common reasons for not seeking needed mental health and substance use treatment include (listed in order of most common to least common): could not afford the cost of treatment, did not know where to go for services, thought they could handle the problem without treatment, did not have time, belief that treatment would not help, might cause others to have a negative opinion, fears/concerns about diagnosis and confidentiality, and health insurance did not cover treatment.⁴ Enduring stigmas, negative stereotypes, and prejudice that result from misconceptions about mental illness, also create barriers to accessing and receiving treatment. Many people try to access services, but have difficulties navigating the systems, finding a provider who will treat them, or getting a diagnosis and treatment plan. For these and other reasons, more than half of North Carolinians with mental health and substance use disorders do not receive treatment.⁵ This gap in service unnecessarily jeopardizes the health and wellness of individuals and causes a ripple effect in costs. Prevention, treatment, and recovery support services for mental health and substance abuse are essential to ensuring positive health outcomes.

Mental Health and Substance Use Treatment Systems in North Carolina

State efforts that ensure appropriate and evidence-based education, prevention, treatment, and recovery resources can minimize the negative outcomes associated with mental health and substance use disorders and improve the quality of life for individuals and communities statewide. However, this is challenging in North Carolina because the state does not have a single coordinated system aimed at providing comprehensive services and supports to those with mental health and substance use disorders. Instead, there is a public system for addressing the mental health and substance use needs of people with Medicaid and, to a limited extent, those who are uninsured or whose insurance will not cover treatment. Medicare beneficiaries and those with private insurance largely receive care outside of the public system in a system that is more fragmented, may have fewer available resources, and typically include a more limited array of services and supports. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has limited state funding to meet the needs of individuals with mental health and substance use disorders who require assistance with housing and employment. The state and local agencies that address housing, education, and employment operate independently and do not routinely coordinate with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or their local LME/MCO.

To understand the challenges confronting North Carolina's current behavioral health delivery system, it is important to understand the history of behavioral health in the state.

History of Mental Health and Substance Use Disorder Treatment

Throughout the first half of the 20th century, individuals with mental health disorders were typically cared for in state-operated institutions with care paid for by state and local governments. However, by the 1950s and 1960s, a confluence of factors all fueled a national movement towards deinstitutionalization. These factors included rising costs, a growing patient advocacy movement, growing awareness of the poor living conditions and treatment of individuals in state institutions, the development of new and more effective psychiatric medications, and a belief that better and more cost-effective treatment could be provided through community-based services.⁶

Federal policy was a significant driver of deinstitutionalization. In the 1960s, support for community-based treatment and recovery services to prevent or reduce prolonged institutional confinement was prioritized as an alternative to institutionalization through federal legislation. With the creation of Medicare and Medicaid^a and disability programs,^b as well as funding through the 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act,^c North Carolina and the nation began to rapidly shift away from institutional care towards community-based care. These new federal laws and programs all favored community-based treatment over state mental institutions.

Throughout the 1970s and 1980s, courts also handed down legal decisions that limited the ability to institutionalize individuals and set minimum requirements for care in institutions.⁷ The move towards community-based services was further accelerated following the U.S. Supreme Court's decision in the 1999 case *Olmstead vs. L.C.*, which held that segregation of persons with mental disabilities in institutional settings constituted discrimination under the Americans with Disabilities Act. The ruling effectively required states to provide services for patients with mental disabilities in community-based settings rather than institutions.

While many people with mental health and substance use disorders successfully transitioned from institutional care to community-based treatment and recovery, it is important to recognize the challenges of these transitions. Many individuals with mental health and substance use disorders remain unserved or underserved, and some end up in jail or homeless.^{2,3} The array of services needed to successfully support individuals with mental health and substance use disorders living in community settings is much broader than what was anticipated 60 years ago. In addition to the need for funding to support treatment and recovery services, other supports are needed, such as housing, education, and employment. Just as state mental institutions were plagued by a lack of resources, **comprehensive funding for community-based mental health and substance use services has never been achieved.** Today, funding for community-based mental health services remains a patchwork of funding sources including federal Medicaid dollars, state funds, health insurance programs with limited coverage for mental health and substance abuse, federal block grant dollars, and a

a Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act of 1965 (P.L. 89-97)

b Starting with the 1956 Amendments to the Social Security Act. (P.L. 84-880)

c Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 U.S.C. Public Law 88-164, 77 STAT

variety of smaller funding streams which are not easily coordinated.⁸ This has led to fragmented systems that struggle to provide comprehensive and coordinated services.⁹

Funding for Mental Health and Substance Use Prevention Treatment and Recovery Services and Supports

Historically, funding for mental health and substance use coverage has been more limited than that for other medical benefits. This is true across all payers.² Health care coverage of mental health and substance use treatment under private insurance has been expanded in recent years under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act in 2010. Both laws addressed existing disparities between insurance coverage for medical and surgical benefits versus mental health and substance use treatment coverage. Although mental health and substance use coverage parity are now required of most health insurance plans, full parity has not yet been achieved. Among private insurance plans, the most common violations are insufficient benefits, higher financial requirements, more restrictive visit limits, prior authorization requirements, and lower annual dollar limits on benefits.¹⁰

The type of insurance coverage an individual has significantly influences their access to mental health and substance use prevention, treatment, and recovery services. Individuals with Medicaid have better access to a wide range of services (outpatient, enhanced, and inpatient) than those with private or no insurance, but experience higher rates of structural barriers such as transportation or employment requirements.¹¹ Individuals with private insurance may have access to transportation and be adequately employed, but they often have less access to services such as enhanced care, which includes higher levels of treatment that can be critical for a successful recovery. Additionally, many individuals with private insurance have high co-pays and deductibles, which can limit their access to services.¹² Increasingly, these individuals, often referred to as underinsured, are turning to their LME/MCO systems for assistance in receiving needed care. These funding concerns can be addressed in parallel by recognizing the barriers and challenges for each group, identifying alternative funding for those in need of care who are underinsured, and creating mechanisms to fund cross-system collaborations that have worked in the past.

North Carolina's Community-Based System to Address the Mental Health and Substance Use Needs of the Population

Before considering how to improve services and supports for individuals with mental health and substance use disorders, it is important to understand the evolution and current state of our publicly funded mental health and substance abuse system, including history, recent reform, and—most critically—future challenges.

In 1977, the North Carolina General Assembly mandated the establishment of local government area authorities at the county level to manage publicly-funded community-based behavioral health services for community members enrolled in Medicaid or who lacked insurance coverage.¹³ Area authorities were responsible for the delivery of publicly-funded, community-based services either directly or using contracted services. The shift away from institutional care towards community-based care has dramatically changed the provision of services for individuals with mental health and substance use disorders. In North Carolina, this shift has contributed to a 10-fold increase in the number of people served by the public system, from just over 30,000 in FY 1961 to almost 350,000 in FY 2013.¹⁴ In addition to greatly increasing the number of individuals served, the types of services provided has significantly increased. Thirty years ago, North Carolinians with mental health and substance use disorders who were also enrolled in Medicaid received outpatient therapy and hospital services. Today there is a full array of enhanced services which includes mobile crisis management, community treatment teams, intensive in-home services, day treatment, partial hospitalization, intensive outpatient programs, community residential treatment, detoxification, and more.¹¹

Today, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) oversees the administration of publicly-funded care provided to people with mental health, developmental disabilities, and substance abuse needs who are enrolled in Medicaid, uninsured, or underinsured. However, the Division of Medical Assistance provides oversight of the funds spent on services and supports for the Medicaid population, or approximately 80% of the funding for the public mental health and substance use system. This includes the provision of prevention, intervention, and treatment services and supports to children and adults who qualify for services.

Eligibility for services depends on age, diagnosed condition, types of service, income, and other conditions. Services are also offered through, or in collaboration with, the Division of Social Services, the Division of Public Health, the Department of Public Safety, the Administrative Office of the Courts, the Division of Motor Vehicles, the Department of Corrections, the Department of Public Instruction, the North Carolina

Community College System, and the University of North Carolina System.

In the past 15 years, North Carolina has undergone an overhaul of its publicly funded mental health, developmental disabilities, and substance abuse services system from a fee-for-service system to a managed care system. In addition to the impact of the Olmstead case, in 1998, North Carolina's General Assembly asked for a study of the state's mental health delivery system. The resulting state audit proposed major changes in the local level governance and structure of the mental health, substance abuse, and developmental disability systems, as well as a number of operating changes at the state level.¹⁵ In response, the General Assembly passed the 2001 Act to Phase in Implementation of Mental Health System Reform at the State and Local Level,^d which promoted deinstitutionalization and privatized clinical treatment services. Prior to this legislation, local area authorities had managed funding and provided services directly to clients. In 2001, the local area authorities' mission began to change to managing, monitoring, and paying for services by contracted providers. This change in function of area authorities to LMEs, officially codified in 2006, was part of a shift to a managed care system for North Carolina's MH/DD/SAS service system.^e

The move toward managed care has also been driven by changes in funding. Over the past 25 years, Medicaid has gone from the smallest funder of MH/DD/SAS services to the largest (80%).¹⁴ As state legislators looked for ways to contain rising Medicaid costs, MH/DD/SAS managed care became appealing. From 2005-2009, Piedmont Behavioral Healthcare implemented a successful demonstration project of MH/DD/SAS managed care, through a 1915 (b)/(c) Medicaid waiver. This model, passed by the General Assembly in 2011^f under the 1915(b)/(c) Managed Care Waiver law, holds LMEs responsible for controlling quality and cost of public behavioral health services. Through the federal Medicaid waiver, the earlier fee-for-service model was replaced with a capitated model, where the state covers a standard monthly fee for each consumer served. Today, LME/MCOs are private companies that receive a set monthly payment from the state, which comes from state and Medicaid funding, to provide mental health, intellectual and developmental disability and substance abuse services for individuals in their service areas who are enrolled in Medicaid or who are uninsured and qualify as a member of a priority populations (See Table 2.1). LME/MCOs do this by contracting with private providers in the community. These changes have led to the consolidation of LMEs to form MCOs across the state. Since 2001, consolidation has resulted in 39 area mental health authorities becoming 23 LMEs, which then became 11, today 7, and soon to be 4 LME/MCOs.¹⁶ The implementation of the Medicaid Managed Care Waiver has saved the state approximately \$70 million a year.^{g17}

Funding of North Carolina's Public MH/DD/SAS System

Today, North Carolina's public mental health, developmental disabilities, and substance use services are provided through a partnership between state and local government and the seven private managed care organizations (LME/MCOs). These entities, now known as LME/MCOs, administer and manage mental health and substance use services for individuals in their catchment areas who are enrolled in Medicaid, and those who are uninsured or underinsured and eligible for state-funded services. North Carolina's publicly-funded mental health and substance use treatment services has two delineated service lines, both administered by the LME/MCOs: Medicaid and state-funded services. The Medicaid managed care program is an entitlement program that funds a robust array of mental health and substance use services for those enrolled in Medicaid. State funded services^h cover services and supports for the uninsured, the underinsured,ⁱ and for Medicaid-enrolled individuals who need services and supports that Medicaid does not cover.¹⁸

d S.L. 2001-437.

e S.L. 2006-142.

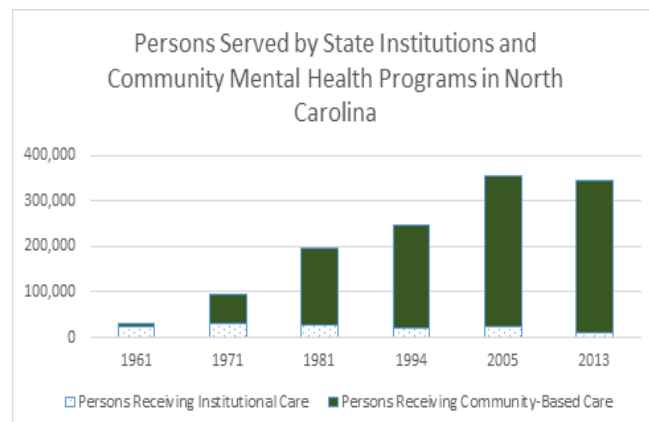
f S.L. 2011-264.

g \$70 million is the amount the state has saved, so the full savings, including federal Medicaid savings, is \$210 million per year.

h Includes single stream state funding and federal block grant dollars.

i Defined as those whose insurance does not pay for a service that they need and cannot afford.

Figure 2.1: Dramatic Increase in Number of Persons with Mental Health and Substance Use Disorders Served by North Carolina's MH/DD/SAS System Over the Past 50 Years



Source: Botts M. Chapter 40: Mental health services. In: *County and Municipal Government in North Carolina*. 2nd ed. Chapel Hill, NC: University of North Carolina; 2014.

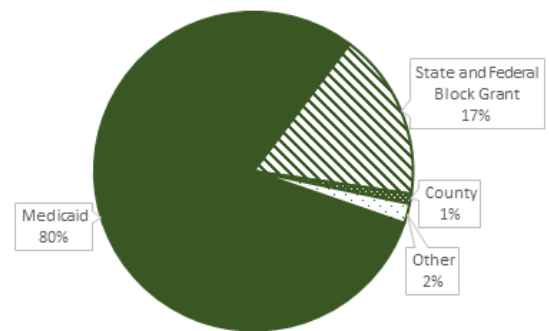
Medicaid-eligible patient services are covered by a combination of federal and state Medicaid dollars. Non-Medicaid patient services are funded by a combination of state and county allocations and federal block grant funds which are allocated to the LME/MCOs directly. The state Department of Health and Human Services oversees state and federal funding for mental health and substance abuse services through two contracts:

1. Between each LME/MCO and MH/DD/SAS, which governs the use of non-Medicaid state appropriations (i.e., single-stream funding) and federal block grants.
2. Between each LME/MCO and the Division of Medical Assistance, which governs the use of state Medicaid funds.

MH/DD/SAS and DMA hold LME/MCOs to contractual requirements including enhanced performance requirements such as community engagement (i.e., engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SAS needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered.

The LME/MCOs are responsible for managing Medicaid, state, and federal block grant mental health, substance abuse, and developmental disability dollars. MCOs receive a per member per month payment to manage all of the mental health, substance abuse, and developmental disabilities services and supports for the Medicaid recipients in their service area. MCOs also receive an allocation of state and federal block grant funds to help provide services to people who are not eligible for Medicaid and are not covered by private insurance. LME/MCOs receive varying levels of local funding as well. This provides LME/MCOs with the flexibility to invest more of their money on prevention, early intervention, and effective outpatient treatment—especially if these services can help reduce more costly interventions or hospitalizations.

Figure 2.2: Medicaid Main Payer for LME/MCO Services



Source: Botts M. The Future of Mental Health Services and Medicaid Reform in North Carolina. Presented to: Health Directors Meeting; April 5, 2016; Raleigh, NC. https://www.sog.unc.edu/sites/www.sog.unc.edu/files/course_materials/Health%20Directors-Mental%20Health-4-2016.pdf. Accessed August 4, 2016.

In FY 2015, the LME/MCOs provided over \$1 billion in Medicaid and state-funded MH/DD/SAS services.^j Of this, \$841 million covered mental health and substance use services to 355,000 individuals enrolled in Medicaid while \$168 million in single stream funding provided mental health and substance use treatment services for 96,000 North Carolinians without health care coverage.^{k,l}

Challenges in the LME/MCO System

Historically, and still today, the availability of community-based mental health and substance use services and supports fall short of the mental health and substance abuse needs of the state’s population, particularly for those who are uninsured, underinsured, and privately insured. Individuals enrolled in Medicaid have funding for services, but may face challenges in getting to services or accessing a particular type of service (e.g., supported employment or multi-systemic therapy). Individuals with private insurance may need enhanced services, which are not typically covered by private insurance, and may be unable to pay for them out-of-pocket. For example, they may have private insurance but be unable to afford the \$3,000 deductible or the \$80 co-pay to see a mental health or substance use specialist.¹⁹ Individuals with no insurance typically cannot cover the out-of-pocket costs of seeing mental health and substance use providers, and access to free and reduced cost services for mental health and substance use disorders is very limited. Many North Carolinians

^j State dollars are only a portion of the funding that LME/MCOs receive. The state pays approximately 1/3 of the cost of care for people enrolled in Medicaid, with the Federal government covering the other 2/3. So the true value of MH/SAS services provided to North Carolinians enrolled in Medicaid in SFY 2015 was approximately \$2.5 billion (\$841 million x 3). North Carolina also funds services through single stream funding. Single stream funding does not have a federal match. The state provided approximately \$1 billion in state-funding (through the Medicaid match and single stream funding), however the full value of care received was approximately \$2.7 billion.

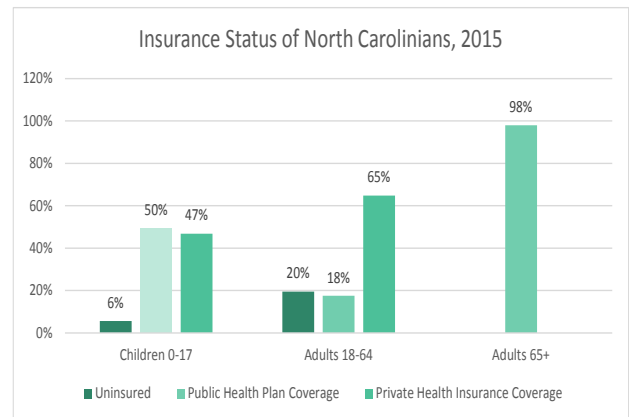
^k Simmons A. Business Systems Analyst. North Carolina Department of Health and Human Services. Written (email) communication. February 29, 2016.

^l Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

face challenges with access to affordable, high-quality care and, instead, remain untreated, or in the most unfortunate cases, end up in the criminal justice system. Emergency rooms have become a common substitute for mental health treatment, rather than community-based treatment or behavioral health treatment centers that are designed to support the needs of such patients. **Comprehensive, coordinated community-based prevention, treatment, and recovery services and supports remain an elusive goal for many North Carolinians with mental health and substance use disorders.**

While designed to improve access to behavioral health treatment across North Carolina, managed care has also introduced its share of new challenges for the state. LME/MCOs, under federal Centers for Medicare and Medicaid requirements for North Carolina's Medicaid Managed Care Waiver, impose stricter requirements and higher levels of scrutiny for authorizing care providers, including physicians, social workers, psychologists, and counselors. Since the public health system overhaul, many providers have been dropped from LME/MCOs or have chosen to withdraw from the organization due to new requirements including extended hours, credentialing, and quality and appropriateness of care reviews. Reductions in participating providers may make it more difficult for consumers in some areas to access services.

Figure 2.3: Insurance Status and Payer Influence Access to Prevention, Treatment, and Recovery Services



Source: Cohen RA, Martinez ME, Zammitti EP. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2015. Atlanta, GA: Centers for Disease Control and Prevention;2016.<http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf>. Accessed September 13, 2016. U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates, Table B27006, Medicare coverage by sex by age.

PORTRAIT OF AN INDIVIDUAL WITH MEDICAID WHO STRUGGLED TOWARDS RECOVERY

Bob is a 44-year-old man living in rural North Carolina. Bob has schizophrenia. Bob's schizophrenia limits his abilities to function socially and complete routine tasks, so Bob receives Social Security disability benefits and, therefore, is eligible for, and enrolled in, Medicaid. Bob has family nearby, but lives on his own in the community. Bob has a long-term history of non-compliance, paranoia, and, occasionally, threatening behaviors. Because he did not stay in compliance with treatment, and frequently changed his address due to paranoia, Bob's Social Security Income was discontinued, which meant he lost Medicaid coverage as well.

Bob is fine for weeks at a time, but when Bob goes off his medication, family members are unable to get him back on track without outside assistance. Unfortunately, due to losing his Medicaid coverage, Bob is only able to qualify for crisis services. However, crisis intervention services are not available until he is a threat to himself or others. When he does become a risk, law enforcement is called and Bob is transferred by police to the local hospital. At the hospital, they put Bob back on his medications. After a few days, Bob is stabilized and he is transferred to the crisis center for a temporary stay to ensure he adheres to his medication routine before being returned to his home.

After many years of increasingly worrisome episodes, family members felt hopeless. They felt the system had been unable to help Bob. Bob's cousin, Lisa, realized that something had to change. Luckily Lisa had an understanding of the various systems that could help Bob as well as the time, energy, and commitment needed to navigate the various systems. First Lisa worked with the Arc of North Carolina, an organization that provides services and advocacy for those with intellectual and developmental disabilities, to get Bob re-enrolled in SSI and Medicaid and set up a system whereby she would help manage Bob's finances so that he would not lose SSI and Medicaid benefits again (this alone involved navigating the requirements of the local Magistrate, the Social Security Administration, and the Clerk of Court). Lisa then helped Bob and his family investigate supportive housing options, although they were limited in his rural community and, ultimately, did not fit his needs. Knowing that continuing in his living situation without any additional supports would result in more encounters with law enforcement and the local hospital if changes were not made, Lisa worked with the local LME/MCO to arrange for support services for Bob. It was determined that an Assertive Community Treatment (ACT) team, a team of community-based medical, behavioral health, and rehabilitation professionals who are trained to work with individuals who actively resist services, would best be able to meet Bob's needs. Bob is now living successfully in the community with support from his ACT team.

Navigating the many facets of North Carolina's public mental health system is not easy. It requires time, dedication, family engagement and advocacy, knowledge of the systems, building trust, and constant communication with individuals in multiple parts of the system. Many individuals with mental health and substance use needs are unable to advocate for themselves or navigate the systems without help. Family members are often similarly challenged in their interactions with the public mental health system.

Medicaid

Medicaid is the largest payer of mental health services in the United States. In North Carolina, the federal government covers 67% of the cost of Medicaid and the state covers 33%.²⁰ In FY 2015, state-match Medicaid dollars paid for \$769 million in mental health services for 312,000 individuals and \$72 million in substance use treatment services for 43,000 North Carolinians.^m Approximately 1.9 million North Carolinians are enrolled in Medicaid,²¹ the vast majority (57%) are children, followed by adults qualifying under the aged, blind, and disabled category (21%), and the remaining 22% are adults who qualify under various categories.^{22,23}

Medicaid covers a wide range of services and supports for individuals with mental health and substance use disorders including health homesⁿ, prevention services, engagement services, outpatient and medication services, community and recovery support services, other recovery support services such as personal care and transportation, intensive support services, out of home residential services, and acute intensive services.²⁴ Of all insurers, Medicaid covers the most robust array of services for individuals with mental health and substance use disorders. Medicaid does not pay for prevention services. Further, LME/MCOs have some flexibility to craft their treatment coverage to meet the needs of their populations.

Medicare

Most adults over 65 receive health care coverage through Medicare. Federal law dictates the rules and regulations of Medicare, and the program is administered and paid for by the Centers for Medicare and Medicaid Services. Under Medicare, individuals have varying levels of coverage for screening, outpatient treatment, and outpatient and inpatient hospitalization. Medicare does not cover enhanced services such as supported employment, supports to people living in their own homes, and community support team services. Individuals enrolled in Medicare can select traditional Medicare, which operates on a fee-for-service model, or choose from a number of Medicare Advantage plans, which operate under a managed care model. Seventy percent of Medicare-enrolled North Carolinians are in traditional Medicare, while 30% are enrolled in Medicare Advantage plans.²⁵ Under both traditional Medicare and Medicare Advantage plans, enrollees can opt to add prescription drug coverage, with premiums that ranging from \$18 to \$100 per month depending on structure and coverage.²⁶

While both traditional Medicare and Medicare Advantage plans provide some coverage for mental health and substance use treatment services, Medicare payments are restricted to certain types of eligible professionals, including psychiatrists, clinical psychologists, social workers, nurse specialists, independently practicing psychologists, and a few others.²⁷ The list of eligible professionals does not include all mental health and substance use treatment professionals in North Carolina (e.g., licensed professional counselors, certified substance abuse counselors, and others), which restricts older adults' access to mental health and substance use services.

Private Health Insurance

Individuals with private health insurance receive services according to the rules of their coverage plan. They may or may not need prior approval for services depending on their insurance plan. Under federal law, health insurance plans must cover treatment for mental health and substance use disorders at the same level as other health conditions. This means that if a health plan covers inpatient or intensive outpatient services for physical health conditions, that plan must cover the same services for mental health conditions. Regulations for mental health parity have increased the range of services available and removed some barriers to services.²⁸ However, **for many individuals with private insurance, the required co-pays or deductibles create a barrier to accessing mental health and substance use services, even when they have health insurance.**

BlueCross BlueShield North Carolina, the largest private health insurance carrier in the state, covers outpatient services including therapy, medication management, telehealth, outpatient detox, and facility-based services, including acute and residential treatment and detox.¹² The specific services covered vary by plan. Generally, under private insurance, home- and community-based services for mental health and substance use prevention, treatment, and recovery are not covered. Examples include mobile crisis management,

^m \$769 million and \$72 million were the state Medicaid costs, so the full cost, including federal Medicaid (which covers 2/3 of the cost of care), was approximately \$2.5 billion per year. (Simmons A. Business Systems Analyst. North Carolina Department of Health and Human Services. Written (email) communication. February 29, 2016.)

ⁿ North Carolina's Medicaid Health Home Program provides care management and wraparound clinical services for enrollees. To be eligible for services, enrollees must have at least two chronic conditions that fall within one of ten diagnostic categories, or one of eight specific chronic conditions. <https://aspe.hhs.gov/sites/default/files/pdf/137856/HHOption2-NC.pdf>

community treatment teams, intensive in-home services, day treatment, partial hospitalization, intensive outpatient programs, and community residential treatment.¹² For patients who have needs that cannot be met by outpatient therapy alone, their only other option is typically inpatient treatment, for however long their insurance will cover, which may or may not correspond to the needs of the individual.

PORTRAIT OF AN INDIVIDUAL WITH PRIVATE INSURANCE STRUGGLING TOWARDS RECOVERY²⁹

Dawn is a 24-year-old woman who has suffered with bipolar disorder since she was a teenager. Dawn has also struggled with cutting, an eating disorder, and substance abuse. Dawn is insured through her parents' private insurance.

Dawn's mental health and substance use struggles first came to light in college, and she willingly entered a mental health facility for 10 days. She was not given a diagnosis and was sent home, where she sought treatment with a therapist. Dawn was recommended for in-patient treatment in a mental health facility, which her private insurance would cover for 30 days. After 30 days, she was discharged without a diagnosis or a transition plan for returning home. In the past 5 years, she has voluntarily been in and out of 22 facilities (each for no more than the maximum covered 30 days). Two years passed between her first visit and a diagnosis of bipolar disorder. Dawn's complex mental health and substance use treatment needs made finding treatment more difficult—some facilities would treat only her mental health needs, while others would only deal with her substance use needs. Because Dawn's insurance will only cover outpatient therapy or short stints in mental health facilities, she has struggled towards recovery for six years without lasting success.

PORTRAIT OF AN INDIVIDUAL WITH PRIVATE INSURANCE WHO CAN'T AFFORD TREATMENT

Steve is a 33-year-old man who has struggled with major depression and alcohol addiction for many years. He works as an auto mechanic making \$53,000/year and purchases health insurance for himself and his family of four through the health insurance marketplace. Steve and his family are enrolled in an average, lower-cost plan. Their monthly premium is \$1138, but they qualify for a \$722 per month subsidy so they pay \$416 per month for health insurance.

Steve takes a generic anti-depressant, prescribed by his primary care doctor, that has a co-pay of \$25/month. However, after the death of his father, Steve, struggling to cope with the pressure of supporting his mother and deal with the loss of his father, starts drinking again. Steve's primary care doctor recommended he visit a therapist. Steve found an in-network psychologist practice, and discovered at his first visit that instead of a \$50 copay for an office visit, the visit was considered outpatient treatment and he would be fully responsible for the cost of the visits (\$100) until he reaches his deductible (\$2,800).¹⁹ Steve's psychologist recommended eight weekly sessions. Unfortunately, Steve cannot afford \$400/month or even \$200/month, so he foregoes treatment.

Uninsured

For decades, North Carolina has faced the challenge of providing high quality care to people with limited access to care who suffer from either substance use disorders, mental health disorders, or both. In 2015, 1.3 million North Carolinians under the age of 65 (16%) did not have health insurance coverage. The gap in service to this population unnecessarily jeopardizes people's health and wellness and causes a ripple effect in costs to our communities.

Individuals without health insurance may receive services through the public mental health and substance use system if they qualify and funds are available. Individuals without health insurance who have a diagnosis of mental health and/or substance use disorder may be eligible for services under single stream funding and/or federal block grant funding. Single stream funding is a way of paying for services for individuals who have a diagnosis of mental illness, a developmental disability, a substance use disorder, or a combination of these who do not have another payer source.³¹ Single stream funding is used to pay for services for people who are uninsured or whose insurance will not cover treatment, as well as individuals enrolled in Medicaid receiving services not covered by Medicaid. The North Carolina General Assembly determines the level of single stream funding each year and the priority populations for the funding (see Table 2.1). The federal government provides funding to states under the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant to provide "prevention, treatment, recovery support, and

other services to supplement Medicaid, Medicare, and private insurance services.”³² North Carolina typically receives more than \$52 million under these two grants, some of which goes towards providing services and supports for individuals without insurance.^{33,34} In SFY 2015, the LME/MCOs provided \$237 million in MH/DD/SAS services under state single stream funding and federal block grant dollars. Of this, \$107 million covered mental health services for 63,335 individuals, while \$61 million provided substance use treatment services for 32,570 North Carolinians.⁹ In SFY 2016, \$271 million was appropriated for single stream funding.³¹

Single stream funding is allocated to LME/MCOs to fund services at their discretion based on population needs and with priority for populations defined by the North Carolina General Assembly.³¹ Service eligibility is determined by an individual’s local LME/MCO. For an individual who is uninsured to get services through their LME/MCO:

1. They must contact their LME/MCO.
2. The LME/MCO must determine, based on an assessment of the individual, if they qualify as a member of a priority population (as defined by the North Carolina General Assembly, See Table 2.1).
3. The LME/MCO must have funding available. If funding is not available, uninsured individuals who fall in the priority populations can be denied services.
4. The LME/MCO must determine what services are appropriate.
5. There must be a service provider who can provide those services.
6. The individual has to be able to access the service provider’s office.

Funding for services for uninsured North Carolinians with mental health and substance use disorders is not enough to meet the current level of need. (See Recommendation 2.4.) The LME/MCO cannot pay for services for individuals who do not meet priority population criteria as determined by the General Assembly. Without other risk criteria, an individual must 3 crisis or inpatient events in 12 months to qualify for services. And even then, only if the LME/MCO has funding available.

Table 2.1 Priority Populations for Single-Stream Funding SFY 2017

Adult Mental Health Priority Populations	Child Mental Health Priority Populations	Substance Use Disorder Priority Populations (Adult and Child)
Individuals at risk of harming self or others	Individuals at risk of harming self or others	Pregnant women who inject drugs
High risk individuals (more than 3 crises and/or inpatient events in 12 months)	High risk individuals (more than 2 crises and/or inpatient events in 12 months)	Pregnant women who use alcohol and/or other drugs
Individuals with severe and persistent mental illness; not stable	Youth who experience first psychosis episode	Individuals who inject drugs
Individuals with co-occurring Mental Health/ Substance Use Disorders (MH/SU) or Mental Health Disorder and Developmental Disability(MI/DD)	Individuals with co-occurring MH/SU or MH/DD	Department of Social Services involved
Homeless or at risk of homelessness	Homeless or at risk of homelessness	Opioid use
Individuals with traumatic brain injury	Individuals with traumatic brain injury	Communicable disease risk/HIV
Criminal or justice system involved	Criminal or juvenile justice system involved	Criminal or juvenile justice involved
Deaf and hard of hearing	Deaf and hard of hearing	Deaf and hard of hearing
Veterans	Department of Social Services involved	Veterans
Individuals with complex medical disorders	Individuals with complex medical disorders	Individuals with complex medical disorders
Department of Justice settlement agreement involvement	Individuals living with an adult with MH or SU Disorder	

Source: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. NC DMHDDSAS FY17 Benefit Plan Eligibility Criteria. North Carolina Department of Health and Human Services website. <https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/Benefit%20Plan%20Eligibility.pdf>. Accessed 9/13/16.

⁹ Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

Strengthening North Carolina's Public Mental Health and Substance Use Prevention Treatment and Recovery Services and Supports

North Carolina's public mental health and substance use disorder service system has undergone tremendous and nearly continuous change over the past 15 years. The North Carolina Department of Health and Human Services has delegated management authority over the public mental health and substance use disorder system to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for single stream funding and service contracts with the LME/MCOs and to the Division of Medical Assistance for Medicaid funding. In addition to these two Divisions, the North Carolina General Assembly has significant influence over the public system through funding. The North Carolina Department of Health and Human Services has identified a number of concerns and gaps in the current service delivery system including emergency department overutilization, lack of available inpatient beds, mismatch between available services and individual needs, lack of prevention services, fragmentation, underfunding, and a heavy focus on individuals in crisis.¹⁸

One challenge that continues to plague the public mental health system for adults is the continued heavy reliance on inpatient services, which is the highest level of care. Although inpatient services are an integral part of the system, the investment of more than 50% of adult mental health dollars at the highest level of services has resulted in **chronic underfunding of the other levels of community-based care that are essential to reducing the need for higher level of care and more expensive services.**¹⁸ However, people do not OFTEN enter services until they are in crisis, in part because they are uninsured or underinsured. There is a need to balance the system with more prevention and other community-based services that can decrease the need for higher levels of care.¹⁸ System balance cannot happen without additional resources in the short-term because funding cannot be removed from inpatient services if a comprehensive system of lower intensity services is not in place to keep people out of higher level services. **Stability of existing funding as well as additional resources are required to correct imbalances in the current public mental health and substance use services system.**¹⁸

LME/MCOs operate under the state's 1915(b)/(c) Medicaid waiver. Under this waiver, the LME/MCOs receive a set amount of money per month for each person eligible for Medicaid under their management. LME/MCOs also receive single stream funding, which is a set amount of state funding for people without health care (non-Medicaid populations) in their catchment areas. When the current MCO system was designed,^P MCOs were directed to keep any savings (called fund balances) to expand access to services or provide innovative services. One goal with this system was that the public mental health system could achieve the right balance of

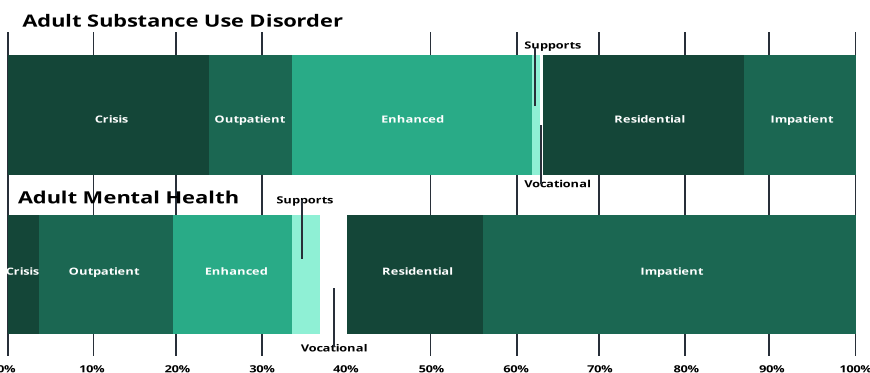
services for each community by way of investing the fund balances in prevention and other community-based services. The MCOs are required by state and federal law to maintain adequate reserves in their fund balances. Fund balances are used to cover system costs if there are delays in reimbursement from the state or federal government. Funds beyond required amounts were available for investment in services, including prevention and community-based programs.

During the 2015 legislative session the MCO fund balances were targeted by the legislature. The legislature passed non-recurring reductions of \$110.8 million and \$122 million to single stream funding, respectively, for the next two budget years, while requiring MCOs to maintain the same level of services. The MCOs were told to cover the cost using the single stream funding fund balances. The LME/MCOs function as

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Figure 2.4: Majority of Dollars in North Carolina's Adult Public Mental Health System Paying for Inpatient Care

FY16 State Fund Expenditures by Age/Disability and Category of Service



Source: Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. October 7, 2016.

private corporations under public rules. The small fund balances available to LME/MCOs for community re-investment were only marginally in excess of the reserves required to make payments on a daily basis to a network of providers and staff. By forcing the LME/MCOs to tap into this limited reserve, the General Assembly has prevented the LME/MCO system from the community re-investment that was the purpose of the fund balance. The fund balances are not being reinvested in the system to expand access or provide innovative services. Therefore, the Task Force recommends:

Recommendation 2.1: Support and expand availability of a full array of mental health and substance abuse services through LME/MCOs.

- 1) The North Carolina General Assembly should:
 - a. Allow LME/MCOs to invest fund balances in expansion of community-based services in future budgets.
 - b. Allocate proceeds from the sale of the Dorothea Dix property to the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services with at least half of the funds going towards providing a full array of mental health and substance abuse services.
- 2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Division of Medical Assistance contracts with LME/MCOs should require LME/MCOs to submit plans detailing how they plan to use their fund balances to expand or innovate services over the next year. Plans should require approval from the Secretary of the Department of Health and Human Services before implementation.

Case Management

Case management services are services provided to individuals to gain “access to needed medical, social, educational, and other services.”³⁵ Case management provides a bridge across multiple systems, including physical, mental health, and substance use treatment services, as well as other services, and may include arranging for appointments, referral forms, transportation, reminders, follow-up, and other communication. Case management is especially important for the many individuals with co-occurring conditions who have to navigate multiple systems for their care. For the 70% of individuals with mental health and substance use disorders who also have a chronic health condition, case management can improve clinical outcomes, increase care quality, and reduce costs. Case management is especially important for those with multiple conditions who are also Medicare and/or Medicaid beneficiaries; a 2014 study found that 41% of individuals eligible for both Medicare and Medicaid had one or more mental health conditions, not including substance use disorders.³⁶ The per member per month cost of Medicare and Medicaid increased as the number of comorbid conditions increased, with a sharp increase when an individual had four or more conditions at the same time. Mental health conditions frequently occur alongside other health conditions (39-63%).³⁶ Providing a bridge to navigate the multiple systems can improve quality and decrease expenses.³⁶ Case management is a Medicaid billable service for certain populations in North Carolina, but most individuals with mental health and substance use treatment needs do not currently qualify for case management services.

Recommendation 2.2: Provide case management and recovery navigation.

The state Medicaid agency should create stand-alone billable case management services with well-defined eligibility criteria, as well as navigator and step-down services for individuals needing less intense case management.

Using Data to Drive Mental Health and Substance Use System Improvement

One of the barriers to improving the delivery of mental health and substance use services is the underutilization of data.³ A vast array of data are collected on individuals who access services through the public mental health and substance use system. Currently, each agency and organization collects pieces of the data, but there is no systematic effort to comprehensively evaluate the data collected by all the state agencies that play a role in addressing the mental health and substance use needs of North Carolinians. Data could be used to assess how well our systems meet the needs of those they serve and to guide policy decisions.¹⁸ Cross-agency data sharing is critical to understanding the complex needs of the individuals and families served by these systems and to assess the effectiveness of services provided. To do this well, the state needs to establish metrics and common data points that are tracked across systems in order to assess patient mental health and substance use treatment outcomes.

The North Carolina Government Data Analytics Center (GDAC), which operates across state agencies, departments, and institutions is a data integration and data-sharing initiative that is intended to leverage the data from multiple systems. Backed by legislation, the GDAC is already supporting the Criminal Justice Law Enforcement Automated Data Services, is working to develop the Early Childhood Integrated Data System, and is piloting a program with Child Protective Services data.³⁷ If all of the state agencies that play a role in addressing the mental health and substance use needs of North Carolinians shared their data with the GDAC, the resulting data set would allow for analysis of the connection between investments and outcomes and provide evidence to drive future investments. As this information is being shared, there is a need for these agencies to pay attention to federal laws and state statutes regarding information sharing such as the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), 42 CFR Part 2, and other federal and state regulations. North Carolina should use public dollars to fund services that work. Data, and the information provided through analytical analysis, provides the means to assess if services are effective and whether publicly-funded services provide a positive return on investment. Therefore, the Task Force recommends:

Recommendation 2.3: Require North Carolina agencies to share data cross-agency.

The Department of Health and Human Services, the Department of Public Instruction, the Department of Corrections, and other agencies working to meet the mental health and substance use prevention, treatment, and recovery needs of North Carolinians should:

- 1) Contribute their data to the Government Data Analytics Center and establish a memoranda of understanding to allow cross-agency data sharing.
- 2) Provide funding to support data analysis through the GDAC.
- 3) Use data to guide policy decisions and measure their impact.

Assessing and Addressing Disparities in Mental Health and Substance Use Prevention, Treatment, and Recovery

As previously discussed, access to services and supports for individuals with mental health and substance use disorders varies based on a number of factors, including insurance coverage, specific type of mental health or substance use disorder, and geographic location. National research confirms significant disparities—such as unequal access to care and varying degrees of quality of care—in mental health and substance use services and supports.³⁸ Certain minorities, including American Indians, Alaska Natives, African Americans, Asian Americans, Pacific Islanders, and Hispanic Americans receive less care and lower quality care than other populations. The rate of mental health and substance use disorders is not higher in these populations, but they have higher rates of misdiagnosis, which may contribute to this burden. For instance, African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with mood disorders.³⁹ For those who are diagnosed, they are less likely to receive the most current prescription drugs.² Asian Americans have low rates of substance use treatment, which is consistent with research that shows that behavioral health services are underutilized by Asian Americans.⁴⁰ Differences in accuracy of diagnosis, receipt of appropriate therapies, and adequate monitoring in both the short- and long-term have been shown to vary by racial, ethnic, geographic, and socioeconomic differences.⁴¹ In North Carolina, unequal distribution of mental health and substance use treatment providers has led to well documented disparities in access to mental health and substance use services.⁴² Among adolescents in North Carolina, there are documented disparities in the gender and race/ethnicity of individuals suspended or expelled from schools and in the juvenile justice system, both of which overlap with the population of adolescents who may need mental health and substance use services and supports.^{43,44}

Currently, as part of their contracts with the LME/MCOs, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services requires each LME/MCO to complete a gaps analysis to assess outpatient, location-based, community, mobile, crisis, inpatient, and specialized services. These analysis focus heavily on the time it takes to access services and distance traveled. The gaps analysis does not look at variation between sub-populations' access to services. If the data is not collected and assessed, differences in access, diagnosis, treatment, and recovery will not be identified or addressed. In order to fully understand the gaps and needs in North Carolina's mental health and substance use systems, LME/MCOs should collect and analyze data by age, race/ethnicity, diagnosis, and other factors. Therefore, the Task Force recommends:

Recommendation 2.4: Assess and address disparities in the LME/MCO system.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services should:

- 1) Require LME/MCO to complete an analysis of type/severity of diagnosis, duration of services, use of psychotropics, and outcomes when available, by demographic data including gender, age, and race/ethnicity as part of the annual gaps analysis.
- 2) Require each LME/MCO to develop strategic plans to address disparities identified in the gaps analysis.

Mental Health and Substance Use Prevention, Treatment, and Recovery Services for Uninsured Residents

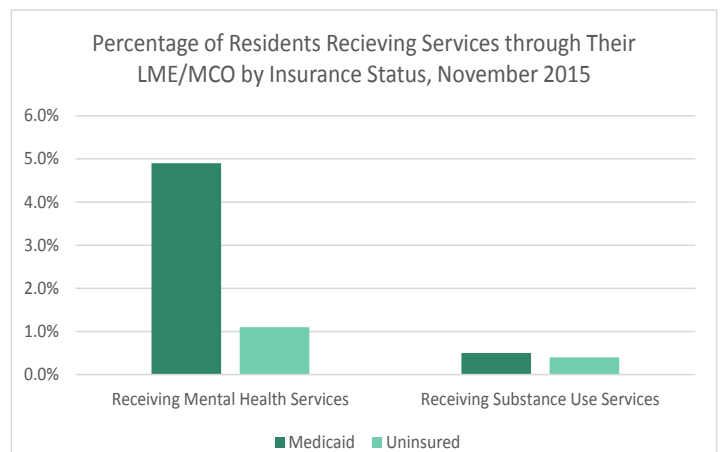
Funding for services for uninsured North Carolinians with mental health and substance use disorders does not meet the current level of need. It is estimated that 17% of adults in North Carolina have mental health and/or substance use disorders and approximately 4% have serious mental health and/or substance use disorders per year. Data from the LME/MCOs in 2015 show that uninsured individuals are much less likely to receive mental health services through their LME/MCO than individuals enrolled in Medicaid. (See Figure 2.2.)

In SFY 2015, \$841 million in state-match Medicaid funds were combined with federal Medicaid dollars to provide \$2.4 billion in mental health and substance use treatment services to approximately 355,000 Medicaid beneficiaries (18% of Medicaid beneficiaries) in North Carolina.^q In the same year, \$168 million in state-funded single stream funding mental health and substance use treatment services were provided to approximately 96,000 uninsured individuals (9% of those without insurance).^r

To provide funding for mental health and substance use treatment services for uninsured residents on par with what Medicaid beneficiaries receive, the state would need to allocate an additional \$482 million annually to single stream funding, assuming no expansion in the population served.^s However, state single-stream funding only serves a portion of the uninsured residents with mental health and substance use needs (see Table 2.1 for priority populations). If the state wanted to fully meet the needs of the uninsured population, the state would need to allocate up to an additional \$1.2 billion.^t

Currently, North Carolina’s Medicaid program covers children 0-21 in families whose income is up to 215% of the federal poverty guidelines (FPG), pregnant women with incomes up to 200% FPG, and adults with children under the age of 18 who live with them and whose family has an income up to 44% FPG, and aged, blind, and disabled.⁴⁵ Since 2014, under the Patient Protection and Affordable Care Act, states have had the

Figure 2.5: Uninsured Individuals are Much Less Likely to Receive Mental Health Services through their LME/MCO than Individuals Enrolled in Medicaid



Source: North Carolina Department of Health and Human Services. LME/MCO Monthly Monitoring Report, November 2015. Adolph Simmons, Jr. M.S., Business Systems Analyst, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication on February 29, 2016.

q \$841 million in state-funded Medicaid costs, so the full amount of services, including federal Medicaid, was approximately \$2.5 billion in 2015. (The state data presented was self-reported by the LME/MCOs to the NC Division of Medical Assistance. According to Dma in SFY 2015, the MCO capitation payments averaged @2.2 billion. Some of the LME/MCOs have “reinvested” prior year earning which could increase their total spending. Adolph Simmons, and September 30, 2016 Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication on February 29, 2016.) There were 1,992,899 Medicaid beneficiaries in North Carolina. (NC Division of Medical Assistance. NC Department of Health and Human Services. Monthly Medicaid Enrollees from SFY2017 through SFY2009.)

r Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

s This calculation holds the number of uninsured served steady at 95,905. \$6,779/Medicaid beneficiary (state and federal funds) - \$1,752/uninsured resident = \$5,027/individual difference *95,505 = \$482 million.

t If the state were to fund services for uninsured at the same level as for Medicaid recipients (\$6,779), assuming same percentage (18%) would need MH/SU services, total cost would be \$1.3 billion. North Carolina currently contributes \$168 million in single-stream funding to meet the needs of uninsured residents. The state would need to increase single-stream funding by \$1.2 billion to provide services for the uninsured at the same level as for Medicaid recipients.

option to expand Medicaid to cover most adults with incomes up to 138% FPG. Expanding Medicaid would

provide health care coverage to adults who are not currently eligible for Medicaid or for health insurance subsidies through the federal health insurance marketplace. Approximately 512,000 North Carolinians would be newly eligible for Medicaid under expansion.⁴⁶ If these adults enrolled, they would have access to mental health and substance use treatment as needed, including counseling, prescription drug coverage, and other services and supports. Expanding Medicaid coverage to new eligibles is not without costs to the state. The North Carolina Department of Health and Human Services determined that expanding Medicaid to new eligibles would result in a net savings to North Carolina of \$40 million in 2017, with costs increasing over the following years to \$119 million by 2021.⁴⁶

Medicaid expansion would not cover all of the state's 1.3 million currently uninsured people, but it would likely reduce the number of uninsured by half a million. Approximately \$562 million in additional mental health and substance use treatment services would be provided to Medicaid beneficiaries in North Carolina, which amounts to approximately 45% of needed services for the currently uninsured.^u Medicaid expansion would also provide coverage for primary care and other health care benefits in addition to mental health and substance use treatment services.

Currently state funding for mental health and substance abuse treatment services is inadequate to meet the needs of the uninsured. This leaves many of our most vulnerable residents without the services they need to be healthy, safe, and productive members of our communities. There are many possible ways for the state to increase mental health and substance use services for uninsured residents. Therefore, the Task Force recommends:

Table 2.2: Public Funding for Mental Health & Substance Use Services, 2015

Public Funding for Mental Health and Substance Use Services, 2015			
	State + Federal Contribution	Persons Served	Average Value of Services per Beneficiary
Medicaid Mental Health and Substance Use Services ¹	\$2,403,610,489	354,572	\$6,779
Uninsured IDD, Mental Health and Substance Use Services ²	\$168,018,325	95,905	\$1,752
			\$5,027
NC Uninsured Population³			1,103,000
Estimated Percentage of Mental Health and Substance Use Service Need of Uninsured⁴			198,540
Estimate of Cost to State to Provide Medicaid-Equivalent Mental Health and Substance Use Services to Uninsured^{5,6}			\$1,177,865,801

¹State Medicaid funding was self-reported by the LME/MCOs to the NC Division of Medical Assistance. Adolph Simmons, Jr. M.S., Business Systems Analyst, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication on February 29, 2016 and September 30, 2016. The North Carolina Institute of Medicine calculated the federal Medicaid contribution was calculated using the state Medicaid contribution, with the assumption that state government contributes 35% of the cost of Medicaid with the federal government contributing 65% of the cost."

²Bowman J. Quality Management Section Chief, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services. Written (email) communication June 27, 2016. Coleman PB. Senior Researcher, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

³U.S. Census Bureau. Health Insurance Coverage in the United States, 2015. Washington, DC. <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>. Published September 2016. Accessed October 5, 2016.

⁴The North Carolina Institute of Medicine estimated the percentage of uninsured residents with mental health and substance use service need using the North Carolina Medicaid mental health and substance use services penetration rate of 18%. It is unknown if the penetration rate for the uninsured would be 18%. Their prevalence and penetration rates could be higher, lower, or the same as the current Medicaid population.

⁵The North Carolina Institute of Medicine estimated the cost to the state to provide Medicaid equivalent mental health and substance use services to the uninsured by multiplying the average value of services for Medicaid beneficiaries by the percentage of uninsured residents with mental health and substance use service need and then subtracting the current state and federal contribution.

^u Expanding Medicaid would bring approximately 512,000*18*\$6,779 = \$624 million in mental health and substance use treatment and recovery services to those covered through expansion. If \$1.2 billion is needed to provide funding for mental health and substance use treatment services for uninsured residents on par with Medicaid (see footnote u), then \$624 million would meet approximately 53% of the gap in mental health and substance use treatment and recovery services for uninsured North Carolinians.

Recommendation 2.5: Expand access to mental health and substance use services.

The North Carolina General Assembly should increase access to and utilization of mental health and substance use services for uninsured residents.

Paying for Positive Outcomes

Funding for mental health and substance use services should be spent on services that have been shown to produce positive outcomes or improved outcomes for individuals with mental health and substance use disorders. Increasingly, the United States' health care system is moving away from a fee-for-service system towards a value-based system with reimbursement based on the quality, cost, and outcomes of services.⁴⁷ One of the goals of value-based care is to better align the incentives of patients, providers, and the payers who usually finance care. Value-based payments are already being implemented by Medicare and Medicaid for select physical health conditions. One of the concerns within the mental health and substance use prevention, treatment, and recovery systems is the lack of emphasis within current systems on outcomes.

Ideally, under a value-based system, reimbursement would incorporate outcome data into payment. However, currently such data are unavailable. In the absence of outcome data, insurers have increasingly developed payment models that incentivize evidence-based strategies, or those that have been proven effective in high-quality research studies. There are evidence-based strategies across the continuum of mental health and substance use care that should be incentivized and promoted. The purpose for using evidence-based strategies is that it increases the likelihood that programs, interventions, and policies will produce positive outcomes while also increasing the efficiency of public resources.⁴⁸ In North Carolina, evidence-based services and supports are being offered by many mental health and substance use treatment and recovery providers, however, most services and supports provided are not evidence-based. As payment methodologies in the health care field continue to evolve, funders of mental health and substance use services and supports should develop payment models that support and promote positive outcomes. Therefore, the Task Force recommends:

Recommendation 2.6: Increase utilization of evidence-based mental health and substance use services and tie payment to positive health outcomes.

- 1) Payers, both private and public, should develop service definitions, contracts, and/or value-based payments to reward providers based on:
 - a) Completion of approved training for evidence-based treatment services and consistently providing evidence-based treatment.
 - b) Use of evidence-based screening and assessment instruments to identify people with mental health and substance use conditions.
 - c) Case mix and the severity of patients' needs.
- 2) Insurers, both private and public, should work together to develop mental health and substance use process and outcome measures (or adopt those developed by CMS) and define value-based payments and/or performance-based incentives for improving health outcomes. Value-based payments and/or incentives should be developed to reward providers based on:
 - a) Consistently reporting process and outcome measures.
 - b) Achievement of positive outcomes for patients.
 - c) Severity of need and case mix of patients

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