



NORTH CAROLINA
**COUNCIL OF
COMMUNITY
PROGRAMS**



September 15, 2008

Tara Larson
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Division of Medical Assistance
2501 Mail Service Center
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Dear Tara,

The NC Council of Community Programs and the NC Providers Council have joint comments that we would like to share with you regarding the rates that were published in the September, 2008 Medicaid Bulletin. Thank you for providing the rate setting methodology that was developed by Mercer Government Human Services Consulting (Mercer) on behalf of the Division of Medical Assistance (DMA). We are pleased to observe an increase in numerous service rates which will better support the maintenance and growth of the MH/DD/SA service delivery system. Conversely, we are troubled to learn of the 7% rate reduction for Assertive Community Treatment Team (ACTT), an evidence-based practice designed to engage individuals with serious and persistent mental illness and co-occurring disorders, and with the most complex and expensive treatment needs. These consumers rely on ACTT services in the community to prevent decompensation which oftentimes results in hospitalization. Facility-based Crisis, a community alternative to hospitalization designed to treat adults in crisis with mental illness and substance use disorders, was also reduced. We perceive the reductions to be counterproductive to the system's goal of expanding the service continuum to include evidence-based practices such as ACTT that are proven to prevent crises and reduce hospitalizations in consumers with high level of care needs. As an example, North Carolina may lose providers of ACTT and Facility-based Crisis rather than achieve the intended reduction in cost to deliver this service. With limited providers qualified to deliver these two specialized services that must be accessible statewide, LMEs may be forced to consider assistance to sustain the services or lose the services altogether.

While the rate setting methodology for the ACTT rate may be reasonable, the use of an average cost can have additional unintended consequences than stated above. The average cost was derived from the actual cost of a large team and the actual cost of a small team, which resulted in a rate reduction for small teams. Small teams will be inclined to replace more qualified staff with less qualified staff in order to conform to the revised business model. This phenomenon has the potential to compromise the quality of the service, not unlike what occurred with the blended Community Support rate. In

addition, the rate setting methodology does not take into account North Carolina's vast rural geography which presents a unique set of challenges. Large sparsely populated geographic areas, rising fuel prices, and the need for availability result in increased costs for rural teams.

The reduction in Facility-based Crisis rates raises several questions in terms of the assumptions driving the change. We believe the analysis may not have considered all of the positions necessary to adequately implement the service: for example, the half-time physician on-call is an underestimate of the actual time required for that position. Additionally, consumers utilizing Facility-based Crisis frequently require medication, the cost of which is absorbed by the service. Medicaid limits billing to 16 hours per 24 day, and while this may address treatment time, it does not cover supervision and monitoring that are frequently needed during the remaining hours when consumers in crisis are likely to need care to assure their safety and welfare.

LMEs are responsible for building service capacity at the local level per NC GS 122C-115.4(2). We rely on the DHHS to implement policies that support our efforts to develop a robust community-based system. The NC Council respectfully requests that DMA rescind the rate reductions for ACTT and Facility-based Crisis. In addition to Mobile Crisis and Walk-In Urgent care, these are two critical services every community needs to reduce the reliance on State institutions. We request that the DHHS consider the potential negative impact on consumer accessibility to services necessary to prevent hospitalization, the on-going concern statewide regarding sufficient community capacity to manage crisis events, and the potential financial impact to the State. LMEs will be inclined to pay the difference between the actual cost of the services and their revenue in order for the services to be readily available to consumers in their communities, thereby reducing the available state dollars for other services needed within their communities.

These are critical issues in North Carolina's service continuum design. If DMA determines that it is not prudent to rescind the rate reductions, we ask that you delay the implementation of the new rates to allow 90 days for LMEs and Providers to develop plans to attempt to mitigate potential service disruption to consumers, and if providers find the reductions untenable, to address financial solvency issues among the limited ACT Teams and Facility-based crisis sites currently in operation across the state.

Respectfully submitted,



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