



NORTH CAROLINA Psychiatric Association

North Carolina Psychiatric Association
A District Branch of the American Psychiatric Association

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THE MISSION OF THE NCPA IS TO:

- Promote the highest quality care for North Carolina residents with mental illness, including substance use disorders
- Advance and represent the profession of psychiatry and medicine in North Carolina
- Serve the professional needs of its membership

March 14, 2013

NC Department of Health and Human Services
Office of Procurement and Contract Services
Hoey Building
Attn: David Womble
801 Ruggles Drive
Raleigh, NC 27603

Re: Response to RFI-DMA100-13

Respondent Information:

North Carolina Psychiatric Association
4917 Waters Edge Drive, Suite 250
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Phone: 919-859-3370

Representatives:

Robin B. Huffman
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The North Carolina Psychiatric Associations (NCPA) welcomes the opportunity to respond to the DHHS Request for Information to improve effectiveness and efficiency in NC Medicaid. NCPA is the voluntary professional association for nearly 900 physicians in the state whose medical specialty is psychiatry and is a District Branch of the American Psychiatric Association.

NCPA has a long history of engagement with our state's public mental health sector. Our association was first formed more than 75 years ago at a meeting of psychiatrists at Dorothea Dix Hospital; in the intervening years our members have served as State Hospital Directors, State Commissioners of The Division of Mental Health, and Medical Directors of all levels of the public mental health system. We take seriously this tradition of responsibility, and have through the years, weighed in with our clinical observations of concerns and problems we have identified and ways to improve our system.

The documents attached to our response not only demonstrate past examples of our feedback, but also have content specific to this RFI. They include:

- A letter of support for NCPA's RFI response with additional suggestions from the North Carolina Council of Child and Adolescent Psychiatry, a separate professional association affiliated with the American Academy of Child and Adolescent Psychiatry, with whom NCPA shares several hundred members
- NCPA's June 2011 letter to the Governor related to waiver expansion
- NCPA's first in a series of three report cards related to reform

NCPA is fully committed to ensure that care to our citizens for necessary mental health and addictive disease treatment and development disabilities supports is available and is provided in a clinically sound and efficient, effective manner. We stand ready to engage in an ongoing dialogue with the Department and its Divisions.

Thank you for this opportunity.

Sincerely,

A handwritten signature in cursive script that reads "Debra Bolick, M.D.".

Debra A. Bolick, M.D., D.F.A.P.A.
President

Enclosures

NCPA GIVES PERMISSION FOR PUBLIC RELEASE OF THIS
DOCUMENT

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Introduction

The North Carolina Psychiatric Association (NCPA) is involved with and knowledgeable about North Carolina’s Medicaid program from diverse perspectives. First, many NCPA members are enrolled providers of care either in private offices or within systems of care including the Critical Access Behavioral Health Agencies (CABHAs) and in academic and hospital settings. We have members who serve as CABHA Medical Directors and a few are CABHA owners. Others serve as LME/MCO Medical Directors, and some have worked as past employees of the LMEs when they provided direct care.

North Carolina’s Medicaid managed care program known as Community Care North Carolina employs twenty psychiatrists within their behavioral health component, and fifteen of these are NCPA members.

In advocating for its members and their patients, NCPA has a long history of involvement in the evolving design of public systems of care. This submission includes as attachments to the narrative examples of input we have offered over the last few years. We suggest here that if some of our advice had been heeded, we could have avoided some of the more egregious problems of the recent past, such as the community support issue, in which hundreds of millions of dollars were spent on clinically questionable services.

This report attempts to be broad but concise. In the interests of brevity, all of the ideas presented here are not fully elaborated in this modest narrative. It is NCPA’s hope that the ideas presented will lead to our being a party to ongoing dialogue and engagement with state leaders and the other parties to the evolution of North Carolina’s Medicaid program.

Key Issues

The content of our response to the Request for Information (RFI) may be divided into three categories as follows: I. Integrated Care, II. Building the Clinical Workforce and Reimbursement Systems for Providers of Care; and III. Medical Leadership.

I. Integrated Care

The RFI specifically asks for ideas about short and long term savings of money, improving the health of Medicaid recipients, and about addressing the physical-behavioral health interface. These topics are related. There is no greater opportunity for realizing reduced medical costs than in addressing untreated comorbid physical-behavioral health conditions, often as they present in primary care settings. There is no greater opportunity for improving health outcomes than delivering more effective care through better coordination of care throughout the often disconnected systems of care.

Unlike other medical specialties, such as cardiology, where there is “an intelligent division of labor” between what is treated in the primary care office and what is treated in the specialist’s office, behavioral health systems do not effectively direct patients to the most appropriate provider of care. Primary care offices often are the default provider for very sick psychiatric patients and specialty behavioral health systems treat many patients who could successfully be served in the primary care office. Only when there is this appropriate division of labor between primary care and specialty behavioral health providers will the system be more efficient and effective.

There are many barriers to developing truly integrated systems of care. One is the lack of a coordinated case or care management system. For the sake of brevity, this report will assume the reader is familiar with the evolution (or de-volution) of case management within the public mental health system of care. Until a truly unified and/or coordinated system of case management for physical and behavioral health for all patients is in place, integrated care is not achievable. Timely case management early in the course of an episode of illness prevents the patient’s journey to a higher and more costly level of care.

NCPA collectively is familiar with the efforts of Community Care of North Carolina (CCNC) in attempting to facilitate integration of care through co-location strategies and other initiatives, including its own case management systems. As we stated above, fifteen NCPA members work within this program as network psychiatrists. We endorse CCNCs efforts to

enroll specialty providers, including psychiatrists in the CCNC Network. However, there are barriers to this becoming a success, chiefly the absence of a reimbursement mechanism for the work of psychiatrists in this kind of integrated system. The lack of a billing code for physician to physician consultation is a specific need. Further details of this issue and possible remedies are beyond the scope of this limited submission, but NCPA would welcome the opportunity for further dialogue on this matter and others related to integrated care.

II. Building the Clinical Workforce and Reimbursement Systems for Providers of Care

Regardless of how well the physical and behavioral health service capacities are integrated into an effective and efficient system, there will always be a need for behavioral health specialty providers. The severity and complexity of some psychiatric patients will require both expertise and settings beyond the capability of the primary care office.

The behavioral health public system of care that North Carolina is now building makes use of a management capacity or Managed Care Organization (MCO) that credentials and oversees providers made up of agencies, including the larger CABHAs, plus licensed independent practitioners (LIPs) who include private psychiatrists and the practices of social workers, psychologists and others. The 11 MCOs are independent from each other with their own processes of credentialing and payment systems. If an individual or organization wants to serve patients from two or more separate MCO catchment areas, they must credential with each separately.

As the 11 MCOs have begun operations there have been numerous and well known difficulties in providers getting paid in a timely manner. Also difficult for some LIPs is the complexity of credentialing, in part due to the absence of credentialing reciprocity among the MCOs. Teaching hospitals such as UNC Hospitals in Chapel Hill find themselves in the position of having to credential with all 11 of the MCOs.

While large organizations have the administrative capacity to manage such complexity, there is real information available that LIPs, including psychiatrists, are leaving the Medicaid system entirely, and if this trend continues, the CABHAs will eventually be the only clinical option for Medicaid enrollees.

State leaders must address the question of whether or not the wholesale departure of LIPs is by design or default. Is this a desirable outcome or an unintended consequence of a faulty strategy? If state leaders wish to have clinical options other than large CABHAs for psychiatric

patients, there must be consistent business and management practices, including credentialing with reciprocity among all MCOs.

One might consider another alternative, to enroll LIPs, including psychiatrists, directly into Medicaid in a manner similar to before the waiver, and not through the MCO. It should be noted that the primary service provided by LIPs, outpatient psychotherapy, makes up less than 1% of the Medicaid budget. These independent practitioners have traditionally provided one of the lowest cost services and in a managed care environment and should be the least managed. Historic data shows that these services average less than 12 visits a year. Disproportionate MCO expense is required to credential and manage this level of care, and the current practices of MCOs are contributing to the loss of this specialized work force for the Medicaid enrollee. Furthermore, there is data available to show that decreased outpatient availability can lead to increased drug costs.

This means of credentialing and paying psychiatrists, strictly within the waiver capitation, also places barriers to integrated care, in that the funding stream sets them apart from the rest of medicine. Some mechanism for reimbursing psychiatrists for providing consultation to other physicians is needed.

Another issue that state leaders may wish to revisit regarding the MCO structure is whether the capitation model now employed is the most effective one. It may be useful to capitate closer to the service delivery, at the CABHA level. However, in a system that is underfunded, we believe, the risks and consequences of a CABHA failure must be carefully considered. Alternative funding strategies may also allow for creation of de facto “psychiatric medical homes” with funding dedicated at the service delivery level for patients whose primary health need is a psychiatric one. In this psychiatric medical home, “reverse co-location,” where basic primary care services are delivered within a facility that has primarily a behavioral health identity, could be another variant of integrated care.

One way to address many of the above issues in this section—and if NC continues to operate a 1915 b c waiver—it should come under a common business structure so that each MCO is directed to adopt uniform management and business practices. This could be done through a contract with an established managed care company engaged to implement a single statewide system managed by locally run public MCOs. In other words NC should engage a respected MCO to provide technical assistance in a time-limited engagement to the operating MCOs system.

III. Medical Leadership

We argue that one element of public system mental health reform over the last decade has been the de-medicalization of the system of care. We believe that the fundamental error with the community support catastrophe was a failure of the determination of appropriate “medical necessity.” We now propose that state leaders revisit the issue of medical leadership at all levels of the delivery system.

We acknowledge that the Medicaid benefit package pays for services that are not strictly “medical acts” but we believe that in a truly integrated system, there would be medical oversight of how these services fit within the overall array of services. Despite its diversity, Medicaid is a medical insurance program, and should be held to the ethical and professional expectations of a medical system of care.

Step one in this review would be to design the positions of CABHA medical director so that these positions are filled by psychiatrists with the appropriate backgrounds and that they work within job descriptions that grant them genuine oversight roles.

A component of this role should involve participation in the process that identifies and measures service quality and outcome. NCPA and the North Carolina Council of Child & Adolescent Psychiatry have members who have extensive knowledge in this area and stand ready to provide leadership about the structure of such processes. Many of these members have been on national committees for quality standards which have developed practice guidelines and quality outcome measures for child and adolescent managed Medicaid. Model structures may be found at <http://www.aacap.org>.

In addition, we ask state leaders to examine whether the structure of CABHAs, in reference to the relationship between physicians and CABHA owners, violates regulations concerning the corporate practice of medicine. A full discussion of this issue is beyond this paper, but the issue has to do with the elevating of the value of business processes to a degree that quality of medical care is compromised. Specifically, these strategies define the cost of employing a physician as too costly and attempts to substitute lesser and non-medically trained individuals to provide services that only physicians should provide. This misplaced direction has created situations in which health care delivery has deteriorated with worse outcomes within a patchwork system. We also believe this practice has contributed to the apparent increase in billing fraud. Our current system makes it difficult for psychiatrists to exert control over how their Medicaid and NPI numbers are used within the billing processes of agencies. Physician

involvement in leadership roles is a necessary component of the maintenance of the goal of appropriate medical care.

We also believe that over the last decade of mental health reform, due to a series of budget cuts, that there has been an attrition of leadership talent and of appropriate compensation for the leadership within DHHS who manages the Medicaid program and the public mental health system. DHHS should study the staffing and compensation structures of high performing state Medicaid programs and strengthen these critical positions. This also includes the issue of the appropriate presence of medical leadership, including psychiatric leadership, at this level.

Summary

The members of The North Carolina Psychiatric Association collectively have an extensive experience and knowledge base from which to advise regarding improvements in cost and quality for Medicaid enrollees. By eliminating barriers to integrated care, by designing systems that appropriately credential and reward providers, and by structuring psychiatric leadership positions throughout the system of care, there is room for considerable optimism in providing better care at reduced cost.

Please see the Following Attachments:

- Letter of endorsement from the North Carolina Council of Child and Adolescent Psychiatry
- June 3, 2011 letter to Governor Perdue Re: statewide expansion of the 1915(b)/(c) waiver for mental health and substance abuse services
- 2005 Report Card on the Clinical Impact of North Carolina's Mental Health Reform by the North Carolina Psychiatric Association

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Response to RFI-DMA100-13

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The North Carolina Council of Child and Adolescent Psychiatry is the regional organization of the American Academy of Child and Adolescent Psychiatry that represents the voice of child and adolescent psychiatrists in this state. Many NCCCAP members are enrolled providers of care in private offices, CABHAs, academic or hospital settings. These child and adolescent psychiatrists work in a variety of roles from clinical to administrative.

There are many issues related to the delivery of mental health care for children and adolescents in North Carolina and we will comment briefly on a few. The members of the NCCCAP present these ideas in the hope that we can become engaged with leaders in the state to promote improvements in the North Carolina Medicaid program and ultimately improve outcomes for children and adolescents with mental illness in North Carolina.

The NCCCAP supports the NCPA position regarding the issues related to integrated care, building the clinical workforce and reimbursement systems for providers of care and medical leadership.

In addition to those issues the NCCCAP would like to highlight systems issues that impact the delivery of care to children, adolescents and families in North Carolina. Most children in North Carolina are involved with the primary health care system and education system. When a child begins to have emotional or behavioral problems that are problematic or chronic they will usually present in one of these two settings. Primary care physicians can work with children and families regarding these problems at first and then may refer to a child and adolescent psychiatrist as needed. There are many models in North Carolina with co-location either physically in their office or with telepsychiatry where CAPs work directly with primary care physicians or patients can be referred to CAP offices. This integrated care is very important to improve the access to care for all children and needs to be supported.

Once children and youth are seen in CAP offices and mental health clinics there needs to be integrated care with the many mental health providers to promote improved outcomes. Currently this is very difficult with most providers housed in different offices and not being able to communicate due to lack of mechanisms and payments to support such coordination of care, especially with the severely mentally ill youth. Indeed, the continuum of care that is necessary to treat children and youth with severe mental illness is not present in most communities in North Carolina and this leads to poor outcomes and overutilization of acute services, especially inpatient and emergency services. There is also no obvious organization or triage of care at the MCO/LME level where a CAP could help with the most severely impaired children helping the

system to consider all factors involved while helping the child, family and providers find the appropriate level of care.

Other child serving systems are also important in delivering care to children. Schools are particularly positive places to offer mental health treatment and North Carolina should fund and promote school based mental health clinics. There is a current federal initiative with Child Welfare to improve the mental health care for foster children with emphasis on psychotropic medication and need to provide appropriate therapy services. Youth in the juvenile justice system have frequently not received services and there is a need to provide mental health services while in secure custody and while on probation to prevent further deterioration. There is a serious need to bridge many services including mental health and substance abuse services; and mental health and developmental services to improve outcomes. And finally, our youngest citizens are showing up more and more in mental health clinics with serious problems and need our help.

We would appreciate the opportunity to work with you to improve children's mental health services in North Carolina.

Sincerely yours,

Allan Chrisman, M.D.

Allan Chrisman, M.D.
President North Carolina Council Child Adolescent Psychiatry



North Carolina Psychiatric Association

A District Branch of the American Psychiatric Association

Celebrating 75 years of serving the professional needs of our membership and advocating for quality care

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- Advance and represent the profession of psychiatry and medicine in North Carolina
- Serve the professional needs of its membership

June 3, 2011

The Honorable Beverly Perdue
Governor, State of North Carolina
20301 Mail Service Center
Raleigh, NC 27699-0301

Dear Governor Perdue,

The psychiatrists of the North Carolina Psychiatric Association (NCPA) have serious concerns about the proposed statewide expansion of the 1915(b)/(c) waiver for mental health and substance abuse services. We believe a hurried transition to such a waiver could seriously undermine efforts to shore up a mental health system fragile from a decade of poorly implemented reforms. We understand that the positive experience with the Piedmont LME waiver is fueling enthusiasm for a rapid expansion, but we think that the speedy extension of a waiver across the state will be disastrous, especially in less population-dense regions.

The reasons for our concern are several and complex, difficult to convey in a simple letter. However, we would be abandoning our hopes for a stable public mental health system and our responsibility for some of the most vulnerable patients in our system if we do not express our apprehension. Ten years ago, our entreaties to proceed with reform in stages were ignored. We appreciate your willingness to consider these thoughts.

As you are aware, such **waivers pose significant challenges to government business infrastructure**. Single county or multi-county LMEs must be transformed into management entities that perform a wide range of critical administrative services: create and manage diverse provider contracts, assure quality for the provider network, execute tight budget controls, etc. For many counties, this transition to a waiver-ready business capability will require an impossibly steep learning curve and make heavy demands on county governments to reinvent themselves as nimble business entities. Some counties have developed these broad managerial capabilities; but for many counties, developing this business infrastructure will be a substantial challenge. In far too many states, such waivers-- with their incentives to under-treat vulnerable patients-- have led to poor and fragmented care.

One of the major flaws in the mental health transformation of the past decade was the elimination of a psychiatric medical home that linked patients to appropriate levels of care. The waiver system is designed to favor large service providers; it presents numerous problems and onerous barriers for small physician practices that are providing basic, inexpensive, federally mandated outpatient psychiatric services. We have forwarded a list of questions and concerns to Secretary Cansler that our members have raised. Just as the reform of the last decade led to disintegration of the professional workforce for our public mental health system, **we fear that added administrative burdens will lead to more psychiatrists and other mental health professionals leaving the Medicaid system.**

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We are also concerned that **North Carolina's noteworthy efforts to integrate mental and physical health care will suffer badly under a waiver**. Two benefits of integrating care are improved care and the potential to realize financial savings when care for the entire person is collaborative and payment systems are not compartmentalized into a physical health payment pool and a mental health payment pool. It seems imprudent to move to a carved out mental health system just as the national health care system has begun embracing integrated care. Carving out mental health in such waivers will create formidable barriers to referral and communication between primary care and mental health providers and will set up disincentives to collaboration that could set back a decade of progress in our integration efforts.

In the early days of reform, an exception to the state's "corporate practice of medicine" standard was tentatively permitted to enable enhanced benefit entities to directly hire psychiatrists. This standard, which allows physicians only to work for other physicians, was established to ensure that appropriate medical care is not sacrificed for profit margins in a business environment. **The waiver model has not been adequately tested in a public safety-net system to ensure that financial incentives to stay solvent will not outweigh corporations dictating care delivery to their employed physicians.** Of further concern is the fact that NC Medicaid does not capitate the services of any other medical specialty; this deviates from the intent of the Mental Health Parity and Addiction Equity Act of 2008. If waivers are to move forward, we feel strongly that psychiatrist specialty services should be removed from the waivers.

In summary, we do not support efforts to rapidly extend a 1915(b)/(c) waiver statewide. Despite this, if an expanded waiver goes forward as planned, we urge complete and independent review of readiness to implement any new waiver counties prior to final approval and implementation and continued review and evaluation of the existing waivers to ensure appropriate patient outcomes.

We would be delighted to meet with you to discuss our concerns.

Sincerely,



B. Steven Bentsen, M.D., MBA, DFAPA
President North Carolina Psychiatric Association

cc: Lanier Cansler, Secretary DHHS

**Report Card on the Clinical Impact
of North Carolina's Mental Health Reform
by the North Carolina Psychiatric Association**

June 2005

I. SUMMARY

North Carolina's Mental Health Reform effort was designed to enhance community capacity and reduce reliance on state hospitals. While there has been anecdotal acknowledgement of increased state hospital admissions and problems with Mental Health Reform, NCPA saw the need to analyze data to quantify the clinical impact of Mental Health Reform. Based on data provided by DMHDDSAS to NCPA on state hospital admissions from July 1999 through April 2005:

- a. Admissions of adult consumers have increased 23.3% since 1999, and have risen dramatically since March 2004.
- b. Admissions of child/adolescent consumers have increased dramatically since August 2003, nearly doubling between July-Sept 2003 and Oct-Dec 2004.
- c. Admissions of geropsychiatric consumers have sustained a 34.7% decrease since 1999.

II. WHAT DOES THIS MEAN?

There are no direct measures of the clinical impact of North Carolina's Mental Health Reform effort on consumers. The best readily available data are on state hospital use by consumers, an indirect measure of clinical impact, but a measure promised to be reduced as a result of Mental Health Reform.

It is clear that Mental Health Reform is not achieving the promised reductions in state hospital admissions of children/adolescents and adults.

Mental Health Reform ran into a "perfect storm" of adverse events: unanticipated budget problems, shortfalls in Medicaid, increased population, more medically indigent (non-Medicaid) consumers needing care, less bridge funding than anticipated, community hospital capacity not increasing (and in fact hundreds of beds being closed over the past decade), and the loss of public sector clinicians (especially psychiatrists). These contingencies, however, should have been taken into account in planning for mental health reform.

Mental Health Reform is based on community capacity being developed, and since such capacity has not yet been fully developed throughout the state, it could be argued that these results are to be expected. However, Mental Health Reform has been under

way since State Plan 2001 was issued in November 2001. Much effort and system change has taken place. It is now almost four years later, time for a consumer-oriented progress report.

III. WHAT TO DO NOW?

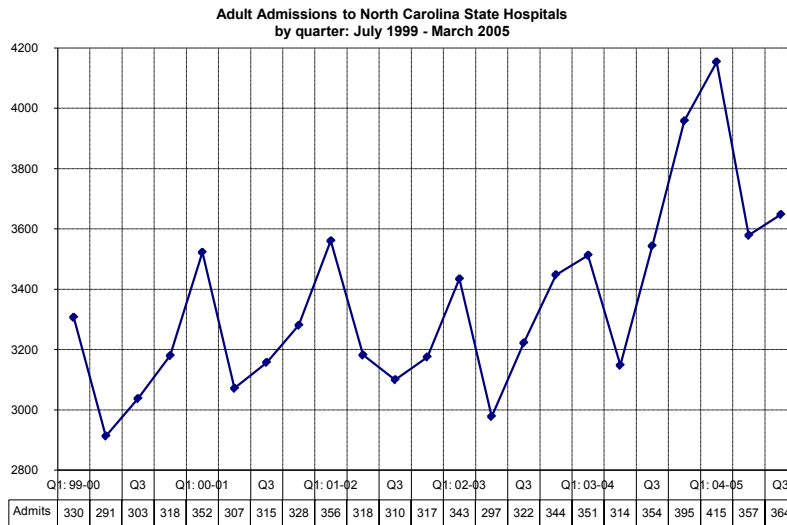
NCPA urges:

1. Address the emergency in North Carolina's Mental Health System as a high legislative priority for the current state budget.
2. The Legislature authorize an immediate independent study of the progress of mental health reform, to make recommendations for needed corrective actions. The study should focus on: (a) provider capacity across the state, (b) recruitment and retention of the mental health workforce, and (c) community hospital and emergency services capacity.
3. Reaffirm the decision of DMHDDSAS to slow down the pace of divestiture of public sector psychiatrists.
4. Preserve clinical services which are functional, unless it is both economically and clinically feasible to divest them. DMHDDSAS must ensure that adequate community capacity is thoroughly documented as part of its approval of local business plans and that divestiture of clinical services is suspended pending demonstration of an adequate provider safety net.
5. Where there are insufficient numbers of public sector clinicians to serve consumers, take active steps to retain and recruit needed staff for the system.
6. State Hospital beds not be downsized until it is clear those beds are no longer needed as a safety net for consumers.
7. DMHDDSAS re-engage with significant stakeholders with regular face-to-face substantive planning and communication efforts.
8. Future DMHDDSAS and Legislative Oversight Committee reports on the progress of Mental Health Reform must focus on person-/consumer-oriented measures of clinical impact.

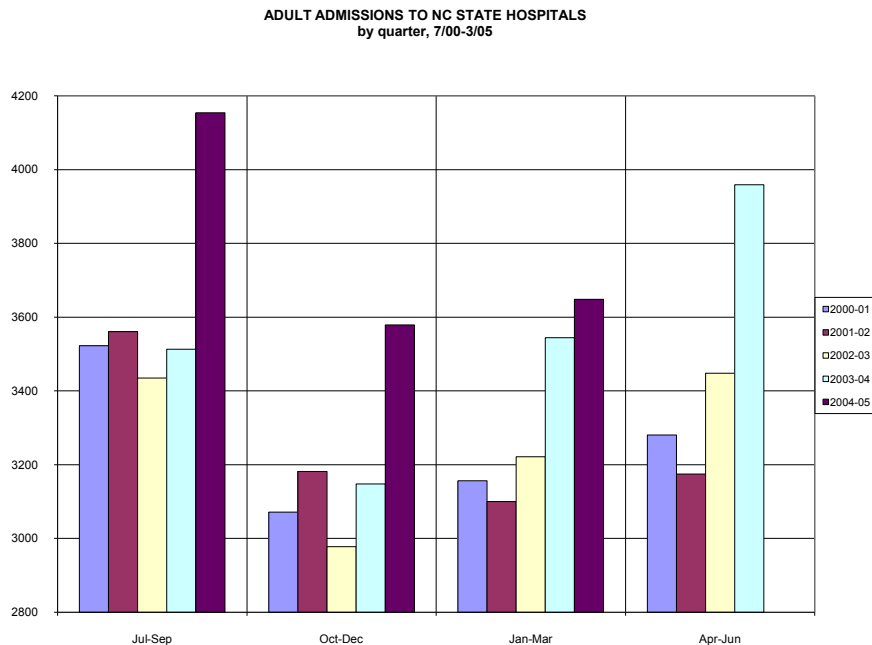
APPENDIX - The Data: Admissions to North Carolina State Hospitals

1. Have Adult State Hospital Admissions Decreased?

No. In fact, adult admissions have risen dramatically since March 2004.

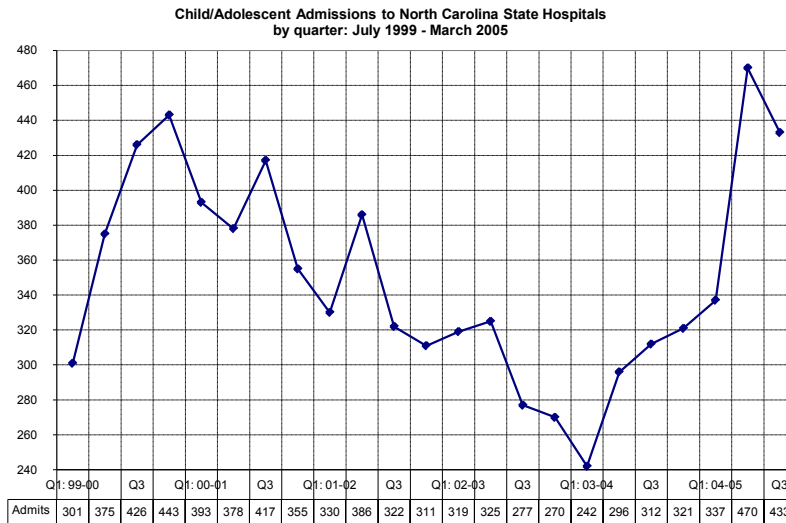


The increase in adult admissions since March 2004 is remarkable. While there has been a seasonal downward trend in adult admissions since September 2004, there is no evidence that adult admissions are likely in the short-term to return to the level prevalent before February 2004. As can be seen in the Figure below, each of the last nine quarters has seen more adult admissions than the same quarter the year before.



2. Have child/adolescent admissions decreased?

Not since August 2003.

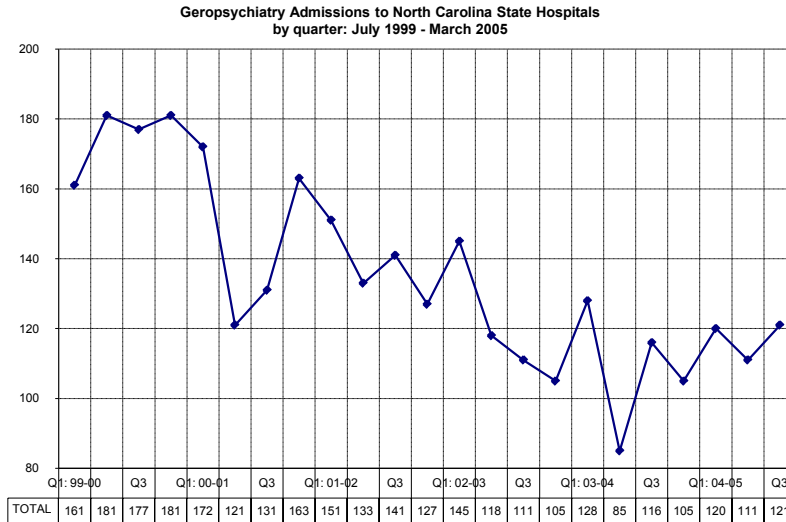


From Apr-Jun 2000 (with 443 admissions/quarter) until Jul-Sep 2003 (with 242 admissions/quarter), North Carolina child/adolescent state hospital admissions showed a remarkable steady decrease of 45.4%.

This encouraging trend abruptly reversed in August 2003. Since then, North Carolina has experienced five straight quarters of increased admissions, to a high of 470 in Oct-Dec 2004, an increase of 94.2% in the five quarters since July-Sept 2003.

3. Have geropsychiatry admissions decreased?

Geropsychiatry is the one age-group whose state hospital admissions have maintained a decline since July 1999-June 2000 (with 700 admissions/4 quarters). Since then, admissions have declined 34.7% to 457 in Apr 2004-Mar 2005.



As the Figure above shows, this trend began with a sharp 30% decrease in geropsychiatry admissions in Sept-Dec 2000; however, this decrease was reversed by a 34.7% increase in admissions over the next two quarters. Geropsychiatry admissions have steadily declined since then, with a slight increase since Jan-Mar 2004.

TECHNICAL NOTE:

Changes in admissions on page one compare the year from April 2004 to March 2005 to the baseline year, July 1999-June 2000.