NC TIDE

North Carolina Training, Instruction, Development, and Education (NC TIDE)

MARCH 2012

Spring Issue

Volume 1 Issue 1

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Special Interests:

"The False Claims Act (State FCA) legislation was enacted by the N.C. General Assembly on January 1, 2010, in Session Law 2009-554 to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent."

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A Message from the President

Victor Armstrong

Greetings,

The service delivery system in North Carolina continues to evolve. As we undergo this evolution, it is imperative that we do so in an efficient, effective, and responsible manner. Every step in this process must be taken with an eye toward the betterment of the system as a whole and the delivery of the best possible product for consumers and stakeholders. In keeping with the "spirit of evolution" our organization has evolved as well. In the spring of 2011, NC FARO was reborn as North Carolina Training, Instruction, Development, and Education (NC TIDE). FARO began as a forum for financial and reimbursement staff of the public system in 1975. Over the years that role expanded to the point where it became necessary to "rebrand" the organization. While the name has changed, the commitment to excellence has not, as evidenced by NC TIDE's mission statement "***A Tradition of Excellence in Providing Training and Promoting Professionalism"***.

NC TIDE membership includes staff from all aspects of the Mental Health, Developmental Disabilities and Substance Abuse Services field. NC TIDE addresses topics ranging from finance and reimbursement to clinical practices, customer service, and community collaboration and outreach, and many more. We continue to enjoy tremendous support not only from LME/MCOs, consumers and families, provider agencies, and advocates, but also from the staff of various state offices such as the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Medical Assistance, and UNC School of Government.

The NC TIDE **Spring 2012 Conference** will be held in Wilmington, NC on April 22 -25, 2012 at Hilton Wilmington Riverside. The NC TIDE planning committee has worked extremely hard to put together a quality conference. The committee has made a conscious effort to include sessions that will be of interest to consumers and families, providers, LME/MCO staff, board members, and advocates. It will be the perfect opportunity for stakeholders to be trained together and to have opportunities to re-connect and establish new networking relationships. As always, the NC TIDE conference will enjoy the resources and financial support of our exhibitors. This year's exhibitors include software and hardware exhibitors, document support, insurance exhibitors, consulting services, providers of services to consumers, and many more. We appreciate our exhibitors for the information and services that they provide and their financial contributions.

NC TIDE is extremely excited about the conference. We are confident that you will want to be in attendance to take advantage of the many opportunities to learn and to network. I look forward to seeing you in Wilmington!

Victor Armstrong, President
NC TIDE

CONFERENCE UPDATE

KEYNOTE ADDRESS: Investing in Yourself (and Your Employees)

As organizations push employees to work and succeed in the bigger, faster, better model, the reality is strikingly opposite. We are sliding down the slope of unproductivity and facing massive health issues, courtesy of increasing and ever-present levels of stress. This session will focus on four essential areas, long neglected by you and your employees, as a means to increase productivity and impact of employees in all aspects of their lives. As the session evolves, you will learn how to identify and rectify your areas of crisis and fully understand why this approach has been successful in dramatically improving the lives of employees, inside and outside of the workplace walls.

KEYNOTE SPEAKER

Shannon Tufts, Ph.D.
Assistant Professor and Director of the Center for Public Technology
University of North Carolina at Chapel Hill

Profile

Shannon Tufts designed and implemented the first local government Chief Information Officers Certification program in the nation and continues to run CIO certification programs for local and state government IT professionals. She created a National Certified Government Chief Information Officer program in 2007, in order to serve the growing needs of public sector IT professionals across the nation. Tufts has taught numerous courses on public sector information systems across the US, including IT investment strategies, embracing technology, project management, and stakeholder engagement in technology-enabled government. She serves on several federal, state, and local government committees to promote the effective use of technology in the public sector. Her publications in the area of e-government and public sector information technology include Humanizing IT: Advice from the Experts with G. David Garson, numerous book chapters, and articles in Social Sciences Computer Review and Popular Government.

Ms. Tufts was selected by *Government Technology* magazine as one of the Top 25 Doers, Dreamers and Drivers for 2010. The magazine honors people "who cut through the public sector's infamous barriers to innovation—tight budgets, organizational inertia, politics as usual, etc.—to reshape government operations for the better." Many of the programs that Shannon has created do not focus on teaching technology skills. Instead, she has been a national leader in developing model programs that give technology professionals the leadership and management skills to make strategic IT business decisions. Tufts holds a BA from UNC-Chapel Hill, an MPA from UNC-Charlotte, and a PhD in public administration with a concentration in public sector information systems from North Carolina State University.

ATTENTION: All Outpatient Direct Enrolled Behavioral Health Providers

Upcoming Provider Audit and Investigation Initiative, February 28, 2012 - June 30, 2012

By Patrick Piggott, Chief, Behavioral Health Review Section, Program Integrity
Division of Medical Assistance

Starting February 28, 2012, the Program Integrity Unit, Behavioral Health Review Section and its Partners will be conducting unannounced and announced provider audits and investigations for several Outpatient Behavioral Health providers identified through IBM Fraud and Abuse Management System and complaints or referrals. The audits and investigations will span all geographical regions of the State and will involve independent providers and group practices to include Critical Access Behavioral Health Agencies – Outpatient group and independent practices. According to Session Law 2011.399 or North Carolina General Statues 108C, these Behavioral Health Providers are designated as "high categorical risk".

There will be four phases during this Audit and Investigation Initiative. Phase I includes attending providers with high dollar claims and the associated group practices, top 50 attending providers with the high dollar claims for a period of 3/1/2009 to 12/31/2011, and providers with complaint/referral allegations. Phase II includes attending providers with paid claims amount greater than or equal to $300,000 by individual calendar years and their associated billing providers. Phase III includes attending providers with paid claims greater than or equal to $200,000 to $299,999 by individual calendar years and their associated billing providers. Phase IV includes attending providers with paid claims greater than or equal to $100,000 up to $199,999 and their associated billing providers.

This Initiative is the first of its kind for Outpatient Behavioral Health providers. The first announcement of this Initiative was conveyed by Program Integrity during the November 2011, 8C Training conducted in Asheville, Charlotte, Raleigh, and Wilmington. Providers should review the Program Integrity Webpages at http://www.ncdhhs.gov/dma/pi.htm, and Special Medicaid Bulletin, http://www.ncdhhs.gov/dma/program%20integrity/Special%20Bulletin102011.pdf, There will be several Partners assigned to this Initiative to include DMA Program Integrity, Behavioral Health Review Section, Public Consulting Group (PCG): Advanced Med (Medi-Medi Contractor for the State of North Carolina); Carolina Centers for Medical Excellence (CCME); IBM Technical and Business Support Team; DMA Clinical Policy-Behavioral Health Section, Information Technology Unit, and Provider Services Unit; Computer Science Corporation-Enrollment, Verification, and Credentialing Unit, and Hewlett-Packard.

Advance Med will focus on Medicare claims associated with each provider's billing and payments received. PCG is an extension of Program Integrity and will continue to conduct onsite audits and investigations.

Program Integrity identifies provider claims for review and assigns cases to an investigator, analyst, or PCG. The full scale of operations includes but not limited to the following:

- Receive Fraud and Abuse Management and Detection Systems leads, complaints, and/or referrals
- Determine a time period to review claims and pull a population of claims
- Establish a statistically valid claim review sample from the population of claims
- Conduct an administrative and/or clinical audit or investigation
- Use the RAT-STATS Software 2007 Version 2.0 (Windows-based software approved by the U.S. Office of the Inspector General) to determine the sample size and extrapolated overpayment amount.

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Program Integrity's and PCG's responsibilities include:

- Initiating contact with the provider, announced or unannounced
- Informing the provider of the post payment audit or investigation process requirements to include entrance and exit conference
- Working closely with the provider to complete the Audit/Investigation in a timely manner with the least disruption to the provider agency
- Advising the provider who to submit documentation to and establishing points of contact during the onsite
- Addressing provider questions regarding the post payment audit or investigation process
- Comply with hours of operation, unless Owner or Management willing to extend the hours during this time.

Provider's responsibilities:

- According to Session Law 2011.399 or N.C.G.S. 108 C-11, providers shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department. Providers who fail to grant prompt and reasonable access or who fail to timely provide specifically designated documentation to the Department may be terminated from the North Carolina Medicaid or North Carolina Health Choice Program
- Establish a convenient workspace for the Program Integrity's or PCG's staff, preferably an office or conference room
- Access to Managerial, Financial, Administrative, and Clinical Staff, if necessary
- Refrain from adjusting claims with Hewlett-Packard for the designated period in question
- Participate in entrance and exit conference.

If the provider's claims are determined to be out of compliance, a Tentative Notice of Overpayment letter will be sent to the provider in the amount of the overpayment. In accordance with 10A NCAC 22F.0402, reconsideration and appeal rights will be offered to the provider if the provider does not agree with the findings of the review. Instructions for the reconsideration review and appeal rights are included with the Tentative Notice of Overpayment letter.

If the preliminary investigation supports the conclusion of possible fraud, as defined in NCGS 108A-63, the case shall be referred to the appropriate law enforcement agency for a full investigation, in accordance with 10A NCAC 22F.0203. As a reminder, the False Claims Act (State FCA) legislation was enacted by the N.C. General Assembly on January 1, 2010, in Session Law 2009-554 to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent. This legislation applies to any service that is reimbursed with State funds, not just claims for Medicaid services. The legislation stipulates that any person who presents or causes to be presented a false or fraudulent claim is liable for three times the amount of damages sustained by the State; the cost of the civil action brought by the State; and penalties of between $5,500 and $11,000.

Review Tool and Guidelines will be posted on the Program Integrity Webpages for provider's convenience and to help providers conduct their own internal quality assurance reviews.

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NC TIDE 2012 Spring Conference

April 22-25, 2012

Location: Hilton Wilmington Riverside

On Becoming a Managed Care Organization

By Mark Besen, Ph.D., Area Director
Onslow Carteret Behavioral Healthcare Services

It was 10pm on a Saturday evening and I was still at work. We all were. We had been at it all day, putting the final touches on a lengthy response to a request for proposals that was due by the end of the business day on Monday. Our response would be close to a thousand pages long. This was the last step in a lengthy process that involved working with two consulting groups over a period of months to help us understand this new concept called a Medicaid Waiver. The process forced us to rethink our entire organizational structure and how services could be delivered to achieve maximum efficiency, effectiveness, quality and accessibility. The state was in the process of transforming the method in which it funded services for persons who were eligible for Medicaid and we were only one of many groups in the process of responding to requests to become a public entity to manage capitated Medicaid contracts. The year was 1995 and the place was Washington State. We were about to enter into a transformation of behavioral healthcare that to this day I still believe resulted in one of the strongest behavioral health service delivery systems in which I have worked.

I had no idea that 17 years later I would find myself in a similar position, this time as a director of a Local Management Entity involved in the current transformation of the behavioral healthcare system in North Carolina. There are still many questions about how the new regional Managed Care Organizations that are being created will perform. Likewise, there is much concern about what the implications will be for providers of services and most importantly for the individuals and families of persons participating in behavioral health and intellectual/developmental disability services. Still, based on my experience there is one thing that I firmly believe. Under a public managed Medicaid system there are many opportunities to improve the quality of care for the citizens of North Carolina through aligning incentives between the Division of Medical Assistance, the Regional Entities Managing the Funding, and the contracted providers of service. So as we prepare for a new session of the NC TIDE conference I thought I would highlight some of the positive ideals to which a publically managed Medicaid system can aspire.

The first ideal is **effectiveness**. Currently under a fee for service system there is little incentive for providers of Medicaid services to focus on meeting demonstrable outcomes of care other than it is the right thing to do. Within a capitated funding system in which the State Division of Medical Assistance and the Regional Managed Care Organizations, i.e. MCO's (and in some cases providers) are at financial risk if they cannot operate within limited funding, there is tremendous incentive for having a network of providers who can effectively help people improve their ability to succeed in their lives without requiring expensive and restrictive levels of care. There will be significant pressure for the new MCO's to invest in only those providers who are able to demonstrate that they can assist populations in reducing the need for emergency room visits for suicide attempts, overdoses or other medical complications due to behavioral health disorders, inpatient psychiatric or substance use hospitalizations, institutional treatment for persons with developmental disabilities, and unnecessary outpatient care as these expenses reduce available funding for those in need in the community. With a closed network system, those providers who can demonstrate the ability to be effective in their treatment will succeed, thrive and grow. Conversely those providers who are unable to achieve expected outcomes of care will not continue to remain in the network. This will result in a higher standard of care for the public.

The second ideal is increased use of **Evidence Based Practice**. Because providers will be under greater pressure to demonstrate that they are able to effectively assist persons improve their ability to function in community settings and develop skills to manage risk factors, providers will have significant incentive to adopt practices that will increase their ability to be effective with the populations they serve. There are many research based practices that are well known

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and have been shown to result in better outcomes. Unfortunately these practices are not currently present in many of the services being delivered in North Carolina. The pressures created by a capitated funding system for Medicaid will drive MCO's to contract for specific practices and encourage provider organizations to adopt practices that will allow them to achieve better results.

A third ideal is **creativity and innovation**. Having to manage within limited funding forces the State, the Regional MCO's and provider organizations to rethink how they provide services. There will be an emphasis on community planning to create more cost effective, accessible and creative alternatives that assist persons in participating in needed care prior to developing a need for more restrictive and expensive services. Examples of the types of new care alternatives that may be created to meet this demand are: 1) free standing, 24 hour crisis centers that people can access instead of emergency rooms; 2) community based crisis residential/detox facilities as alternatives to inpatient care; 3) urgent medication clinics or intake assessments including participation of a prescriber where persons may receive timely access to psychiatric medications at their first visit; 4) increased systems of natural supports and peer driven resources such as wellness cities, free education classes on skills development through community colleges, and use of technology to link people with similar support needs and 5) emphasis on consumer run business and residential alternatives to institutional settings for person with developmental disability. What is especially exciting is that under a managed Medicaid system, savings that occur by reducing need for more expensive and restrictive care can be put back into developing greater community resources.

Finally, a fourth ideal of a publically managed Medicaid is that when it comes to community behavioral health**, public is better than private**. After spending over 25 years in clinical practice and management of large community behavioral health organizations, I am of the opinion that a sense of community involvement and investment makes an enormous difference in the outcomes that can be achieved in system redesign. Although I may catch grief from certain parties for taking this position, it has not been my experience that large, for profit, nationally based managed care companies share the same community investment as locally based public entities. Relationships and willingness to partner with community stakeholders and developing a clear understanding of the local needs of communities is critical in creating effective resources to meet unique community needs. The boards of the regional managed care entities will include local community representatives and county commissioners who are invested in the welfare of their region. The staff of the new MCO's will live and work in the same areas where they are responsible for managing services. These will be the same services that their neighbors, friends and family may access. The new MCO's will not be profit based. With the exception of ensuring there is enough funding in a risk reserve pool, there is no incentive to make a profit so more funding goes back into developing effective resources for local communities. These things make a difference.

So as we prepare for another energizing and I hope valuable session of NC TIDE, I wanted to provide a message of hope and encouragement regarding the changes that are taking place within North Carolina. With all of our combined efforts I know that we will achieve a more effective and accessible network of services for those most in need.

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NC TIDE Spring 2012 Conference

REGISTRATION SAVINGS!

- Register 4 individuals for the FULL conference from only your agency and get the 5th registration from your agency FREE (one day registrations do not count).
- Register 3 CFAC individuals for the FULL conference from only your agency and get one staff member from your agency registration FREE (one day registrations do not count).

Transition to Waiver Model Puts Focus on Patient Outcomes

By Michelle Edelen, Communications and Training Team Leader
Department of Health and Human Services

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is quickly approaching a new frontier as it works to create a better more efficient and effective model for serving individuals with mental illness, intellectual and developmental disabilities and substance abuse disorders. The new landscape we are about to inhabit was written into legislation in June 2011 as House Bill (HB) 916. The bill instructed the Department of Health and Human Services (Department) to proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities and substance abuse disorders through expansion of the 1915 (b)(c) Medicaid Waiver. The Department's Divisions of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and Medical Assistance (DMA) together with local management entities (LMEs), Piedmont Behavioral Health (PBH) and key stakeholders put together a strategic plan delineating specific strategies and agency responsibilities to achieve the objectives and deadlines set forth in the legislation.

Established in 2005, Piedmont Behavior Health (PBH) was for several years the states only waiver entity. With the new legislation, North Carolina will have a total of 11 local management entity-managed care organizations (LME-MCO) by January 2013. Six LMEs were selected through a Request for Application (RFA) process that looked for entities which met very specific requirements such as population requirements of 300,000 by 2012 and 500,000 by 2013. In the previous RFA application process, four LMEs submitted applications. Of the four, Western Highlands and Mecklenburg proceeded forward. Subsequently, HB 916 allowed Sandhills Center and East Carolina Behavioral Health to proceed without resubmitting new applications. Additionally, each LME-MCO had to submit a strategic plan delineating specific strategies and agency responsibilities for the achievement of statewide expansion of the 1915 (b) (c) Medicaid Waiver. The LMEs selected to proceed forward with LME-MCO implementation were announced by August 2011. The proposed transition timeline for the LME-MCOs is as follows.

The current LME-MCO, PBH, will be expanding on the following schedule:

- PBH was originally comprised of Union, Stanly, Cabarrus, Rowan, and Davidson counties
- Alamance and Caswell Counties were added October, 1, 2011
- Five County LME, consisting of Franklin, Vance, Granville, Warren & Halifax counties were added January 1, 2012
- OPC LME, consisting of Orange, Person, and Chatham counties will be added April 1, 2012

The following LMEs will be expanding to become LME-MCOs on the following schedule:

- January 3, 2012
    - o Western Highlands Network, consisting of Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey counties

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- April 1, 2012

  o East Carolina Behavioral Health LME, consisting of Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington counties

- July 1, 2012

  o Sandhills LME, consisting of Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties

  o Smoky Mountain Center, consisting of Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga, and Wilkes counties

- January 1, 2013

  o Pathways, consisting of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, and Yadkin counties

  o Eastpointe, consisting of Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson counties

  o Mecklenburg LME

  o The Durham Center, consisting of Durham, Wake, Cumberland, and Johnston counties

  o CenterPoint, consisting of Davie, Forsyth, Rockingham, and Stokes counties

  o Southeastern Center (ECCS), consisting of Brunswick, New Hanover, Pender, Onslow, and Carteret counties

The DMH/DD/SAS has worked with DMA and the newly selected LME-MCOs to ensure a strong implementation process. Several supports have been implemented to foster consistent communication between the DMH/DD/SAS and the LME-MCOs. One example is the Department of Health and Human Services Strategic Implementation Plan. This plan is organized around a framework encompassing the State's vision for the Waiver initiative and goals. It is based on an assessment of strengths and the challenges that lie ahead. At its core, the plan will provide a vehicle for active communication with all stakeholders across the State and for coordinating detailed implementation tasks among the Department, DMH/DD/SAS, DMA, LMEs, providers and consumers and family members.

Another support which has been established is the Department of Health and Human Services Waiver Advisory Committee. This committee serves as an advisory body to the Department that will provide input and consultation over the following:

1. Implementation/Operational phases of the 1915 (b) (c) Medicaid Waiver.
2. Ongoing LME-MCO operations (Medicaid managed care, Innovations, and LME operations).

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Additionally, the committee will

- Review quarterly and annual report summaries of LME-MCO performance
- Provide consultation around local and statewide system goals
- Review outcome measures and trend data
- Highlight and recommend areas of best practice
- Assist with problem identification and resolution.

The committee membership consists of representatives from LME-MCOs, local providers, State and Local Consumer and Family Advisory Committee members, External Advisory Committee members, County Commissioners, NC Council of Community Programs members, DMH/DD/SAS staff, DMA staff and the Deputy Secretary for Health and Human Services. This broad representation is congruent with the belief that it takes stakeholders from across our system to make the LME-MCO model the success we all desire it to be.

An additional support is the establishment of Intra-Departmental Monitoring Teams (IMTs). These IMTs have DMH/DD/SAS and DMA staff representation and are specific to a set of LME-MCOs. The agenda is consistent for each IMT and it facilitates an opportunity to report on functional areas of development for each LME-MCO. One IMT meets via conference call with the LME on Wednesday of each month. For example, Mecklenburg, Smoky Mountain and CenterPoint meet the 2nd Wednesday of each month. The IMT meeting is a useful tool for continued and necessary communication between participants.

The supports established to facilitate success do not just stop at Committees and Strategic Plans. They also include clarification and dialogue on consistent methods of payment for LME-MCOs. The DMH/DD/SAS issued two memos on January 25, 2012 which address the LME-MCO System Management Administrative Allocation Plan and the Community Funding Efficiency Plan.

Because of the transition of LMEs to LME-MCOs, the Systems Management payments which were allocated between Medicaid and State funds will end. Moving forward, DMA will cover the cost of administration and care coordination related to managing the Medicaid contract through an administrative percentage of its monthly capitation payments to LMEs. Similarly, DMH/DD/SAS will cover the cost of administration and care coordination related to managing State funds through an administrative percentage of the community service funds. The goal is to allocate sufficient funds to each LME/MCO to perform administrative functions related to management of State funds and federal block grant funds, and as required to deliver State-funded Community Program services.

The Community Services administrative rate has two components that comprise the Agency's overall administrative rate. They are the General Administration including Care Coordination and Risk Reserve. Under this plan, there are no longer separate allocations for "Services" and Systems Management." There will be a single allocation which includes both service dollars and systems management dollars.

Additionally, the DMH/DD/SAS staff, NC Council staff and the LME Management Systems Workgroup agreed upon the following changes related to the Community Funding Efficiency Plan.

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• In order to meet the legislative $25 million fund balance reduction for the FY 2012 appropriation established by the General Assembly, per HB 200 [10.11.(a) - (f)], expenditure and reporting of the LMEs use of fund balance, the LMEs will

a. Reclassify a portion of their reported State Non-UCR expenditures [beginning on July 1, 2011] in an amount equal to or greater than the LME's allocated responsibility, per the Division's 2011 Allocation Letter, for the $25 million in fund balance expenditures mandated by the General Assembly. This amount will be reclassified to show it was expended from fund balance and will not count towards the LMEs earnings of their Single Stream allocation. Note: A separate process will be applied for the Beacon Center.

b. The same Non-UCR reclassification will apply for those LMEs that committed at the beginning of the fiscal year to spend some of their fund balance dollars toward the $20 million "encouraged" reduction from fund balance.

• A new category will be included on the quarterly Fiscal Monitoring Report for the LMEs to report all related expenditures by the LME for the implementation and/or conversion to a Managed Care Organization (MCO).

• The LME Performance Contract for FY 2012 will be followed for payment and settlement of single stream funding. The Division will track each LME's reported earnings through shadow claims and Non-UCR monthly expenditure reports. If the LMEs' earnings through shadow claims and Non-UCR expenditures are less than 85% of the LME's single stream payments at the end of each of the remaining months in the fiscal year, the LME's single stream payment will be withheld until earnings and reported expenditures reach at least 85% of payments made.

• The DMH/DD/SAS will compute the amount each LME is required to earn through shadow claims and Non-UCR expenditures for FY2012, in accordance with the contract. Those LMEs that have not earned 7/12ths of the required amount as of January 31, 2012 will be contacted to determine why earnings are not on track. Funds may be reallocated from under-earning LMEs on a one-time basis this fiscal year in accordance with Section 10.8(d) of HB 200.

The transition of LMEs to LME-MCOs has been a major undertaking. It has required significant shifts, both internal and external, for the LMEs so they can manage services in a more comprehensive manner. The internal shifts have impacted the Information Technology (IT), Financial/Claims Adjudication and Utilization Management (UM) systems, the provider network as well as customer service and administrative functions. The external shifts have impacted boards of merging entities, providers, consumers and family members, County Commissioners, County Social Service organizations and many other stakeholders such as law enforcement, hospitals, school systems and other community stakeholders. These transitional shifts have occurred in a very short amount of time and the work efforts involved have been very intense. The Department, the DMH/DD/SAS, the DMA, the LME-MCOs, PBH and all other stakeholders are learning to work together collaboratively more so now than ever before. To ensure that the transition to the statewide waiver model is successful for all involved, each of these partners must ensure that they are supplying their necessary (although sometimes different) solutions.

Why Customer Service?

By Larry C. Elmore, MHA, MSW, LCSW
Director of Quality Improvement
Daymark Recovery Services
June 30, 2011

A couple of years ago, the Center of Medicare and Medicaid Services (CMS) decided to challenge the hospitals of America to look at customer service. The first response from individual hospitals and the hospital industry as a whole was "why?" While the provision of healthcare is technically a "service", and patients are kind of like customers, hospitals could not fathom why the Federal Government wanted to tie Medicare payments to the provision of good quality healthcare services. Besides, everyone knows that "healthcare" in the United States is the best in the world, or is it?

Several years ago, I attended a healthcare conference on improving customer service and the speaker was a very crusty, older Emergency Department Nurse Manager. For those of you who remember Roseanne Barr, this woman made Roseanne look like a mild mannered pre-teen. It was hard to believe that she was going to lead a workshop on providing good customer service!

She started off by saying that her training, and her experience, had taught her that she was there to "…put butts in beds, not kiss them!" She went on to say that her twenty years of Emergency Department work in one of Chicago's most marginal hospitals had proven that she was right. She ran a high volume and reasonably efficient Emergency Department.

Then her hospital administrator began to look at the numbers and the number of customers, especially paying customers, was declining. The neighborhood wasn't changing; it was simply that those that could afford to go elsewhere were going elsewhere! Given that the ED is the front door of the hospital, it was there that the hospital administrator chose to start. And, for the first time in her life, this experienced ED manager had to think about how to improve customer service and build customer loyalty. Literally, her job depended on it.

Does this have any applicability to the behavioral health system in North Carolina? Do we treat our "clients", "patients" or, as CARF would say "persons served", as customers? Do we really believe that our jobs depend on the people coming in the door seeking services?

In the CABHA where I work, the "Calendar year 2011 Consumer Satisfaction Survey" results were recently distributed. Truthfully, we looked pretty darn good! The average score for CY 2011 was 96% compared to 94% for 2010 and 93% for 2009. For those of you who are not familiar with how we survey, it has twelve (12) questions aimed at eliciting a response around timeliness/service availability, treatment goals and progress, courtesy/ respect, cultural sensitivity, and treatment outcomes.

When you look beyond the numbers, you'll find some dissatisfaction with wait time to see physicians, time of day that services are provided, and lack of one-on-one counseling.

Telemedicine, which is one of our largest services, is surveyed separately. Again, the overall numbers were good (averaging in the 90+ percent range), but they also included a few dissatisfiers. Consumers complained about the TV image quality, difficulty hearing, tardiness of the physician, and their overall preference for a personal face-to-face contact.

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How can we, or you for that matter, improve on what you are already doing? Below are a few tips that you'll find in any article on Customer Service. While they might appear to be "no brainers", you'll be amazed at the difference it will make if put into practice! These are the very same practices that companies like Apple Computer, Nordstrom's and Starbucks use. They are:

- **Personal contact** – When possible meet with the consumer or their family in person rather than communicating by phone or by e-mail;
- **Communication** – By all means communicate! This is the most frequent dissatisfier in healthcare, especially behavioral healthcare;
- **Timeliness** – Health issues provoke anxiety and people don't like to have to wait for appointments, to see someone or to get a call back;
- **Friendliness/Approachable** – Is it hard to imagine that we might be intimidating? According to CMS data, providers are very intimidating and seeking help is difficult;
- **Attention To Details** - Remember the old saying "the devil is in the details?" It is still true. A successful therapeutic relationship can be ruined by failing to pay attention to the details, like keeping appointments, being on time or following up as you promised; and
- **Honor Your Promises** – Finally, consumers of behavioral health services often seek help as a last resort. They are looking to you to provide comfort and guidance. Don't betray their trust. It was hard to come the first time and, if betrayed, they may never return.

As a provider of behavioral health services in North Carolina, you must exhibit a living and verifiable (through surveys) commitment to good customer service. Customer service is about one thing – proving to the people who use our service that it is worthwhile and something they would use again or recommend to others!

Keep up the good work!

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NC TIDE 2012 Spring Conference

Take advantage of savings for your organization – register by April 2, 2012

Registration Agenda is available on NC TIDE website at www.nctide.org

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An Extension on Hotel Room Reservation Has Been Given, But Ends March 28, 2012

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