STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

NEW VISTAS – MOUNTAIN LAUREL, INC.

MENTAL HEALTH SERVICE PROVIDER

MAY 2007

OFFICE OF THE STATE AUDITOR
LESLIE W. MERRITT, JR., CPA, CFP
STATE AUDITOR

PERFORMANCE AUDIT

NEW VISTAS – MOUNTAIN LAUREL, INC.

MENTAL HEALTH SERVICE PROVIDER

MAY 2007

STATE OF NORTH CAROLINA
Office of the State Auditor

Leslie W. Merritt, Jr., CPA, CFP
State Auditor

2 S. Salisbury Street
20601 Mail Service Center
Raleigh, NC 27699-0601
Telephone: (919) 807-7500
Fax: (919) 807-7647
Internet http://www.ncauditor.net

May 15, 2007

The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Ms. Carmen Hooker Odom, Secretary
North Carolina Department of Health and Human Services
Ms. Carol Minton, Board Chair
New Vistas - Mountain Laurel, Inc.

Ladies and Gentlemen:

We are pleased to submit this performance audit entitled *New Vistas – Mountain Laurel, Inc*. The objective of the audit was to determine the cause(s) of the demise of this entity. Ms. Minton and other appropriate members of management reviewed a draft copy of this report. An official response from the Board of New Vistas - Mountain Laurel Community Services is included in the appendix to the report.

We wish to express our appreciation to Board Chair Minton, the Board of Directors, CEO William Callison and his staff for the courtesy, cooperation, and assistance provided us during the audit.

Respectfully submitted,

Leslie W. Merritt, Jr.

Leslie W. Merritt, Jr., CPA, CFP
State Auditor

TABLE OF CONTENTS

Summary

The demise of New Vistas - Mountain Laurel, Inc. (NVML) was an unfortunate event in the system of mental health reform. There were contributing factors to the closure of NVML that are attributable to systemic issues within mental health reform; but many of the problems encountered by NVML would severely compromise the ability of any organization to survive. Those problems included:

1. NVML was created by the area authorities as a single source provider that did not meet the newly established requirements of mental health reform.
2. NVML was not able to overcome the cultural challenges necessary to function as a private provider. The majority of the personnel had worked in an environment that was not conducive to profitability and struggled with the move to service delivery in the fee for service model.
3. NVML's business plan did not adequately address the strategic issues prerequisite for it to be a successful business venture.
4. NVML did not adjust timely to regulatory changes affecting the mental health billing process.
5. NVML encountered financial instability from its inception, including inadequate capital resources, cash flows, information systems, and financial management systems.
6. NVML experienced staffing deficiencies including loss of key personnel, staffing turnover, and insufficient staff training.
7. NVML's communication with its stakeholders diminished over time that resulted in difficult working relationships and an overall loss of confidence in NVML's ability to be successful.
8. NVML was not receptive to stakeholder assistance.

The Chief Executive Officer of NVML made many statements as to why NVML failed. One such statement discussing what led to the closing of NVML noted "*a 25% fee reduction, a merger, a re-engineering of your entire clinical model, hiring 200 staff and then a new computer system all in 12 months, you start to see the picture of the overwhelming challenges at hand*." The 25% rate reduction speaks to the rate-setting process that was applicable to all providers, but was particularly detrimental to NVML's core services. The merger, re-engineering, hiring of staff, and implementation of a new computer system were business decisions made by NVML in its attempt to become a successful provider in the current mental health reform environment.

We also identified several global mental health issues that have been challenges to mental health reform. Issues noted were:

1. What roles should the State and the counties play and where does their authority begin and end in the implementation of mental health reform?
2. Will all services be available and provided in each designated service area of the State?
3. What will prevent the private provider network from only providing profitable services and delivering services to only those patients who are fully funded and easier to care for?
4. Should there continue to be two different processes for authorization and utilization management services (State funded vs. Medicaid funded)?
5. There continues to be a need for standardization of forms, contracts, and processes at the local level in an effort to bring stability to the business environment.
6. Can the administrative processes related to the provision of care be streamlined to reduce the overhead costs?
7. Should the current rate structure address differences between rural and urban areas?
8. Questions arose throughout our fieldwork related to the functions of the local management entity and its responsibilities. Those concerns were regarding the appropriate number of entities, the provision of case management activities, authorization management, and billing/payment functions.
9. There is a need for crisis centers to provide clients treatment during a mental behavioral emergency. This need must be addressed in relation to the phase-out of the State mental health facilities.
10. NVML is the second spin-off entity to cease operations. Closer scrutiny may need to be given in the development of the provider network to ensure that organizations can survive in the private fee-for-service environment.

NEW VISTAS - MOUNTAIN LAUREL'S RESPONSE

The response from the New Vistas – Mountain Laurel, Inc. (NVML) is included in the appendix.

Introduction

BACKGROUND

Prior to 2001, mental health services had been delivered for an eight-county area in western North Carolina by three area authorities:[1] Blue Ridge, Trend, and Rutherford-Polk. Counties served by these three area authorities were Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey.

In 2001, the General Assembly of North Carolina adopted mental health[2] reform legislation. One of the objectives of the reform was to transition area authorities from service providers to managed care entities. The State's plan provided for the formation of regional units, described as Local Management Entities (LMEs), to provide oversight and management of mental health services for a designated region of the State.

In January 2004, the LME formed by county officials from the eight-county region became operational and was identified as Western Highlands Network (WHN). WHN was responsible for merging the three area authorities and developing a private service provider network. In developing this network, WHN was concerned about the possibility of an insufficient number of private providers to deliver all mental health services. To address this concern, WHN contracted with Mountain Laurel Community Services, Inc. (Mountain Laurel) to serve Henderson and Transylvania counties; and New Vistas Behavioral Health Services, Inc. (New Vistas) to serve Buncombe, Madison, Mitchell, Polk, Rutherford and Yancey counties. Divestiture of services from the area authorities to both organizations was completed by March 2004. Both of these organizations had as its mission to be the safety-net provider[3] in their region; however, both organizations experienced operational challenges.

As a result of financial difficulties and the quest for administrative costs savings by creating a consolidated service provider, Mountain Laurel and New Vistas entered into formal merger negotiations in early 2005. New Vistas began managing Mountain Laurel in June of 2005. In January 2006, Mountain Laurel and New Vistas merged to form New Vistas - Mountain Laurel, Inc. (NVML).[4] The combined organization was the largest provider in the region served by WHN. During 2006, the new combined organization continued to experience losses and struggled to generate positive cash flows. Effective October 31, 2006, NVML ceased providing clinical services.

[1] Area authority: Mental health, developmental disabilities, and substance abuse service entity for a designated region of the State.

[2] The term mental health is used consistently throughout the report as a shorthand for mental health, developmental disabilities, and substance abuse.

[3] Safety Net Provider: A mental health behavioral entity that will provide services to all persons needing treatment regardless of their ability to pay.

[4] In describing the merger process in the Background section of this report, we believe it would be cumbersome and unnecessary to discuss the report issues in the context of two separate entities. Therefore, from this point forward, we will refer to the combined organization as NVML.

[This Page Left Blank Intentionally]

OBJECTIVES, SCOPE, AND METHODOLOGY

This audit of New Vistas - Mountain Laurel, Inc. (NVML) was performed as a result of a formal request by North Carolina Senator Tom Apodaca, Representative Carolyn Justus, and the Henderson County Board of Commissioners. The objective of the audit was to determine the cause(s) of the demise of NVML.

The scope of our audit encompassed the operations associated with this entity to provide mental health services. Our audit period primarily covered the period 2003 through 2006.

To accomplish our objective, we interviewed board members, organization management, contractors, personnel from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within the North Carolina Department of Health and Human Services, other providers, local management entity personnel, Buncombe County personnel, former employees of the NVML and the Blue Ridge Area Authority, and regional mental health advocates. We reviewed the North Carolina General Statutes relating to mental health reform. We also reviewed the Organization's procedures, financial reports and other documentation provided by management to support actions taken.

We conducted this performance audit according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence that provides a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This report contains the results of the audit including conclusions and recommendations. Specific recommendations related to our audit objectives are reported. Because of the test nature and other inherent limitations of an audit, together with the limitations of any system of internal and management controls, this audit would not necessarily disclose all weaknesses in the systems or lack of compliance.

Our fieldwork took place from November 2006 to February 2007. We conducted this audit under the authority vested in the State Auditor by *North Carolina General Statute* 147-64.6.

[This Page Left Blank Intentionally]

Premise for Reform

The passage of mental health reform legislation did not provide a clear road map as to the process of implementation. Piloting the reform initiatives was not an option; therefore, local mental health area authorities were obligated to implement reform efforts within the parameters established by legislation. The management of the Blue Ridge Area Authority, in looking to provide continuity of mental health services while minimizing the uncertainty of reorganization, established NVML as a spin-off[5] service provider under the new legislative requirements. The intent was that NVML would become the single source provider of the full spectrum of mental health services, including services to the indigent population. The decision was made based on the best information available at the time and within the limited timeframe established by legislation. Due to the complexities of the mental health reform initiatives, this decision was flawed from the beginning.

Creation of a Single Source Provider

Mental health reform directed that area authorities and county programs become local management entities and that public services delivered directly by those programs be divested to private providers. NVML was one of several spin-offs created in response to this transformation to the new service delivery system. The divestiture of services was designed to segregate the management of mental health service systems and the delivery of those same services. It was also a movement from publicly funded treatment services to privately provided services. However, it also placed a tremendous amount of responsibility on a sole source[6] provider to immediately perform at optimal levels, both administratively and programmatically.

The spin-off of an organization is more than just the legal incorporation of a new organization. Important aspects that need to be addressed include the establishment of a quality board of directors, determining capital asset needs for the organization, establishing systems for recruiting and retaining qualified staff, establishing necessary financial systems for sustainability, and developing the necessary organizational culture to accomplish the mission of the entity. Spin-offs also generally require close oversight and support by its originating organization until the spin-off entity can function independently.

In the NVML situation, the initial focus in this transformation process was to minimize the impact of these events on the consumers and to ensure the provision of safety-net services that other private providers might not be interested in providing. An organizational spin-off from the old Blue Ridge Area Authority allowed for a seamless transfer of services to NVML with consumers continuing to be served in the same physical locations. To the consumers, the structural change in service delivery was in name only. However, this type of transformation has its problems. NVML, as a spin-off safety-net provider, was not in a position to control its revenue streams, was dependent on external billing systems, was faced with increased transactional costs related to service delivery, and struggled with its administrative capacities. These conditions contributed significantly to the NVML demise.

[5] spin-off: a division of a larger entity that becomes a new organization

[6] sole source: a situation in the marketplace where there is a single source of supply to meet your needs

The Need for Cultural Change

The mental health service culture of an area authority prior to reform can be described as follows:

- Clients were generally expected to be treated at a facility for mental health services;
- For the most part, the professional mental health staff were facility rather than community based in serving clients;
- The number of patients seen by professional mental health staff was not a major component in measuring performance;
- Clients primarily had one provider for mental health services; therefore, competition for services was minimal;
- The area authority's existence was determined by established funds allocated from government sources, not how profitable services were;
- The area mental health authority was available to provide mental health treatment for everyone regardless of their ability to pay (safety-net provider).

Many of these practices continued into the operational life of NVML and contributed to its financial difficulties and ultimate demise.

As a spin-off, the new organization was the recipient of the management style and many of the clinical personnel of the old area authority. NVML's initial management style was to provide services in primarily a facility-based environment to all clients regardless of the client's ability to pay or whether the cost of services exceeded the reimbursement rate. According to NVML management, "*the fact that the transition was ostensibly seamless lulled many into thinking that it was back to business as usual with the spin-offs simply becoming a private version of the area authorities. They had the same clients, at the same location, and worked with the same colleagues.*"

The majority of the clinical personnel had worked in an environment where they were virtually the only comprehensive mental health provider in the region supported by a known annual funding stream. The old environment also included a significant capital base comprised of cash reserves and buildings that provided further financial stability. With the dissolution of the old area authority, control of this capital base was quickly assumed by local county governments. According to NVML management, "*many staff maintained a sense of entitlement and a denial that our financial landscape was radically different from their former public sector employer context.*" The business plan within a provider network is geared more towards profitability – more patients served, elimination of no-shows, and minimizing non-billable staff. The move to a for profit way of doing business required a rethinking of staff roles and functions. This would require the staff to be less advocacy oriented and more cost/performance oriented.

A major focus for NVML was serving as the local provider of safety-net services. This required providing services that many providers believed were not profitable such as serving State-funded clients and providing psychiatric and emergency services. In exchange for providing these services, NVML management believed that the mental health community was obligated to provide NVML special considerations such as additional funding when required. We found that another spin-off provider discontinued providing these types of services because of the inability to recover costs and/or obtain subsidy funding. As a result, these services were provided by the local management entity in that region. However, NVML continued providing the non-profitable services because management believed that these services were core to its mission and would not be available in the region from other providers. In hindsight, NVML management states the decision should have been made to eliminate those services that had no contribution margin.

Table 1

Safety-Net Provider

One constant theme throughout our review of NVML was the implications that came with being the local area's safety-net provider. The organization's business plan identified safety-net services as being psychiatric, crisis, and emergency services. It further identified crisis response services as a loss leader and essential to the reform efforts. We found that the term safety-net services meant different things to different people, depending on their vision for the reform efforts. One definition for a safety-net provider would be a provider that by mandate or mission, organizes and delivers a significant level of health-related services to the uninsured, Medicaid, and other vulnerable populations. NVML was created to address this situation and saw this as an essential element to their mission. It is also evident that if these types of services are not properly managed, the financial toll for the organization would be overwhelming. The questions that arise include:

- What are safety-net services and what service types would fall within that definition?
- Who is responsible for ensuring that such services are available within a particular area? Is this a State, County, Local Management Entity, or Provider issue?
- Should Local Management Entities be authorized to provide such services? Should that authorization only occur if such services are not already available in the area?

NVML was created and continued to operate as a facility-based provider. Higher fixed costs are inherent to this style of operations as building and overhead requirements are necessary to maintain an establishment to treat clients. However, revenue steams were dependent on clients attending scheduled appointments. This was identified as a major issue within the system. When patients failed to appear for appointments, this was an anticipated billable service for NVML that resulted in lost revenues. Had the business plan for services transformed its focus earlier on providing more community-based services, the staff would have had a greater opportunity for limiting its non-billable activities. There also may have been a greater opportunity for generating more revenues by treating additional clients in the community-based setting by eliminating a major obstacle of many clients, the inability to get to and from scheduled appointments.

An Optimistic But Flawed Business Plan

In the establishment of NVML, a business plan was developed for the transfer of the service delivery functions from the Blue Ridge Area Authority and to identify start-up costs for the new organization. We requested a copy of the plan so that we could understand what steps were taken in preparation for the creation of this new service provider organization. The majority of the plan documents provided to us dealt with the issues of service delivery. There were some budget projections for the original four-county area to be served; however, there was limited documentation to support the source or methodology for the projections. It should be noted that losses of $843,000 and $430,000 were projected for both FY2004 and FY2005, respectively. In addition, some very specific financial challenges for the NVML organization were identified as per Table 2.

Table 2

Identified Financial Challenges

- Direct service levels will need to significantly increase from current levels of productivity in order to achieve the necessary revenue targets;
- These significant productivity gains will become more difficult to achieve as new service definitions anticipated to be effective July 2004 require "retooling" of services;
- Many of the safety net services (psychiatric, emergency, and rural county services) do not currently generate sufficient revenue to cover expenses and many of the more profitable services which have "underwritten" these services will not be provided by New Vistas;
- Many of the targeted population clients require significant non-billable assistance to support their treatment needs and frequently missed appointments, further adding to the challenge to be financially viable on fee for service funding;
- New Vistas will have a very limited asset base necessitating renting or leasing facilities, furniture and equipment, which typically cost more than ownership;
- New Vistas has no reserves to weather any type of "rainy day" adverse set of circumstances;
- New Vistas will also experience cash flow needs as revenue recovery times exceed expense payment time frames.

Excerpted from Business Plan presentation to Blue Ridge Center Area Board on September 24, 2003.

One of the key reasons for business failures is the fundamental shortcomings in business planning. Planning in this situation actually identified some possible huge obstacles for the long-term success of the NVML organization. However, the planning was not grounded in realistic expectations and the critical nature of many of these obstacles were never sufficiently addressed. Current accurate information is necessary to make these types of projections and it is not readily evident that this type of information was obtained. The creation of the NVML organization under the auspices of mental health reform was a new venture. All aspects of the business plan were projections as to the best-case scenario for the transfer of the on-going service delivery functions. However, as discussed throughout this report, each of identified financial challenges was never successfully addressed. The last two identified financial challenges in the business plan (see Table 2) dealt specifically with the anticipated cash flow difficulties that the NVML organization would encounter. A review of the NVML financial statements identifies a dependency on revolving lines of credit for operational purposes due to a lack of available cash reserves.

Adjustments to the New Service Definitions

Service definitions describe the services that providers can be paid for in the state's public system of mental health service delivery. The definitions include descriptions of provider requirements, staffing requirements (including experience/training/education components), service types/settings, entrance criteria, and expected outcomes. These service definitions are crucial to the provider's authorization, billing, and reimbursement of delivered services.

NVML management consistently identified the implementation of the new service definitions, effective March 20, 2006, as a contributing factor to its demise. Some problems expressed by management included the quick timing (60-day notice) for the implementation of the definitions, the lower authorization rate for NVML core services under the new definitions, and the need to establish a new clinical model. We obtained a memo written by NVML management in the first quarter of 2006 that stated NVML was "*in the midst of an intensive planning process to bring our organization into compliance with the new service definitions by March 20th. This is a monumental task with profound implications for our service delivery model, as well as our projected financial performance.*" The memo also states that NVML had approved a budget in December 2005, with the key assumption that the service definitions would not be put into effect for the remainder of the fiscal year and that the impending implementation was "*quite unanticipated*." The organization was faced with the reality of amending its budget and establishing a new clinical model.

The new service definitions should not have been a surprise. In fact, the NVML business plan developed September 2003 (see Table 2), identified the organization's need to retool its services to meet these anticipated changes. Drafts of the new service definitions had been available for some time before their official approval by the U. S. Department of Health and Human Service, Centers for Medicare & Medicaid Services. All service providers were subjected to the new service definitions and their financial impact. It appears that the greatest impact to the NVML organization was the rate paid for individual, office-based counseling. This was a service and clinical model that NVML was founded upon; however, it was a service that was de-emphasized in favor of the new community-based services model. While NVML was immediately impacted by the now lower reimbursement rates for these office-based services, those services no longer fit the clinical model necessary to survive in new reform environment. NVML's inability to timely adjust its business strategy was a contributing factor to its ultimate demise.

As late as February 2006, management was in the initial stage of developing a plan to link staff compensation to service delivery in the transition to the new service definitions. Documentation indicates staff had been sent to numerous training sessions beginning in January 2005. NVML management indicated that the delay in preparing for the new service definitions was the result of several postponements of the implementation by the State oversight agency and information that the new service definitions had been placed on hold indefinitely. NVML eventually decided to reduce its office-based services and move towards the community-based model. This required the immediate hiring of approximately 200 staff on a fee-for-service basis and the movement of staff not achieving productivity targets to a fee-for-service basis. This had a huge impact on an already struggling organization.

Financial Instability from Inception

Key elements for any successful business venture include sufficient operating capital, functional management information systems, and strong financial management systems. NVML had deficiencies in all three areas from its inception.

Sufficient operating capital is a necessity for a service provider's financial stability. NVML's operational model consisted of obtaining prior authorization to perform services, performance of those approved services, and seeking reimbursement for those services delivered. Adequate cash reserves were necessary to provide for operations for the period of time between performing services and actually receiving payment for those services. At the time NVML was created, it was unknown how much money it would take to get the organization started. The business plan projected a first-year deficit of $843,000; but it was based on the operational projections of the old area authority. Initial funding was provided to NVML in the amount of $930,000 from Blue Ridge Human Services Facilities, Inc. Western Highlands Network (WHN), the local management entity, advanced NVML at least $500,000 based on anticipated service delivery. Buncombe County provided an interest-free loan in the amount of $350,000 for start-up purposes. In addition, NVML began relying on significant lines of credit with local banks that would eventually total $2.2 million.

NVML experienced operational issues from the beginning. It is not evident that actual costs of services before and after the system transition were adequately identified. Costs such as building and management information system lease payments, previously blended into a public funded model, were now fixed operational costs. NVML experienced substantial payment denials because services were deemed as billed incorrectly. NVML also struggled to manage its authorizations for billable services, which are critical to the reimbursement system. The organization admits to identifying over $1 million in unauthorized services that potentially could have been billed. The immediate impact of these issues was on cash flow. With less revenue recognized than anticipated, NVML consistently increased its reliance on existing lines of credit for operations.

Managed care relies heavily on increasingly sophisticated data systems. It is essential that a provider have management information system capabilities, personnel, and technologies that can perform administrative functions, monitor performance, and provide real-time reports of operations. NVML management information system was inherited from the old area authority/new local management entity. The systems' original requirements were different from that of a service provider. Drastic modifications were necessary to the system before NVML could initiate the billing process. Most of these modifications were done in conjunction with the information systems staff at WHN. While the problems were being addressed jointly, the needs for the two organizations were diverging. Also, codependency was being developed by NVML staff such that an over-reliance was placed on WHN staff to accomplish the billing and reimbursement processes. Proper expertise was not devoted to the conversion of the management information system such that NVML could independently perform the necessary functions for it to be successful.

There was no test period for the NVML billing system as would be expected in the normal implementation of a new system. It started with a copy of the WHN database and processing

began immediately. Time and effort was being spent on keeping the information systems operational versus developing the most efficient processes for NVML. Again, this was due to limited expertise, particularly with the billing and reimbursement processes, being devoted to the system conversion. The problems reached such a critical point that NVML made a decision to convert to a new management information system. However, this decision occurred in the 2006 fiscal year and required substantial financing and staff effort.

NVML also had problems with its financial management systems. Critical financial management systems should provide for a good billing system, a prompt financial reporting model, properly identified and aged receivables, and a real-time report of cash flow and/or cash collections. Financial management staff should be knowledgeable of actual operating costs and capable of monitoring and evaluating financial data to ensure that resources are properly allocated. While there appeared to be reporting units established within the systems, it was evident during our review that the data provided was not consistently reliable. NVML management stated that "*the combination of having a lack of financial expertise and a system that could not be relied upon for timely, accurate reporting had profoundly negative implications for the ability of management to identify problem areas, assess true financial performance, and take corrective action."* It should be noted that NVML management persistently advocated to its stakeholders the need for systematic, programmatic, and financial changes. However, the inability to produce reliable financial projections and to identify specific costs of services resulted in prospective funding sources to be skeptical of the accuracy of NVML's financial statements and unreceptive to their presentations.

A review of the financial statements for NVML (or the organizations which merged to form NVML – New Vistas Behavioral Health Services, Inc, and Mountain Laurel Community Services, Inc.) identified financial and organizational issues impacting them operationally. The independent audit for FYE June 30, 2005, noted that New Vistas Behavioral Health Services, Inc. had significant audit adjustments posted resulting in a previously reported net income amount to become a reported loss of approximately $500,000. The majority of these adjustments were directly related to the accounts receivable and uncollectible amounts. In addition to the financial statements, the independent auditor issued management letters for both FY2005 and FY2006 that communicated many areas of concern to the NVML Board. Those issues included:

- deficiencies in the billing/collection process;
- deficiencies in recording accounts receivable/bad debts;
- deficiencies in the computer system;
- deficiencies in the accounting system and the ability to close the books;
- utilization of staff and processing deficiencies;
- utilization management;
- inadequate policies and procedures.

As evidenced by the continuing financial, operational, and information system issues noted, the board and management were unable to appropriately address matters that were significant to the operational viability of the organization.

The merger between New Vistas Behavioral Health Services, Inc. and Mountain Laurel Community Services, Inc. created additional stress for NVML. The merger of the two organizations officially took place January 2006. It was anticipated that the merged organization would benefit by economies of scale – reduced administrative costs, a consolidation of limited capital bases, and a centralized information management system. But there were also issues that negatively impacted NVML due to the merger activity. The merged company was now operating two separate information and financial management systems, neither functioning at optimal capabilities. NVML was growing at a time when financial resources were scarce and it was in the middle of transitioning its clinical model. Moreover, operational losses generated by the Mountain Laurel organization contributed to the financial challenges of the merged entity. Merger activity only contributed to the overall instability of the organization and made it more difficult to make necessary organizational change.

Staffing Deficiencies Contributed to Problems

Staffing costs are the largest expense for most businesses in a service industry. For fiscal year 2006, NVML incurred salary related expenses of $17,150,000, which represented 75%[7] of its total expenses. NVML incurred additional contractual services expenses totaling $456,000 because the organization contracted with consultants to perform necessary tasks, including financial management and reimbursement services, areas key to the mission of the organization.

Table 3

Employee Turnover Factors Provided by New Vistas Management

Key Management and Financial/Administrative Staff:

- Concerns about job security;
- Job stress and heavy work load;
- Constant crisis management for survival;
- Performance issues;
- Insufficient management tools and rework of claims;
- Concerns about the merger;
- Ability to obtain employment elsewhere;
- Rework of claims due to outdated information management systems.

Program Staff:

- Large paperwork requirements;
- Fear regarding professional liability;
- Recruitment from other providers;
- Inability to meet productivity standards;
- Non-competitive compensation;
- Move to private practice;
- Job security fears;
- Lack of overall job satisfaction.

Staff turnover was a significant problem for NVML. Particularly concerning was the turnover in its leadership staff including the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Controller, Reimbursement Director, and Information Technology Director. The management team brings leadership to an organization and sets the stage for an entity's culture, organization, values, and philosophies. Financial management expertise was lacking throughout the history of the organization. The NVML CEO stated, "*Both organizations had insufficient*

[7] $17,150,000 in salaries and fringe benefits expense divided by $23,000,000 in total expenses. Total support and revenue for the same period was $22,100,000.

internal financial expertise and were forced to rely significantly on retained financial consultants throughout their three year history." A full-time CFO was hired for NVML in January 2006, but remained only a few months prior to leaving and the position was not filled again. The NVML CEO stated, "*Recruitment was aggressive, however, the unique experience that the job required, coupled with extreme financial instability from the outset made filling this position exceedingly difficult*." Turnover in these key areas forced NVML to turn to consultants to fill those roles. While NVML was obtaining needed assistance to address financial management and reimbursement concerns, the consultants were only a temporary fix and were not in a position to provide a long-term, continuing solution to NVML's need for management oversight.

Additional staffing concerns were noted with instability and inexperience at the Reimbursement Director positions from the outset at both New Vistas Behavioral Health Services, Inc. and Mountain Laurel Community Services, Inc. Both initial directors left after employment periods of a few months. The NVML CEO stated, "Our reimbursement area suffered from being unprepared *to deal with the complexity and pressure to bring in cash in the new world of fee-for-service reimbursement for a now private provider*." Further, replacement reimbursement directors hired did not have significant billing experience with Medicaid or State funds, the primary sources of revenue within the mental health system. The billing staff at both locations experienced a 100% turnover rate. The constant turnover directly affected NVML's ability to adequately train its reimbursement personnel. The NVML CEO stated, "*Little training was afforded to reimbursement staff due to a lack of knowledgeable resources internally or at WHN*." In addition, the NVML CEO stated, "*CMHC[8] training notes were being developed by WHN and New Vistas, however little time was available for this effort due to urgent needs to problem solve around the CMHC system issues and time devoted to the IS conversion. Inadequate resources within WHN to provide training on its computer system also contributed to problems in the reimbursement area. Finally, turnover amongst all levels of reimbursement staff compounded the ill effects of having insufficient capability to provide reimbursement training*."

Ineffective Communication Between Area Partners

The Role of NVML

There was never a clear understanding between the local management entity, Western Highlands Network (WHN), and NVML on its role in providing mental health services. NVML was created by management within the old area authority system simply to divest service activities. NVML management understood its responsibility as providing mental health services for all people regardless of service profitability and the client's ability to pay. In exchange for providing these services, NVML management believed the counties served and the WHN would provide financial subsidy to address cash flow deficiencies and to ensure the continuation of services. As NVML was by far the largest provider of services to those clients receiving state-funded and safety-net services, this affirmed its position as a unique provider within the system. Also, when NVML approached County and WHN representatives to discuss eliminating non-profitable services, the response was negative according to NVML management. The negative response was because officials believed the community could not afford to lose its major provider of those

[8] CMHC Systems is a behavioral healthcare information management software for mental health, substance abuse, addiction services agencies, developmental disability centers, and behavioral health-related managed care organizations

services. Although these actions fail to take into consideration the changing business environment under the auspices of reform, these communications led NVML management to believe all parties would support their efforts to continue to provide all services.

Communications Over Reimbursement Issues

Communication between NVML and WHN gradually deteriorated. The authorization and reimbursement processes were crucial to the success of NVML and problems existed for both areas from inception. NVML management indicated that they were unclear why many of the reimbursement claims were rejected. WHN management stated that their authorization and reimbursement processes were specific and reasons for denial were clearly identified. During the service divestiture, both parties worked closely together to address known billing issues. As their roles became more defined, NVML became more independent in its processing of claims. WHN management stated there was a decline in requests for meetings between the two entities concerning billing errors and corrective actions. In discussions with WHN management, it was noted that the LME provided frequent training opportunities for all providers for many issues, particularly authorization and reimbursement. NVML staff were not on record as consistently attending these training opportunities. It appears that participation by NVML staff in these training activities was limited. NVML continued to struggle with its denial of claims which significantly impacted its cash flow situation. Our discussions with other providers cited communication with their LME as a key to success, especially in the area of denied claims. Providers also stated that the clean bill percentage[9] needed to be above 90 percent in order to be successful. The clean bill percentage for NVML was approximately 70 percent.

Communication With Key Stakeholders

Buncombe County is by far the largest affected county in the region. We noted that it provided NVML financial incentives in the form of reduced or waived rent, interest-free loans, loan guarantees, and offers of management assistance. In return, Buncombe County asked for detailed financial information related to the costs of services. While there were many meetings and presentations between both parties, county officials indicated that NVML management could not provide consistent, detailed, written communication about the services that were unprofitable and causing the entity to fail. In an effort to get an understanding of NVML's financial situation, the County hired a consultant to provide financial oversight to NVML. Eventually, the inability to communicate detailed and consistent financial information to county management led them to withdraw all financial assistance to support operations. As NVML's lines of credit were dependent upon this support, this removal of assistance ultimately forced the closure of NVML.

[9] Clean bill percentage: Percentage of claims submitted without errors.

Offer of Assistance Was Rejected

Buncombe County offered NVML various forms of operational assistance over its tenure. One such offer included the opportunity to use the County's information systems to process claims, assistance with payroll functions, and assistance with other accounting functions. The County indicated that it was in a better position to address the cash flow needs that appeared to be crippling NVML. NVML declined this offer for a variety of reasons, the most important appearing to be the perceived oversight of the County and NVML's inability to control its business model. NVML management chose to accept the recommendation of its CFO/financial consultant to obtain a new system at a budgeted cost of $773,000 for software, licensure and implementation expense. Additional costs were involved in the lease of necessary hardware. As of June 30, 2006, NVML was using two separate computer systems and making numerous manual adjustments to record transactions. The lack of integrated systems resulted in substantial hours spent researching transactions, correcting errors and reconciling accounts. These circumstances directly affected NVML's operations and management's ability to obtain timely and accurate information.

Table 4

NVML Identified Computer Issues

- System utilized a 30-year-old software structure that caused data to be exceedingly difficult to obtain;
- System lacked edits to ensure all necessary data were collected;
- Report and claim generation was time consuming and cumbersome; and
- Posting of payments was chronically behind due to time consuming processes the system required.

NVML Reasons for Rejection of Offer

- A plan of execution never formalized;
- Failed to fulfill the long-term vision of NVML to function with an integrated information system which brought together the general ledger, payroll, billing, and clinical records systems;
- Stated that the medical billing system for the County was not in place; therefore, NVML faced the difficulty of maintaining two systems with the manual posting of journal entries from one system into the other. This would not have been a significant improvement over the existing system and would have required significant additional staff time for training that was not available;
- Considered this solution interim in nature with another conversion in the near future;
- Perception of County's control as fiscal agent for the primary provider serving eight counties;
- Concerns over the County's software fees;
- NVML's Director of Administrative Services/CFO (consultant) suggested not to go in that direction and to "stay the course." This officer also suggested purchasing a system that was specifically designed to meet the needs of a private community mental healthcare provider.

NVML did accept the County's offer to provide salaries for several staff members including accounting personnel. However, this arrangement was short-lived. Discussions with county officials indicated that the offer was terminated as county reimbursed staff were performing tasks that were not in line with their expertise and therefore not bringing the expected stability to NVML.

During our review, there were numerous discussions about NVML's inability to qualify clients for Medicaid reimbursement for services. The administrative requirements for Medicaid reimbursement process were less onerous and therefore, less costly to the organization. In that regard, the NVML requested assistance in the form of a shared Income Maintenance Caseworker. A contract was executed by both parties and Buncombe County required this employee to be on its payroll with the costs to be shared. Buncombe County was not able to fill the position prior to NVML's decision to cease operations.

[This Page Left Blank Intentionally]

GLOBAL ISSUES/CHALLENGES TO MENTAL HEALTH REFORM

During our review of the closing of NVML, we identified several systemic items that appear to be challenges to the success of reform efforts. We are presenting many of those issues below; however, these items are presented only to generate discussions among interested stakeholders about the direction that mental health reform should take. We have not performed sufficient research on these issues at this time to provide appropriate feedback or solutions.

Assignment of Responsibility: Who's In Charge?

Reform legislation was passed in fiscal year 2001 and the North Carolina Department of Health and Human Services was put in charge of spearheading reform efforts. However, there are many stakeholders in the current service delivery system and it is not clear what roles are to be performed by the various players. Much authority has been delegated to the county level; however, the State is ultimately responsible for ensuring that reform efforts take place. The roles that the State and the county play need to be further defined to ensure proper checks and balances and eventually accountability within the system.

Array of Services

The NVML CEO stated, *"The NVML service array was determined by stakeholder expectations (primarily WHN and counties) as well as financial capability. Mountain Laurel and NVML Boards were originally charged with the mission to provide a full array of services, but especially those seen as 'safety-net' services (i.e., psychiatric, crisis, and emergency services). The LME and the county officials who constituted the LME Board had this expectation as well."* As services are being moved to the private provider model, it is not certain that all services will be available in all areas. Should there be a default provider of specific services to ensure that all necessary services are available? Who should be that provider and what mechanism should be in place to fund these activities? See discussions per Table 1 related to concerns with the provision of services.

Cherry Picking

Cherry picking is a metaphorical expression meaning the act of selecting the best or most desirable item. For many mental health private providers, financial survival requires selecting only the patients who are fully funded and easier to care for. This is inter-related with the provision of a full array of services. Currently, there are no processes in place, rules or incentives, which would make it attractive for private providers to take on services that they deem as undesirable or unprofitable. However, if all providers practiced "cherry picking," the potential for gaps in service are increased and the potential arises that clients may not be adequately served.

Dual Authorization Processes

Currently, there is a dual authorization process for mental health services dependent on the funding stream. State-funded service authorizations and utilization management are completed through the regional LME, and procedures regarding state-funded service authorizations vary across services requested and LMEs. The management over State-funded services is more stringent due to the limited availability of state funds. Medicaid service authorizations and

utilization management are outsourced to ValueOptions, a private company. Medicaid allows for a greater number of unmanaged care visits that results in easier access into the system. The services being delivered to clients should be the same regardless of the funding stream. The more complexities built into the authorization process, the greater the transactional costs are for providers. It also presents barriers to the collection of programmatic data related to all mental health populations.

Need for Standardization

The Division of Mental Health conducted a web-based provider survey in the fall of 2005. About 500 providers responded to this survey. One of the primary themes identified from the survey was the need for standardization. Some providers ranked the need for standard systems and processes across the state as the number one priority. As a result of the survey, the Division established a Provider Action Agenda Committee with the overall goal to strengthen and enhance the provider community for the direct benefit to individuals and families who receive services. The focus on standardization is to be on forms, contracts, and processes at the local level in an effort to bring some stability to the business environment. The Department of Health and Human Services is currently addressing some of these issues as identified in its 2006 State Plan.

Administrative Overhead

Administrative processes vary between services, across providers, across LMEs. In a system of managed care, it is important to place as much of the mental health resources in the services category. Why does it require a different number of forms to process one particular service versus another service? Are there services that require more scrutiny than others? Complicated, labor-intensive administrative processes could affect the ability of private providers to function in a competitive environment. The focus of reform should be on the delivery of services - standard assessment processes, timely authorizations, consistent delivery systems, accountability through electronic billing systems, and simplified cost reporting. There is a need to avoid duplication and increase consistency in an effort to reduce administrative costs for providers.

Rural Rates versus Urban Rates

Rural and urban areas differ in many ways, including demography, environment, economy, social structure, and availability of resources. A greater percentage of the population lives in urban areas. Studies have indicated that rural populations tend to be more elderly, have higher levels of poverty, suffer greater health risk, and have considerable less access to health insurance coverage and available providers. Rural providers are highly dependent upon Medicare and Medicaid for sources of revenue. In a system of reform based on private providers, it is essential that providers be available to perform the necessary services. Currently, rates are consistent across all areas of the state. Consideration may need to be given to the current rate-setting processes to ensure financial incentives are adequate to provide for the desired levels of care.

The Role of the LME

Currently, there are 30 Local Management Entities (LMEs). Reform legislation stated that the total number of area authorities and county programs shall be reduced to no more than 20. The Department of Health and Human Services' plan submitted to the Legislative Oversight Committee on January 1, 2005, indicated that it no longer adhered to the goal of 20 LMEs. In our discussions for this report, it was repeatedly pointed out that the current number of LMEs was too high. The importance of the number of LMEs lies in the distribution of funding for the state-served clientele. Resources continue to be divided amongst a larger number of oversight entities that is greater than proposed. Funding formulas continue to be derived from the mechanisms that were in place for the old area authorities.

In addition, there is concern as to what role the LMEs should be performing within the reformed system. It is clear that one of the primary functions of the LME is to develop a provider network. That would encompass care coordination across the network of providers; however, questions arose as to provision of case management, authorization management, and billing/payment functions. As the LME role has divested of services and evolved into a managed care entity, the role and responsibilities of the LME needs to be more consistently defined.

Crisis Centers

The scarcity of crisis centers was a topic that continually surfaced during our audit. With North Carolina's four mental health hospitals being overwhelmed, much discussion concerned the place where clients could obtain assistance during a mental health emergency. Also, the availability of local crisis facilities is necessary for treatment to be community based. The lack of such facilities is forcing the mental health population into homeless shelters, emergency rooms, or incarceration facilities. There appears to be a need for services within the local catchment areas[10] to address those behaviors that require immediate professional attention, but not necessarily require the severity of hospitalization.

Spin-off Organizations

NVML is the second spin-off entity to cease operations since reform efforts began. One of the surviving spin-off entities receives additional assistance, particularly in the form of operational subsidies. That does not appear to fit into the fee-for-service reimbursement mechanism envisioned under the private provider model. Numerous comments were made during our audit as to the difficulties encountered by staff moving from a quasi-governmental environment to a provider network geared towards profitability. Closer scrutiny may need to be given in the development of the provider network to ensure that organizations can survive in the private fee-for-service environment.

[10] A catchment area is a defined geographic area, defined by population, which receives mental health services as a unit.

[This Page Left Blank Intentionally]

Response to NC State Audit: Recap and Remaining Issues

From the Board of New Vistas Mountain Laurel Community Services

Opening Comments

The Board of Directors and management of New Vistas Mountain Laurel Community Services (NVML) thanks the NC Office of State Auditors for its extensive study and reporting in response to questions raised about the closure of NVML. The audit team has been professional and responsive in their work with NVML and the community. We find the written report to be objective and fair overall with special strength in the presentation of facts related to the inception of NVML and the challenges which NVML faced as it sought to fill its initial charge and mission as the safety net provider of mental health services in an eight county area of western North Carolina.

We are particularly encouraged that the outcome of this report may be to ultimately strengthen the system of community mental healthcare in our State. To that end, we attempted to identify for the auditors those challenges which were unique to our circumstances and those that may have broader implications for future service delivery. While there were certainly difficulties faced and missteps along the way which NVML and our stakeholders collectively must "own," these are in the past. The greatest contribution that can be made from this point forward is to use the NVML experience to assist leadership at all levels…State, county, LME, and providers…to meet the needs of some of our most vulnerable citizens.

NVML appreciates the opportunity to respond to this audit report. There are several areas of clarification and correction which are needed and summarized below.

- NVML always understood its mission, and regularly confirmed with stakeholders that its mission was to be the safety net provider of mental health services for children and adults in the Western Highlands LME region. As the safety net, NVML served clients regardless of ability to pay and maintained services vital to client care which were severely under funded such as psychiatric services, emergency services, state funded services, and free medication programs. There is considerable evidence that the void in these areas created by our closure has not and will not be filled without substantial realignment of financial incentives for private providers. The disparity between the levels of service offered a state funded client as opposed to Medicaid clients is particularly disturbing. The continuing erosion of psychiatric service capacity is another critical issue that must be addressed.
- It is important to point out that sudden and precipitous rate reductions such as the recent cut in community support reimbursement simply cannot be sustained by a system that is as fragile as ours. NVML suffered five such fee reductions (the greatest being a 25% reduction for our core services in July, 2005). Moreover, we were forced to absorb these without cash reserves. From our inception, we found it impossible to plan and gain the confidence of those in a position to support us

(i.e. counties, creditors, foundations, etc.) when our level of reimbursement had no degree of predictability or assurance.

- An unintentional consequence of mental health reform has been a profound increase in the level of administrative paperwork required of providers. NVML suffered greatly from this and the result was staff turnover, higher costs, lost revenue, and less time available to direct towards care.
- The audit references "ineffective communication between area partners." As NVML efforts to advocate for system improvements and support became more assertive, the result was often alienation from stakeholders. Our hope is that current providers will be heard by local and State governments, as well as LMEs, in an environment of collaboration that results in continuous enhancement of services.
- Staff turnover was identified in the report as a significant destabilizing issue for NVML. Job satisfaction and security within an environment of constant change and crisis management was particularly difficult to attain at all levels of our organization. During our existence, Western Highlands Network experienced similar turnover at the senior leadership level, losing a CEO, COO, CFO, Director of Services Management, and Director of Reimbursement. We are extremely grateful and appreciative of the great number of NVML staff who persevered to provide excellent work in the face of the exceedingly challenging circumstances we endured.
- The increasing reliance of NVML on its line of credit was largely driven by the inability to capitalize the transitions needed to successfully navigate the huge amounts of change thrust upon the organization over relatively brief periods of time. This lack of capital and cash reserves was responsible for the limited capacity of NVML to abandon existing revenue streams associated with facility based services while investing in the anticipated community based model. In addition, repayment of nearly $1 million in debt owed to Western Highlands and Buncombe County exacerbated the need to use credit lines as resource of last resort.
- It was clear to NVML that new service definitions would be developed during the early phase of mental health reform. Repeatedly NVML was told by state and LME staff and NC legislators that these definitions would occur "later, rather than sooner." NVML was not 'surprised' by new service definitions, just the timing of the announcement and the 60 day implementation notice.
- The merger between New Vistas and Mountain Laurel was one of several challenges which NVML faced during its tenure. While the timing was difficult, the evidence we provided clearly shows that Mountain Laurel would have been insolvent many months before NVML closure if the merger had not occurred. The decision to merge had costs and benefits for both organizations. Yet, the merger was in keeping with NVML's mission to preserve safety net services for the Western Highlands LME eight county region.
- There are several key and significant discrepancies regarding to stakeholders and their willingness to provide meaningful and effective assistance to NVML. At each point where assistance was offered there were compelling NVML business issues

which were not addressed by the offers of help… in fact, several offers could be seen as having the potential to further destabilize NVML operations and alter its mission. Furthermore, many requests for assistance by NVML which we deemed to be of great importance in establishing financial and operational stability were denied by stakeholders. It is more accurate to characterize our solicitation efforts for support as bringing to the fore a disagreement as to the type of assistance that would best meet NVML's needs.

- The 70 percent rate of "clean" claims generated by NVML contributed substantially to its financial duress. However, the sheer volume of claims as a large provider coupled with an onerous authorization system prone to human error and an inadequate information management system leased from Western Highlands made the effort to improve cash collections fruitless. The need to improve cash flow along with a mandate from Western Highlands to get our own information system were pivotal factors in NVML's decision to commence a computer system conversion.
- NVML made it a priority to give Buncombe County access to timely financial information it certainly deserved and needed to support our organization. In fact, county management was formally invited to attend monthly NVML board finance committee meetings. We appreciated the need to keep stakeholders fully informed at each point in our three year history and made our best efforts to do so.

The following pages are arranged as a synopsis of NVML's tenure along with questions and issues we believe are important to analyze and learn from as NC mental health reform moves ahead and the system continues to evolve.

The Beginning

On May 22, 2003, New Vistas board members made a presentation and request for support to the Rutherford/Polk Area Authority Board. That presentation began with:

OUR CHALLENGE

With no assets, no staff, no services, and no cash, do the following:

- *Create a viable service provider spread over 8 counties - most of which are rural;*
- *Deliver quality, client centered services in local community settings;*
- *Have those services delivered by a knowledgeable and competent staff;*
- *Stand in the gap as the provider of safety net services;*
- *Compete in the open marketplace for other services;*
- *Do all of that even though state government has yet to clarify many issues, not the least of which are reimbursement rates.*

(And by the way, be ready by January 1, 2004)

OUR OPPORTUNITY

Even with all of this, Western North Carolina Human Services, Inc. (the initial name for New Vistas), is uniquely positioned to succeed

Its board is comprised of deeply concerned citizens, representative of a wide array of interests and skill sets who, on a regional basis, maintain relationships with many contacts of influence and good will

There is already recognition on the part of the area boards, the evolving LME, local governments, and various advocacy groups that development of the new service delivery system will only happen through the collaboration and cooperation of existing as well as developing provider groups like WNCHS

The existing care giving network, consisting of trained, competent professionals already skilled in community based service delivery, provides a readily available resource for workforce recruitment

As a private organization, there may be opportunities for flexibility, innovation and creativity in service delivery that would not necessarily have been possible under the current model

CASH FLOW

It is the key issue for quickly stabilizing services for clients in the near term and then developing as a viable provider of safety net services over the long term

The Original Understanding

As can be seen, at this very early date, the board of WNCHS (later New Vistas) was very much aware of the enormity of what it was being asked to accomplish - and that enormity was well known to all stakeholders who were trying to operationalize something euphemistically entitled "Mental Health Reform." The board was encouraged in its efforts to make the divestiture transition as transparent for clients as possible and was assured that there would be united support to do so.

The board of New Vistas (NV, later NVML)) embraced the tenets of mental health reform which they understood to be:

- Regional mental health (MH) agencies would move from service delivery to service contracting and oversight;
- A standardized "core" of MH services would be developed;
- Services would move over time from a facility based to a community based model;
- State funding for this transition would be significant.

Doing these things, then, would result in:

- A reduction of administrative costs would free up resources for service delivery;
- An increase in the number of private providers competing for reasonably funded services;
- A reduction in overall clinical costs to the system through increased competition;
- A move towards the equalization of service availability between rural and urban areas;
- A decrease in admissions to state mental hospitals;
- An increase in flexibility and innovation in service delivery at the local level;
- An overall improvement in consumer choice of providers and interventions.

The Uphill Battle

Even though NVML would wind up assuming the vast majority of the old area authorities' service delivery, its financial starting point was far different from the area authorities ending point. The old area authorities enjoyed the benefits of a substantial asset base that included:

- Unrestricted Local Maintenance of Effort funding;
- Cash Reserves;
- Facilities;
- Information Systems.

These resources carried different weights under the area authorities as opposed to a newly-formed New Vistas and Mountain Laurel:

Maintenance of Effort

- The area authorities received direct county funding for MH services.
- Though under reform counties were required to maintain at least the same level of funding as pre-reform, the amount of those funds that were made available for NVML progressively eroded over time.

Cash Reserves & Fund Balances

- When the area authorities ceased doing business, the cash reserves and fund balances they enjoyed reverted to the counties.
- In contrast, NVML had to develop lines of credit and incur substantial interest costs in order to maintain operations due to the lack of such a ready reserve.

Facilities

- The area authorities were housed in facilities provided them for MH services.
- NVML was required to 1) rent those same facilities from the counties (in whole or in part) or 2) purchase those facilities from the counties, thereby incurring substantial facilities payments.

Information Systems

- The area authorities were provided with their own information systems to facilitate their operations.
- NVML had to incur substantial lease payments made to the LME to maintain its operations on that same IS system.
- Because that system was not able to fully support NVML's operations, an extraordinary large capital expenditure had to be initiated to acquire a fully integrated IS system capable of sending and receiving standardized transactions and code sets.

The Missing Asset Base

- Combined, these four areas accounted for $15+ million in assets that were developed over time to support MH services in the counties.
- The area authorities' efforts to provide needed local MH services traditionally benefited from the support derived from these assets.
- These assets were no longer focused completely on benefiting MH service delivery in the eight counties.

- Although NVML received start-up assistance from the counties, that level of assistance never approached the resource level that the area authorities enjoyed.

The Lack of a Shared Vision

What did we, the board of NVML, learn from this four year experience? That there is plenty of responsibility to be taken by everyone involved.

State Government

- Eliminating transition funding;
- Not anticipating the significant start up costs that providers would have to incur;
- Not addressing the under-funding of psychiatric and emergency services;
- Reducing Medicaid funding in the face of reform;
- Waffling on implementation dates for community services;
- Allowing a multi-LME system to develop that required significant amounts of funding without significant amounts of added value;
- Implementing an authorization system that was based on specific services provided by individual/solo practitioners rather than large group providers;
- Making frequent changes leading to rework and/or retrofit of provider processes.

County Governments

- Not appreciating the level of financial support needed to keep a safety net provider viable;
- Assuming that they could not favor a safety net provider over any other provider;
- Leveraging NVML in such a way as to make existing facilities a revenue center;
- Using local maintenance of effort funds to expand services as opposed to using it to maintain core safety net services;
- Failing to address historic differences in urban/rural county dynamics.

The LME/Western Highlands Network

- Being charged with becoming a de facto managed care entity without bringing in personnel with managed care core competencies;
- Adding administrative requirements to various claims development/submission/reconciliation processes that made timely payment for services delivered difficult and keeping clinical staff focus on paper and not people;
- Being unable to address the significant deficiencies of its IT systems.

NVML Board

- Believing that the vision of developing a large safety net provider would be embraced by all stakeholders;
- Assuming start-up support would last over the long term;
- Not allowing NVML management to act like any other willing provider in service delivery selection and provision (i.e.: by eliminating those services that had no contribution margin);
- Acceding to counties' demands for facility payments;
- Providing services to all comers thereby shielding the local community from the impact associated with the fragmentation of services caused by divestiture of the area authorities.

Final Thoughts

Some observations on NVML's service delivery and performance (given its mission as a safety net provider):

- In a sense, NVML did its job too well. By delivering MH services to all in need regardless of adequate funding sources, the various stakeholders were sheltered from the reality of how precarious NVML's financial situation actually was and how dependent NVML was on the united support of all involved;
- In the end, the large number of clients being served by NVML was never the issue; the large number of clients receiving services that had insufficient funding was the issue;
- Through the efforts of the board, management, and staff of NVML, service delivery lasted far longer than otherwise would have reasonably been considered possible;
- Ultimately, NVML became what it was originally asked to become. Unfortunately, by then, the large safety net provider model was no longer wanted or supported;
- By dissolving as it did, when it did, NVML was able to meet all its fiduciary responsibilities while assisting in an orderly transition of clients to other providers. In that there is a sense of overall relief and gratefulness.

Questions Left on the Table

Remaining issues left to process (by all stakeholders):

- Will the State actually save dollars in the aftermath of system reform, i.e., when there are fewer employees on state payrolls, lower pension fund obligations, etc.?

- Will those in positions of influence continue to make decisions in isolation - without taking into account the destabilizing effects these decisions may have on the system as a whole?
- Will the benefits of having multiple LME's across the state ever be defined and quantified?
- Will the large amounts of liquid and hard assets that ended up under the control of some counties remain dedicated/restricted to MH services/support only?
- Will "privatization" end up meaning "fragmentation" to a point where there will be a growing number of under funded services with no willing provider?
- Will actual MH service delivery continue to erode, i.e. even though clients are assigned a provider, will they actually receive fewer and fewer services?
- Will community support services end up costing too much money for the level of services rendered and to the detriment of other vital services in the continuum of care?
- Will there be long term consequences of the undermining of the free medication/samples program? If so, what consequences?
- Will reform ultimately end up accelerating the shift (and related costs) of MH services to primary care physicians, hospital emergency rooms, jails and prisons?

Finally, in the next chapter of MH program delivery in North Carolina, there are these questions:

- As "owners" of our MH system, can we reach an inclusive, collaborative, transparent, broad-based provider and consumer informed vision of service delivery across the State?
- Can we call into action a planning process that clarifies issues and brings discussion to a broader plane?
- Can we identify disparities and differences across the State and unite them in a system of thought and care that, in our jointly-held consensus, has the best opportunity for success in the realms of both consumers and providers?
- Can we use what we've learned through the NVML experience, and through other related experiences, to imaginatively develop new possibilities for an MH system our state can point to with respect and gratitude as it positions North Carolina as a leader in multiple fields of endeavor?

[This Page Left Blank Intentionally]

ORDERING INFORMATION

Audit reports issued by the Office of the State Auditor can be obtained from the web site at www.ncauditor.net. Also, parties may register on the web site to receive automatic email notification whenever reports of interest are issued. Otherwise, copies of audit reports may be obtained by contacting the:

Office of the State Auditor
State of North Carolina
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Telephone: 919/807-7500

Facsimile: 919/807-7647