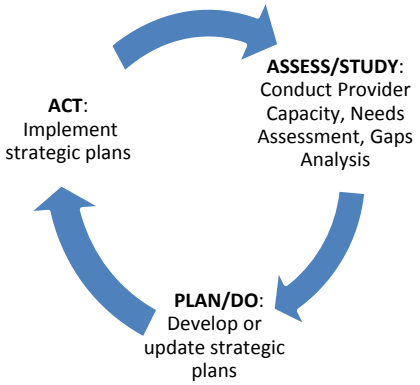
2015 Provider Capacity, Community Needs Assessment and Gaps Analyses
Requirements for North Carolina LME/MCOs

Overview

The purpose of this document is to provide requirements to Local Management Entities/ Managed Care Organizations (LME/MCOs) for conducting the 2015 Community Needs Assessment, Provider Capacity and Gaps Analyses in accordance with performance contracts with LME/MCOs. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA) each have contracts with LME/MCOs containing requirements for assessments of community need, provider capacity, gaps in services and strategic plans to address gaps. Please see Attachment A for the DMH/DD/SAS contract requirements, and Attachment B for the DMA contract requirements and an excerpt from the North Carolina 1915(b)/(c) Medicaid Waiver.

The 2015 LME/ MCO Community Needs Assessment, Provider Capacity and Gaps Analyses is one part of a continuous assessment and action process with each component driving the focus of the next:



- **Assess** and study the LME/MCO's community to determine needs and provider capacity to deliver services;
- Develop or update LME/MCO strategic **plan**s, such as local business plans,network development plans and strategic initiatives, as needed to incorporate results from the LME/MCO Needs Assessment, Provider Capacity and Gaps Analyses;
- Implement strategic plans through local initiatives, quality improvement projects and other **act**ions;
- Review and **assess** action steps that have been taken and determine progress and challenges in meeting community needs and adjusting provider capacity to respond to gaps in services.

Submission Information

The deadline for submission is close of business April 1, 2015. The suggested length is 20 to 40 total pages plus appendices. Submit reports to DMH/DD/SAS at contactdmhquality@dhhs.nc.gov and to DMA at Katherine.Nichols@dhhs.nc.gov.

Format

I) Executive Summary: Provide a 2-3 page summary of progress in addressing priorities from last year's analysis, newly identified needs/ gaps, and priorities to be addressed in the coming year.

II) Demographic data: Describe the demographic make-up of the LME/MCO's catchment area. Include information about unique, underserved and special populations (for example, ethnic groups, people who are sexually aggressive, people with traumatic brain injuries, military members and their families, and people who are in jails or prisons).

III) Provider capacity and service utilization data

Determine the current provider capacity to provide access to services for Medicaid beneficiaries and indigent populations in each county of your catchment area. Consider agency providers, licensed independent practitioners (LIP) and LIP group practices. Consider children (age three - 11), adolescents (age 12 - 17), young adults (age 18 - 20), adults (21 – 64), and older adults (age 65 and older) who are covered by your Medicaid PMPM payment and those who received State-funded services during SFY 2013-14.

Complete the Provider Capacity workbook, which will be provided by DHHS, and attach it to your submission as Appendix A. For each service and provider type, report by funder for the entire LME/MCO network the total number of providers and the total unduplicated number of people served and the number of people served in each disability. Individuals may be counted more than once in the disability-specific numbers.

IV) Access and Choice

The DHHS contracts with the LME/MCOs require that individuals have access to services within a 30-minute drive time or 30-mile radius (45 miles/45 minutes in rural counties) of their residences and a choice of two provider agencies, where possible. To demonstrate adequate coverage and choice, submit the following information for each service grouping below. See Attachment C for details and Attachment D for urban and rural designation of counties.

a) For outpatient services, submit two geographic access maps (one for each funding source) that visually show provider locations and a 30-minute drive time or 30-mile radius (45 miles/45 minutes in rural counties) around locations. Also, submit two charts, one for Medicaid beneficiaries and one for persons served with State funds, to show numbers and percentages of individuals who have a choice that meets the time/distance standards of (1) zero providers, (2) only one provider, and (3) two or more providers.
b) For location-based services, submit two geographic access maps for each service (one for each funding source) that visually show provider locations and a 30-minute drive time or 30-mile radius (45 miles/45 minutes in rural counties) around locations. Also submit two charts, one for Medicaid beneficiaries and one for persons served with State funds, showing the maximum distance any individual must travel to receive a location-based service.
c) For community services, submit two geographic access maps for each service (one for each funding source) that visually show provider locations and each provider's designated service area. Also submit two charts, one for Medicaid beneficiaries and one for persons served with State funds, showing the maximum distance any provider must travel to deliver a community service.
d) For crisis and inpatient services, submit two geographic access maps (one for each funding source) that visually show provider locations. Multiple services may be shown on the same map, if clearly indicating service type and location. Also submit two charts, one for Medicaid beneficiaries and one for persons served with State funds, showing the maximum distance any individual must travel to receive a crisis or inpatient service.
e) For specialized services, list each service showing the provider name, provider county, provider state, if not NC, and funding source.
f) Provide a list of waivers of access and choice requirements that have been requested from and approved by DMA or DMH/DD/SAS to date.

V) Needs identified by community stakeholders: Provide a summary of stakeholder and community-reported perceived needs and gaps:

a) Identify briefly how input was gathered from consumers, families and stakeholders (for example, local or state surveys, focus groups, local collaboratives, community forums, complaint trends, etc.)
b) List themes identified across stakeholder and community groups

c) Describe whether current perceptions and feedback are similar to the previous year and what prior year initiatives may have positively affected current stakeholder and community perception and feedback

VI) Analysis

Determine the needs for each age-disability group and special population. Consider the service capacity and utilization data, community-identified needs, and the LME-MCO's trends on DHHS annual and quarterly performance measures. Also consider other sources of data that could indicate future needs (for example, population health surveillance data and national trends). Include analysis of successes and challenges in implementing current DHHS initiatives, including:

a) Transition to Community Living
b) Crisis Solutions Initiative
c) Integration of physical and behavioral health care

VII) Priorities and Strategies

Determine the LME-MCO's priorities for the coming fiscal year and briefly describe strategies for meeting those priorities. Priorities and strategies should address how to:

a) ensure consumer access to and choice of providers as required by the DHHS contracts;
b) address priorities of community stakeholders;
c) address needs of each age-disability group in the Medicaid and indigent populations;
d) address needs of underserved and special populations in the catchment area;
e) reach and sustain statewide standards on DHHS contract measures;
f) ensure progress on the following DHHS initiatives:
    i) Transition to Community Living,
    ii) Crisis Solutions Initiative, and
    iii) Integration of physical and behavioral health care

    and the LME-MCO's choice of one or more of the following:
    iv) services and programs for people with traumatic brain injuries,
    v) a full service continuum for both children and adolescents,
    vi) recovery-oriented care for persons with substance use disorders, or
    vii) increasing the use of enabling technologies.

VIII) Appendices

Include the following in the submission of your report:

a) Appendix A: Provider Capacity Data – Complete the Capacity workbook which will be provided later by DHHS. See Section III above for details.
b) Appendix B: Consumer Choice Charts and Geographic Access Maps. See Section IV above for details.

Conclusion

DMH/DD/SAS and DMA staff will jointly review the information submitted and provide the LME/MCO with a response within 60 days following the submission date. DHHS will use the information to inform the NC Legislature and public of our progress, challenges, and upcoming needs and to guide DHHS identification of future priorities.

Understanding gaps in services at the local, LME/MCO and state levels is critical for maintaining effective, viable service systems that balance need with capacity and resources. DMH/DD/SAS and DMA appreciate the time and effort taken to conduct the needs assessment, provider capacity and gaps analyses.

Attachments

a) Attachment A: Excerpts from DMH/DD/SAS contracts with LME/MCOs
b) Attachment B: Excerpts from DMA contract
c) Attachment C: Services
d) Attachment D: Designation of urban and rural counties

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Attachment A

Excerpts from Section 5 of Attachment 1: Scope of Work of 2013/2014 Contracts Between
LME/MCOs and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services

5.0 Provider Relations and Support
5.1. Assessment of Adequacy of the Provider Community
Under the terms of this Contract, the DHHS delegates the authority to develop and manage a qualified provider community in accordance with community needs including enrollment, disenrollment, and certification of providers including assessment of qualifications and competencies in accordance with applicable state and federal rules, standards and the provider qualifications established by the LME-MCO and deemed necessary for the effective provision of quality services. Any LME-MCO that receives state or federal funding for a Cross Area Service Program (CASP) (as described in Attachment I, 7.3.7), to provide comprehensive regional or statewide services across multiple LME-MCOs, shall collaborate with the DMH/DD/SAS to designate a provider to receive such designated CASP funds to serve the needs of an identified population.

The LME-MCO shall conduct a community need and provider capacity assessment during the first quarter of this contract, using a standardized process and reporting format defined by the Secretary. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age-disability providers for each service. The assessment shall include input from consumers, families, community stakeholders, and CFAC. In evaluating the adequacy of the provider community the LME-MCO shall consider issues such as the cultural and linguistic competency of existing providers and provisions of evidence based practices and treatments and the availability of community services to address housing and employment issues. The assessment shall also measure the availability of providers willing to participate in community emergency response efforts, such as providing services in temporary housing shelters in the event of a natural disaster which triggers an evacuation. The LME-MCO shall report the results of the assessment using a standardized format to the DHHS, CFAC and the Area Board, and provide updates as needed to the Board and CFAC. The LME-MCO shall demonstrate that it is engaged in development efforts to address service gaps identified in the assessment.

In addition, the LME-MCO shall assess community need and provider capacity for children's services within the LME-MCO catchment area. The LME-MCO shall contract with a sufficient number of state-funded and non-Medicaid federally-funded service providers to ensure that children receive services in settings which are more likely to maintain or develop positive family and community connections.

If the gap analysis identifies an absence of provider(s) for any MH/DD/SA service, the LME-MCO's shall submit a plan to DHHS for developing a local provider community that offers choice for each service in their LME-MCO catchment areas in the next state fiscal year.

5.2. Choice of Providers and Treatment

The LME-MCO shall ensure that, except for services with very limited usage or services for which there is not sufficient demand or funding to support more than one provider, consumers have a choice of service providers consistent with CMS waiver requirements and DMHDDSAS. However, the LME-MCO is vested with the responsibility, under this contract, to decide the number of providers and which providers shall become members of the LME-MCO's provider network after the initial closure of the provider network.

For State-funded services, consumers shall have a choice of at least two providers for every service, except for those services with very limited usage and where alternative providers cannot be recruited.

The LME-MCO shall endeavor to ensure consumers have a choice of evidence based practices and treatments. The LME-MCO shall give consumers information on available providers to support selection of a provider.

Provider Capacity, Community Needs Assessment and Gaps Analyses
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Attachment B

Division of Medical Assistance Contract
Contract Excerpts regarding Provider Choice

6.8 Choice of Health Professional:

To the extent reasonably possible, LME/MCO shall offer freedom of choice to Enrollees in selecting a Provider from within LME/MCO's qualified Provider Network. LME/MCO shall ensure a choice of at least two Providers for each service, except specialties specifically approved by DMA in writing. Requests for exceptions may be based on such factors as medical necessity and demand. For example, exemptions may be granted if the demand for services, particularly facility based services or niche services, does not support two Providers.

An Enrollee who has received prior authorization from LME/MCO for referral to a Network Provider or for inpatient care shall be allowed to choose from among all the available Network Providers and hospitals within LME/MCO, to the extent reasonably possible.

LME/MCO shall coordinate its services with the services its Enrollees receive from other LME/MCOs, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) in order to avoid unnecessary duplication. In accordance with 42 CFR 438.208, LME/MCO shall share with other LME/MCOs, PIHPs and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (see Section 6.13) so that those activities need not be duplicated.

ATTACHMENT S (of Contract)
ACCESS AND AVAILABILITY STANDARDS

ACCESSIBILITY

A. Geographic Location: The Provider Network for all covered in-plan services must be as geographically accessible to Medicaid Enrollees as to non-Medicaid Enrollees.

B. Distance/Travel Time: Medicaid Enrollees should have access to Network Providers within thirty (30) miles distance or thirty minutes' drive time, 45 miles or 45 minutes in rural areas. Longer distances as approved by DMA are allowed for facility based or specialty Providers.

Excerpt from North Carolina 1915(b)/(c) Medicaid Waiver

"Enrollees will have free choice of providers within the PIHP serving their respective geographic area and may change providers as often as desired. If an individual joins the PIHP and is already established with a provider who is not a member of the network, the PIHP will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the PIHP will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve institutional services or highly-specialized services which are usually available through only one facility or agency in the geographic area. All PIHPs contract only with assertive community treatment (ACT) providers under the State Plan who maintain fidelity to the latest TMACT scale or its successor. This will ensure that all providers maintain fidelity to the current ACT model as it is updated. These services will be phased in and available as outlined under the settlement agreement with the United States Department of Justice."

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Requirements for North Carolina LME/MCOs

Attachment C
Service Groupings

Outpatient Services – All individuals must have a choice of two different provider agencies within 30 miles or 30 minutes (45 miles or 45 minutes in rural counties) of their residences.

Location-based Services – All individuals eligible for the services below must have access within 30 miles or 30 minutes (45 miles or 45 minutes in rural counties) of their residences and a choice of two different provider agencies for each of the following:

Services	Adult MH	Child MH	Adult SUD	Child SUD	Adult I/DD	Child I/DD
Psychosocial Rehabilitation	✓					
Child and Adolescent Day Treatment		✓		✓		
SA Comprehensive Outpatient Treatment Program			✓	✓		
SA Intensive Outpatient Program			✓	✓		
Opioid Treatment			✓			
Day Supports					✓	✓
Adult Developmental Vocational Program					✓	✓

Community/Mobile Services – All individuals eligible for the services below must have access to and a choice of two different provider agencies for each of the following:

Services	Adult MH	Child MH	Adult SUD	Child SUD	Adult I/DD	Child I/DD
Assertive Community Treatment Team	✓					
Community Support Team	✓		✓			
MH/SA Supported Employment Services	✓		✓			
Intensive In-Home		✓		✓		
Multi-systemic Therapy		✓		✓		
(b)(3) Waiver Peer Support	✓	✓	✓	✓		
Traumatic Brain Injury Services (non-residential)	✓	✓	✓	✓	✓	✓
Mobile Crisis	✓	✓	✓	✓	✓	✓
(b)(3) Waiver Individual Support (Personal Care)	✓	✓	✓	✓	✓	✓
(b)(3) Waiver Respite		✓		✓	✓	✓
Home-based I/DD Services					✓	✓
I/DD Supported Employment Services					✓	✓
(b)(3) Waiver Community Guide					✓	✓

Crisis and Inpatient Services: All individuals eligible for the services below must have access within the LME-MCO catchment area to at least one provider agency for each of the following:

Services	Adult MH	Child MH	Adult SUD	Child SUD	Adult I/DD	Child I/DD
Inpatient Hospital – Adult	✓		✓			
Inpatient Hospital – Adolescent		✓		✓		
Inpatient Hospital – Child		✓				
Facility Based Crisis	✓		✓			
Crisis Respite	✓	✓	✓	✓	✓	✓
Detoxification (non-hospital)			✓	✓		

Specialized Services – All individuals eligible for the services below must have access to at least one provider agency for each of the following:

Services	Adult MH	Child MH	Adult SUD	Child SUD	Adult I/DD	Child I/DD
Partial Hospitalization	✓	✓				
MH Group Homes	✓					
Traumatic Brain Injury Services – residential	✓	✓	✓	✓	✓	✓
Psychiatric Residential Treatment Facility		✓		✓		
Residential Treatment Levels 1-4		✓		✓		
Child MH Out-of-home respite		✓		✓		
SA Non-Medical Community Residential Treatment			✓	✓		
SA Medically Monitored Community Residential Trx			✓	✓		
SA Halfway Houses			✓	✓		
I/DD Group Homes and AFLs					✓	✓
I/DD Out-of-home respite					✓	✓
I/DD Facility-based respite					✓	✓
Intermediate Care Facility/IDD					✓	✓

The chart on page 11 indicates the information to be submitted for each service group.

Summary of Submission Requirements for Each Service Grouping

Service Group	Applicable Populations	Included in Provider Capacity Workbook	Maps	Charts
Outpatient Services (Including intake, diagnostic assessment & testing, evaluation/management, psychotherapy, MH/SA counseling, & medication management services)	All Medicaid beneficiaries All persons served with State funds	Number of providers and individuals served in applicable fiscal year by funder	One map for each funding source showing coverage based on provider locations and time/distance expectations	One chart for each funding source showing number and percent of consumers with a choice of 0, 1, or 2+ providers within the time/distance expectations
Location Based Services	All Medicaid beneficiaries eligible for service All persons in relevant age-disability group served with State funds	Number of providers and individuals served in applicable fiscal year by funder and service	One map for each service and each applicable funding source based on provider locations and time/distance expectations.	One chart for each funding source showing maximum distance any individual must travel to receive each funded service
Community Services	All Medicaid beneficiaries eligible for service All persons in relevant age-disability group served with State funds	Number of providers and individuals served in applicable fiscal year by funder and service	One map for each service and each applicable funding source showing provider locations and each provider's expected service area.	One chart for each applicable funding source showing maximum distance any provider must travel to deliver each funded service
Crisis & Inpatient Services	All Medicaid beneficiaries eligible for service All persons in relevant age-disability group served with State funds	Number of providers and individuals served in applicable fiscal year by funder and service	One map for each service and each applicable funding source showing provider locations (All services may be shown on one map, if each service type is clearly indicated.)	One chart for each applicable funding source showing maximum distance any individual must travel to receive each funded service
Specialized Services	All Medicaid beneficiaries eligible for service All persons in relevant age-disability group served with State funds	Number of providers and individuals served in applicable fiscal year by funder and service	None	List for each service, showing: • Provider name • Provider county • Provider state, if not NC • Funding sources (Medicaid, State)

Attachment D, Designation of urban and rural counties, is provided as an Excel spreadsheet named AttachmentD_UrbanRuralCounties.xlsx.