

**STUDY: Elements of Success in a 501c-3 spin off under NC Reform**  
**Attachment I**  
**Comparison Chart**

<b>Comparison Item</b>	<b>New Vistas/Mt. Laurel Western Highland LME</b>  <b>Divestiture started October, 2003 Full Divestment in March 2004</b> <b>(New Vistas merger with Mt. Laurel Jan 06)</b>	<b>Hope Ridge Centerpoint LME (CPHS)</b>  <b>Divestiture started July 1, 2004</b>	<b>DAYMARK Recovery Services (DRS) PBH LME</b>  <b>Incorporated: 7-03 Beginning of Operations: 1-1-04</b>	<b>DAYMARK Recovery Services (DRS) Centerpoint LME (CPHS)</b>  <b>Contract start date: August, 2005</b>
<b>1. Leadership</b>	<p>New Vistas/Mtn Laurel director was from a private hospital setting; no experience with NC public mental health system.</p> <p>Director at LME changed in mid 2006; new director from out of state.</p> <p>LME Finance Director retired Spring 2006; resultant loss of system knowledge and expertise</p>	<p>Hope Ridge Director hired with no previous experience in NC public sector; however she was well experienced in managed care due to prior experience with an MBHO</p> <p>LME leadership (Director and Asst Director) retired in October 2004; new Director was an attorney with 501c3 and litigation experience from out of state</p>	<p>Consistent leadership at the PBH LME level. Same leadership post-reform that managed the prior Area Program; navigated a merger to become five counties and spun off a successful 5013c, DAYMARK Recovery Services (DRS).</p> <p>DRS director had been clinician in System for long time; also served as Area Director for Davidson County since July 2003. Relationship between PBH director and Spin-off director already in place.</p>	<p>New LME Director engaged multiple providers to establish choice and robust fee-for-service network.</p> <p>In first quarter of business, most of the providers gravitated to non-core and non-medical services, creating service gaps.</p> <p>In same quarter, LME leadership became aware of their own IS/data concerns. DRS and LME have developed contracts to address service gaps</p>

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			<p>Key PBH staff provided expertise and support for DAYMARK Recovery Services</p>	<p>and IS deficiencies in billing, claims payment and tracking encounters.</p>
<p><b>2. Collaboration and Planning</b></p>	<p>Extensive planning around the mission and expectations of a spin off with little planning around a cost model to be successful. Some capitalization of spin off, but most capital resources returned to the counties for other uses.</p> <p>\$1.2 M spent attempting to set up IS and management infrastructure. Remainder of capitalization needed to float losses when they</p>	<p>Extensive planning and collaboration at onset. Lack of continuous communication and collaboration with Hope Ridge going forward; appointment drive system was not meeting needs, service and billing errors not corrected in timely fashion resulting in long payment lags. CBS-Community Support not addressing crisis needs for consumers.</p> <p>Lack of planning around</p>	<p>Extensive planning included staffing patterns and productivity studies, overhead and related funding. This information used to establish one-twelfth capitation allocations.</p> <p>Ongoing communication and collaboration; included weekly problem solving meetings the first year and at least monthly thereafter. Collaboration on system planning included the</p>	<p>CPHS provided one-twelfth capitation payments on a hold harmless contract. DRS provided billing data (encounter data) to CPHS so CPHS could draw down IPRS dollars.</p> <p>Within first six months, it became evident that DRS was providing all core and most of the medical services; in response, CPHS provided supplemental</p>

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	<p>shifted from advanced payments to Fee for Service.</p>	<p>management of state dollars.</p>	<p>development of crisis services and the "Advanced Access" model.</p> <p>Initial capitalization included IS system and hardware, office equipment and furnishings, as well as one-twelfth capitation payments for an unspecified period of time.</p>	<p>funding to underwrite core and medical services in a non-cost reimbursement method.</p>
<p><b>3. IS system</b></p>	<p>LME hosted information system for New Vistas.</p> <p>New Vistas did not have real time data; could not challenge data that was provided by LME.</p> <p>Still used calendar-based appointment schedule vs. automated version.</p>	<p>LME provided all IS support, including billing, payment, enrollment, etc. Hope Ridge paid the LME for IS services.</p> <p>Unable to provide real time data on productivity and service utilization.</p>	<p>PBH provided a complete provider information system as well as an Information Systems Director that had been specifically recruited to manage the information system. Benefits included:</p> <ul style="list-style-type: none"> <li>• Ownership and total control</li> <li>• Real time data</li> </ul>	<p>The PBH donated IS system provided DAYMARK the infrastructure to expand into Centerpoint after the collapse of Hope Ridge. DRS was able to purchase enough capacity for added users with start up money provided by Centerpoint via a contract signing</p>

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	<p>Fee paid to LME for the LME's management of New Vistas' claims.</p> <p>Unable to provide real time data on productivity and service utilization.</p>		<ul style="list-style-type: none"> <li>• Full electronic clinical system allowed streamlined processes and efficiency</li> <li>• Had data to use in problem solving with LME around reporting issues</li> <li>• Real time productivity reports for staff</li> </ul>	<p>bonus designed to start provision of services early in contract period.</p> <p>Able to negotiate transfer of software and licensing agreements.</p> <p>Produces real time productivity reports for staff</p>
<p><b>4. IPRS: state billing system and target population requirements</b></p>	<p>LME required provider to bill within 60 days of date of service. Often unable to bill within the 60 day period leaving "dollars on the table".</p> <p>Requirement to use Target Populations; result is extensive process on the front end to categorize</p>	<p>Unclear what data requirements were set forth because most of this type of information not in contract format.</p> <p>Multiple billing problems-not known whether problem on provider side, LME side or combination of both.</p>	<p>Waiver exempted PBH LME from IPRS reporting.</p> <p>No IPRS target populations simplifies enrollment, clinical and reporting processes.</p> <p>Treated diagnosis is used in billing (greater accuracy in reporting)</p>	<p>DAYMARK and LME work together weekly to improve data, billing, reporting and authorizations. DAYMARK provided IS assistance that allows Centerpoint to sort billing and payment information to various providers; benefit to all the Centerpoint</p>

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	<p>consumers when enrolled.</p> <p>Requires initial diagnosis vs. treated diagnosis.</p> <p>Each claim needs to be associated with a target population.</p> <p>IPRS pre-dated Reform; no anticipation of System's needs and how it would impact LME functions in their role of intermediary.</p>		<p>Direct relationship with PBH on billing and payment; PBH is not intermediary.</p> <p>LME has 90 day billing requirement, but flexible if COB exists.</p> <p>Billing of COB problematic; slow response from insurers delays reimbursement.</p>	<p>providers.</p> <p>LME has had difficulty in managing limited state IPRS resources across provider network.</p> <p>Non-Medicaid consumers are often served by multiple providers; diagnosis and assigned target population must match; providers submit conflicting information.</p>
<b>5. Access</b>	<p>To assure choice, the LME originally wanted all treatment referrals to be processed through them.</p> <p>Consumers given the 1-800 # if they went to a provider first. This system created problems. A year</p>	<p>LME operates an Access Center. Consumers are to call first, then get referred back to Hope Ridge or other providers. Can result in delay to first appointment.</p>	<p>Consumer can access directly through DAYMARK Recovery Services; DAYMARK enrolls consumers; provides data to the LME</p>	<p>DRS is major access point for most consumers; supplies data to CPHS. CPHS STR is also heavily utilized by consumers. CPHS sends many IPRS consumers directly to DRS.</p>

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	later a compromise was reached: for consumers who called or came to New Vistas, they could share information about choice and then allow the consumer to sign a document stating they had been offered choice of provider.			
<b>6. Service Mix</b>	Full continuum of services: traditional outpatient, core emergency, medical services, case management/community support and group homes	Full continuum of services: traditional outpatient, core emergency, medical services, case management/community support, sprcialized programs like partial hospital and day programs.	Partial continuum of services: Assessment, Psychiatry, Outpatient Crisis/after hours.  Also have some JCPC grants, DSS Family Preservation Grant.  Not contracted for Case Management or Community Support services.	Full continuum of services: traditional outpatient, core emergency, medical services, community support services, mobile crisis and partial hospital.
<b>7. Provider enrollment</b>	Unique billing number	Same as New Vistas	Provider numbers are	\$250,000 in claims

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<b>for billing purposes</b>	required for each clinician for Medicaid billing.  3 months delay to obtain numbers for clinicians.  Other Medicaid services such as Community Support do not require individual staff numbers, thus giving providers of Community Support a significant advantage over outpatient providers.		agency based (DAYMARK has only 3). Providers directly enroll with PBH.	outstanding at any given time because DRS is waiting for staff provider numbers.  Community Support providers have an advantage because provider numbers are not required for billing.  Shift in other providers to provide Community Support, has resulted in decrease of Medicaid and overly enrolled IPRS (capped funding)
<b>8. Rates</b>	Were subject to 25% reduction in Medicaid rates as mandated by State; impact was to discourage the provision of outpatient services	Same	No reduction in outpatient rates 7-1-05	25% reduction in Medicaid outpatient rates in 7-05; no incentive to provide outpatient services.

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<b>9. Facilities</b>	<p>Mt. Laurel owned 3 facilities, but used properties to develop a line of credit, ultimately resulting in bank activities to foreclose.</p> <p>New Vistas rented at fair market value; did receive one year free rent from one of the Counties.</p>	<p>County facility; nominal rent.</p>	<p>PBH community mental health centers were all in county facilities. Counties charged from none to nominal to very high rent. DAYMARK negotiated similar rent. In the one county with the very high rent, PBH subsidized DAYMARK's rent.</p>	<p>Whatever the county charged is passed on to providers; minimal to no cost. CPHS has covered rent to remain in Stokes County for provision of Medical Services.</p>
<b>10. Authorizations</b>  <b>For IPRS, each LME determines authorization requirements</b>  <b>ValueOptions: Authorization for each service by specific staff</b>	<p>NO unmanaged visits for IPRS</p> <p>ValueOptions for Medicaid; significant staff turnover at ValueOptions is hardship because auths are not valid for consumer if attending clinician changes. ValueOptions has been</p>	<p>One unmanaged visit for IPRS.</p> <p>Medicaid: ValueOptions, same as New Vistas</p>	<p>Authorizations not required until October 1, 2006 when payment system shifted from capitation to fee for service.</p> <p>Basic authorization consists of 8 unmanaged visits for adults; 12 for children.</p>	<p>Authorizations after the fact for IPRS. One unmanaged visit for IPRS.</p> <p>Medicaid: ValueOptions, same as New Vistas</p>

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<b>(so, auth not valid, if staff person is sick, resigns, etc). Process is not electronic, mostly by fax.</b>	unable to keep up with authorization demands and turn around of requests has been very slow.		Data transfer process is fully electronic; extremely efficient.	