REPORT OF THE
MECKLENBURG AREA MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND SUBSTANCE
ABUSE SERVICES PROGRAM

ORGANIZATIONAL REVIEW

Michael Moseley
Independent Consultant

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INTRODUCTION

This review represents a targeted assessment of the Mecklenburg County Area Mental Health, Developmental Disabilities and Substance Abuse Services Local Management Entity (LME). More specifically, the consultant was retained to:

- assess the LME organizational structure;
- assess the LME contracted services;
- provide written recommendations regarding the LME organizational structure and the management of contracted service providers; and
- provide a written assessment of the LME organizational structure and the management of contracted services.

The on-site review was undertaken over a two-week time period. Interviews of LME staff and of provider agency representatives were conducted targeting, as applicable, the above-referenced subject matter. In addition, the consultant reviewed pertinent State laws, rules, and policies; materials regarding the organizational structure as well as provider contracting processes of other select local management entities in North Carolina; and associated documents pertaining to the Mecklenburg LME. The report of findings and recommendations does not consider ancillary issues, which surfaced either during interviews with LME and provider staff or from the consultant’s personal observations, as such matters were beyond the scope of the review.

LME staff was extremely cooperative throughout the review process, and the assistance of the LME’s Deputy Director and Administrative Support Coordinator was especially invaluable in terms of their response to requests for documents and in making arrangements for meetings with co-workers and provider agency staff.

Below are the consultant’s summary findings and recommendations based on the issues assessed during the review, with further detail provided in subsequent sections of the report:

SUMMARY FINDINGS

- The Mecklenburg LME fulfills its functions as required by law. However, the LME’s current organizational structure impedes the effectiveness and/or efficiency of its staff in the discharge of their responsibilities and duties.
- Staff was generally complimentary of the LME and of the knowledge and passion of its leadership, but reported that there are limited opportunities for staff input into planning, policy development and decision-making processes.
- The Deputy Director’s span of control, scope of responsibility and delegated authority are limited.
- The role of the Division of Consumer Affairs and Community Services is substantial, and in some instances may create the potential for conflict.
The scope and volume of responsibilities assigned to staff of the Provider Relations Section are extensive, which results in some work assignments receiving less than the desired amount of attention. Furthermore, some of the assigned responsibilities appear to be conflictual in nature.

Contract management for the LME resides with the Provider Relations Section.

The Division of Forensic Evaluations and System of Care appears to be somewhat segregated from the rest of the LME.

The Medical Director and the Clinical Director do not appear to be utilized in the most effective and efficient manner.

Contracts managed by the LME are not re-bid on a regularly scheduled basis, and the role of the Financial Services Section is limited in the contract review process.

**SUMMARY RECOMMENDATIONS**

- The culture of the Mecklenburg LME should change to better involve staff at all levels in agency planning, policy development and decision-making.
- The functions of the Deputy Director’s position should be reviewed to ensure increased span of control, scope of responsibility, and decision-making authority.
- The Division of Consumer Affairs and Community Services should be reviewed for the possible reduction of its scope of responsibilities.
- The Provider Relations Section should be re-organized to establish a firewall between provider support and provider accountability duties, and its contract management duties need to be re-located elsewhere within the agency.
- Further local review is proposed to ensure that the work of the Forensic Evaluations and System of Care Division is better integrated into the on-going operations of the LME.
- The responsibilities and duties of the Medical Director and the Clinical Director should be reviewed to ensure the maximum utilization of their expertise and time.
- All contracts supported by State and/or local funds should be re-bid on a regularly-scheduled basis every three to five years.
- The Financial Services Section of the LME should assume a more substantial role in the contract review and re-bid processes.

**AGENCY OVERVIEW**

The Mecklenburg County Area Mental Health, Developmental Disabilities and Substance Abuse Services agency, a local County government department, has two distinct entities underneath its organizational umbrella. The LME is responsible for the oversight and management of the public mental health, developmental disabilities and substance abuse services system within Mecklenburg County. According to the LME’s annual report for fiscal year 2008-2009, “this oversight is accomplished through provider development, provider monitoring, provider contracting, Best Practice implementation and care coordination for individuals who receive public sector services.” The other entity of the LME is the Provided Services Organization (PSO), which directly provides certain highly specialized services to individuals within the Mecklenburg service catchment area. **The PSO was not subject to this review.**
The LME oversees the provision of a range of federal, State and locally-funded services to adults, adolescents, and children with mental illness, developmental disability and substance abuse problems. Offerings include early childhood intervention; substance abuse prevention; screening and evaluation; emergency and mobile crisis; community support and in-home support; peer support; outreach and skill development; social setting detoxification; and residential, inpatient, and outpatient services. Direct services are provided by more than one-hundred community-based agencies under the management oversight of the LME’s ninety-nine administrative, professional, and support staff.

The LME monitors service providers to ensure compliance with contract requirements, memoranda of agreement, and applicable federal and State rules and regulations; and requests plans of correction when providers are found to be out of compliance with contract requirements, agreement terms, or applicable rules or regulations.

**ASSESSMENT METHODOLOGY**

**Interviews of LME Staff**

The consultant engaged in on-site interviews involving forty-one of the LME’s ninety-nine staff, or 41.4% of the workforce, to ensure a representative sample of interviewees among agency staff. Approximately one-fourth of those interviewed had been employed by the LME for 2-5 years, one-half for 6-15 years, and one-fourth for over 15 years. Interviews included all LME senior and mid-level managers (including the legal counsel and clinical director), all available contract analysts/service coordinators, and all fiscal analysts involved in the provider contract review and monitoring process. In addition to these staff members, representatives of all other organizational work units (with the exception of non-supervisory employees assigned to the Utilization Review Section) were interviewed. Interviews, ranging in duration from approximately forty-five minutes to more than an hour each, were conducted during the period November 8-19, 2010. Interviews of staff responsible for billing and reimbursement tasks, as well as those performing claims processing duties, were held in two separate group meetings. All remaining interviews were conducted on a one-on-one basis.

Certain general questions were asked of each LME staff member interviewed. They were:

1. How long have you been employed at the LME and where were you employed previously?
2. What is your job title?
3. How would you describe your duties?
4. What are your perceptions of the LME in terms of its organizational structure?
5. Have you experienced any significant issues related to the organizational structure that have resulted in organizational ineffectiveness or inefficiencies?
6. What modifications, if any, would you recommend that might improve organizational effectiveness and/or efficiency?
Additional questions were asked of all staff based on the need for further clarifying information, and staff engaged with the provider contracting process were asked questions specific to their role and experience in the contract process. Responses to all questions were documented by the consultant for subsequent analysis.

**Service Provider Agency Interviews**

To gain their general insights regarding the LME/provider contracting process, the consultant interviewed representatives of two community provider agencies – one agency characterized as having a positive relationship with the LME and another with a long history of self-reported, negative interactions with LME management and staff. Questions directed to these individuals focused on their experiences in seeking contract opportunities with the LME; their views of the contractual process; and the nature of their interactions with LME staff engaged with them in contract negotiations, provider support, monitoring, and other provider relations activities.

**Review of Documents**

In addition to the interviews of LME and provider staff, the consultant reviewed a number of documents to help guide and support the assessment process. They included:

- The Mecklenburg County Area Mental Health FY 2008-2009 Annual Report
- Report of LME Provider Contracts by Fund Source and Contract Amount
- Report of LME Provider Contracts by Fund Authority, Fund Name, Service Provided, and Contract Amount; with assigned LME Contract, Fiscal, and Utilization Management Staff Liaisons
- Report of LME Provider Relations Data for the First Quarter of FY 2010-2011
- Sample of LME/Provider Contracts for State-funded and County-funded Provider Activities and/or Services per Disability Population Area
- LME Request for Proposals Financial Review Document
- Mecklenburg LME Table of Organization and of Other Select LMEs
- NC General Statutes Pertaining to the Functions of LMEs
- Report of the NC Department of Health and Human Services (DHHS) Independent Evaluation of the LMEs (i.e., Mercer Report)
- NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and NC Division of Medical Assistance (DMA) System Reform Implementation Updates (as applicable)
- NC DMH/DD/SAS Critical Access Behavioral Health Agency (CABHA) Policy and Procedures
FINDINGS AND RECOMMENDATIONS

LME Administrative Structure

NCGS 122C-115.4 states, in part, that “Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level.” The statute further indicates that an LME “shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.”

In accordance with the provisions of the above-referenced statute, the primary functions of an LME are to include:

1. access for all citizens to required core services and administrative functions (i.e., screening, assessment and referral, emergency services; service coordination; and consultation, prevention, and education) and a uniform portal of entry into care;
2. provider endorsement, monitoring, technical assistance, capacity development, and quality control;
3. utilization management, utilization review, and determination of the appropriate level and intensity of services;
4. authorization of the utilization of DMH/DD/SAS facilities and authorization of eligibility determination requests for recipients under the CAP-MR/DD waiver;
5. care coordination and quality management;
6. community collaboration and consumer affairs, including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee;
7. financial management and accountability for the use of State and local funds, and information management for the delivery of publicly funded services; and
8. development of a waiting list of persons with developmental disabilities that are waiting for specific services.

The NC DMH/DD/SAS, pursuant to legislative requirements and via an established administrative cost model, fully funds the LME to ensure the implementation of the required LME functions. Separate State funding is allocated to each LME to support the provision of services.

A cursory review of the organizational structure of a select number of LMEs throughout the State revealed that there are differences, yet distinct similarities, in their designs. However, each is organized such that the State-required and State-funded functions are clearly recognizable. In this regard, the current structure of the Mecklenburg LME fulfills the requirements of State law. Furthermore, the Mercer consulting firm, which was retained by the NC DHHS to evaluate the fulfillment of LME functions, concluded in 2008 that the Mecklenburg LME was among the top performing LMEs in North Carolina. Even so, further review by this consultant identified several areas that should be addressed to improve clarity, effectiveness and/or efficiency of operations.
Administrative Structure and Organization Culture

The vast majority of staff interviewed was generally complimentary of the Mecklenburg LME, and of the knowledge and passion of its leadership. However, many staff felt rather strongly that the culture of the organization needed to change. For example, staff suggested that the structuring of the organization appears to be based on personalities as opposed to the functional needs of the agency. This was particularly reported as it related to assignments to certain members of the senior management team, which will be expanded upon in a subsequent area of this report.

Employees appear to work well together, and there are a number of collaborative efforts underway in targeted areas. For example, various work unit representatives meet together at the beginning of the year to discuss provider contract allocations. In addition, collaborations were initiated a few weeks ago to discuss risk management implications of provider behavior performance and appropriate follow-up action. However, the perception among those interviewed is that this does not seem to be a widespread occurrence across the total organization, and that the organization “needs to find a way for people to work together more”. The perception is that participation in collaborative activities has historically occurred between the same staff members, and that limited forums are in place within which collaborative problem-solving is fostered. Increasingly, staff reported that one-on-one interactions between employees have recently increased rather dramatically, which apparently has not always been that way in the past.

Based on reports from nearly all of those interviewed, decision-making clearly resides at the top of the organization, with the delegation of responsibility without associated authority. Several interviewees made comments such as “this is a top-down organization” and “everything starts at the top”. There were also employees who indicated that meeting formats and agendas were not always conducive to open discussion. Consequently, they are reluctant to share their viewpoints during meetings. Others reported that their suggestions are oftentimes “blocked from getting to upper management” for consideration.

There were numerous reports of work units and of staff with different functions/job roles engaging in overlapping work tasks. This appeared to be an area of significant concern for most staff.

Staff also reported frustration that “things tend to stay the same because that’s the way they’ve always been done.” This was a repeated theme throughout the interview process. As such, it appears that continuous quality improvement is not integrated into the fabric of the organization and, thus, embraced and implemented by managers throughout the organization.
Recommendation(s):

1. The culture of the LME needs to change such that input into key planning, policy development, and operational decisions are initiated from internal and external stakeholders of the organization. Input into decision-making from staff throughout the organization, consumers, providers, and other stakeholders should be proactively solicited, valued, and entertained as key decisions are being considered.

2. The Director needs to empower staff throughout the organization by delegating authority to appropriate individuals, work units, committees and problem-solving teams in order to create an environment of shared decision-making. Furthermore, the Director needs to promote on-going dialogue and collaboration among staff of varied divisions and sections.

3. The Director needs to create a climate within the organization which allows for new ideas to emerge and where innovative thinking becomes the norm rather than the exception.

4. The Director needs to ensure that assigned quality improvement charters are addressed by applicable managers rather than being seen as solely the responsibility of the Quality Improvement Section.

Role of the Deputy Director’s Office

The Deputy Director’s Office is responsible for the oversight of information technology, utilization review, and clinical operations; and is assigned lead responsibility in relation to agency Medicaid waiver planning. The Deputy Director also serves as the second-in-command of the organization and acts as the person in charge during the absence of the Director. However, the position’s span of control, scope of responsibility, and delegated authority are limited. Consequently, when the Director is away, the Deputy Director is unable to make decisions except in those areas which reside directly underneath the position’s realm of responsibility. The incumbent has to, therefore, either contact the Director for guidance, await the Director’s return, or attempt to address certain matters without sufficient knowledge and/or information. This tends to frequently delay actions that sometimes require immediate attention. Staff suggests that this typically occurs most often in relation to issues pertaining to the Financial Services or Provider Relations sections.

Staff reported that there have been previous discussions regarding the potential expansion of the Deputy Director’s role, but no action was taken.

Several staff interviewed indicated that they were unclear as to what the role of the Deputy Director was, and others felt that the position was not needed.
Recommendation(s):

The Deputy Director’s span of control, scope of responsibilities, and delegated authority should be increased. In doing so, consideration should be given to the possible re-alignment of certain functions from the Division of Consumer Affairs and Community Services to the Deputy Director’s Office. Consideration should also be given as to whether the Deputy Director should continue to be the organization’s lead person in planning for the Medicaid Waiver or whether lead responsibility should be assigned to a subordinate underneath the Deputy Director.

Role of the Division of Consumer Affairs and Community Services

The Division of Consumer Affairs and Community Services is responsible for the oversight of network development, including provider network coordination, housing development, case coordination activities, outreach, and cultural competency planning and implementation; liaison with the Consumer and Family Advisory Committee; and provider endorsement, contracting and monitoring. The responsibilities of this division are substantial and, in some instances, may create the potential for conflict. For example, provider development activities, which staff assigned to the Provider Relations Section also assist with, could lead to (perceptual or real) conflicts when staff is also handling provider complaint, compliance, or enforcement tasks. Furthermore, the consultant understands that some of the assignments to the Consumer Affairs and Community Services Division may have been made due to the Division Director’s extensive knowledge of, and on-going personal interest in, certain assigned responsibilities.

Each LME in the State is structured somewhat differently, and some of the areas assigned to Consumer Affairs and Community Services reside elsewhere in other LMEs. There also appear to be some overlapping duties assigned to this division and others (e.g., both Utilization Management staff and Consumer Affairs and Community Services staff handle care coordination tasks related to complex consumer cases).

Recommendation(s):

1. The Division of Consumer Affairs and Community Services should be reviewed for the possible reduction of its scope of responsibilities. In doing so, consideration should be given to the possible re-assignment of those responsibilities related to housing coordination, case coordination, outreach, and the coordination of cultural competency to the Deputy Director’s Office.

2. The Division of Consumer Affairs and Community Services’ Provider Relations Section should be re-organized. (See rationale and recommendations below.)
Role of the Division of Consumer Affairs and Community Services’ Provider Relations Section

The Provider Relations Section is responsible for assisting with network and provider development activities, and for ensuring appropriate provider performance. Specific duties in relation to providers currently include network development, endorsement (i.e., approval for entry into the public system), contracting, credentialing, technical assistance and training, monitoring and follow-up, responding to provider inquiries, investigating complaints lodged against providers, compliance, and enforcement (which may result in the removal of endorsement). All of the duties are required to be performed by the LME per State statutes. However, the prescribed criteria and response schedules associated with them place a significant burden on staff.

For example, during the first quarter of FY 2010-2011, Provider Relations Section staff conducted 164 service provider monitoring visits, 18 additional monitoring visits specific to providers of CAP-MR/DD services, and 70 provider endorsement visits. In addition, staff issued 57 plans of correction (POC), resolved 47 POC deficiencies with providers, completed 70 provider monitoring tool reviews, and conducted 5 reconsideration reviews following provider appeals of LME endorsement decisions.

All of the noted duties are singularly important and essential, requiring focused attention and a substantial time commitment. Furthermore, the lack of sufficient attention to any one of the referenced areas of responsibility could result in unsatisfactory provider performance and, consequently, place consumers served by them in vulnerable circumstances. However, with the exception of only a couple of persons interviewed by the consultant, the collective opinion of staff across work units was that the scope and volume of responsibilities assigned to Provider Relations staff were too extensive. Of particular note, staff within the section self-reported that time constraints prevented them from addressing all assigned areas as they should, with one staff member voicing concern in “trying not to drop any balls”. Even so, staff indicated that some of the duties (e.g., the provision of technical assistance and training) generally went lacking.

In addition to concerns regarding the scope of responsibilities, the consultant noted (and most staff agreed) that a number of the duties appeared to be conflictual in nature. For example, some of the assigned duties were characterized as provider support activities (i.e., network and provider development, endorsement, contracting, credentialing, technical assistance and training, responding to provider inquiries, and perhaps monitoring and follow-up). Conversely, other duties were seen as adversarial in nature (i.e., conducting complaint investigations involving providers, and engaging in compliance and enforcement activities).

A Compliance Unit was previously established within the LME, but later abolished. It appears that it was disbanded due to overlapping tasks with Provider Relations.

There were also competing opinions offered as to whether contract management should continue to reside in Provider Relations.
Recommendation (s):

1. The role and functions of the Provider Relations Section should be separated into two distinctly separate work areas to establish a firewall between provider support and provider accountability duties. One example of how the separation of responsibilities might be organized, among other possible options, is as follows:

   Provider Relations Section – network/provider development, endorsement, technical assistance and training, credentialing, and the handling of provider inquiries.

   Provider Accountability Section – monitoring and follow-up, the handling of provider complaints and associated investigatory activities, compliance, and enforcement.

2. Contract management oversight responsibility for the LME, which currently resides with the Provider Relations Section, should be moved to another area within the organization. Although Provider Relations staff would retain a role in the process along with Utilization Management, Legal Services, and Financial Services, the management oversight function appears better suited for assignment to the Financial Services Division.

Role of the Division of Forensic Evaluations and System of Care (SOC)

The Division of Forensic Evaluations and System of Care occupies a unique role within the LME in that its work heavily funded by federal grant funding. Reporting directly to the agency Director, the Division Director has broad influence throughout the organization in shaping the agency’s SOC culture.

The Division Director also serves as the organization’s overseer of child mental health services, given that the primary focus of the federal Substance Abuse and Mental Health Services Administration SOC initiative targets children and youth with serious mental health problems and their families. However, although the division is reportedly well-run and has garnered Statewide and national recognition, it appears to be segregated from the rest of the LME. For example, it initiates its own Requests for Proposals (RFPs) and contracts for child-related services.

Recommendation (s):

Further local review is proposed to ensure that the work of the Forensic Evaluations and System of Care Division is better integrated into the on-going operations of the LME. In addition, since the division is such an integral component of the organization, there needs to be created (if not already in existence) a transition plan to ensure the continuance of the division’s work focus once federal grant funding ceases to be available.
Role of Medical Services and Clinical Services

Medical Services as well as Clinical Services provide essential leadership roles in relation to the LME’s responsibilities in managing clinical activities involving individuals served by, and throughout, its provider community. Both the Medical Director and the Clinical Director review individual consumer cases for service appropriateness. They also participate in leadership roles on various committees and in case-specific review tasks involving utilization management and related functions.

Several staff suggested the need for the increased availability and involvement of the Medical Director and the Clinical Director in certain clinical activities. Interestingly, both the Medical Director and the Clinical Director self-reported a feeling of being underutilized and undervalued. (The Clinical Director reported for the Medical Director.)

**Recommendation(s):**

Efforts should be undertaken to identify additional duties and responsibilities that could be assigned to both the Medical Director and the Clinical Director to ensure that their expertise and time are maximized and utilized in the most effective and efficient manner.

Provider Contract Management and Processing

The processing of contracts is a shared responsibility across several organizational units. However, staff expressed a mixed view as to their understanding of where the management oversight responsibility currently resided. Indicative of this lack of clarity, one staff member reported that SOC contracts are “owned” by the SOC Director, that the Financial Services Division “owns” other service contracts, and that miscellaneous contracts (e.g., contracts for substance abuse prevention activities, equipment maintenance, etc.) are “owned” by Provider Relations. The vast majority of staff interviewed reported that the management of all contracts was under the purview of the Provider Relations Section.

The consultant concluded that the organizational oversight for contract management is presently assigned to the Provider Relations Section. However, upon interviewing all staff connected to the contracting process, the consultant surmised that the role of Provider Relations staff in the process seems to be limited. In summary, an LME core team comprised of Provider Relations staff (referred to as service/contract coordinators), Provider Relations supervisors, fiscal analysts, and the SOC Director, among others, convenes at the outset of the fiscal year to determine the services to be provided by contract providers and how available funds should be distributed. Once determinations are made, the service coordinators communicate the decisions to the provider agencies. If a provider agency is displeased with the allocation amount, then the service coordinator communicates the provider’s response back to the assigned fiscal analyst, who reports the information to the finance/budget team.
This team then decides what the final allocation amount will be and the service coordinator communicates the decision to the provider.

The service coordinator subsequently keys relevant information into the eCura system, completes the boilerplate contract (via the State-mandated template for State funded services and County-required template for County funded services), and transmits the completed document to the assigned fiscal analyst to ensure its completeness and accuracy. Subsequently, the draft contract is passed along to legal counsel for final review. During the process, fiscal and legal staff tends to pose questions to the service coordinators regarding contract specifics, which service coordinators are usually unable to address without consultation with other more involved and knowledgeable staff.

Upon the execution of the contract, the service coordinator is responsible for monitoring all aspects of the contract for adherence to contract requirements, including the expenditure of funds, service provision expectations, and reporting requirements. Given the limited nature of the service coordinator’s role in the contractual process, it gives rise to the question as to whether Provider Relations really “owns” the process.

The LME enters into contracts with service providers who, in turn, agree to provide needed services to citizens of Mecklenburg County. Medicaid providers are endorsed by the LME, but actually contract with the State Medicaid agency (i.e., DMA). However, providers of services that are funded by State and/or local funds are required to enter into a contract with the LME. As such, the Mecklenburg LME manages a substantial number of contracts, the majority of which have been in force for many years. Current contracts generally range in dollar amounts totaling several thousand dollars to in excess of two million dollars.

Once executed, contracts are renewed at the beginning of each fiscal year when funding allocations are determined. Thereafter, unless significant compliance issues arise, contracts tend to remain in force. Staff reported that only one such contract has been terminated in recent history.

Staff also reported that the only time that the LME sought new contract providers was when new funding was made available (typically from State, local or federal grant dollars) for the creation of new services or when an expansion in the scope of existing services was needed. To seek provider interest, RFPs or Requests for Information (RFIs) are issued on an as-needed basis. Otherwise, contracts are not routinely re-bid to ascertain the availability, interest, and capacity of prospective providers. The LME’s failure to have a process in place for the periodic re-bidding of contracts results in repeated complaints from providers desiring to enter the system, feeling that they are being intentionally shut out of the system or prevented from contracting for certain services.
Recommendation(s):

1. The LME’s contract management process should be located external to the Provider Relations Section as well as the Division of Consumer Affairs and Community Services. Due to the significant fiscal implications related to the process, the Financial Services Division appears to be a more reasonable assignment area for contract management.

2. All contracts of the LME that are supported by State and/or local funds should be regularly re-bid in accordance with a pre-set review schedule – ideally every three to five years. Due to the high volume of contracts currently in place, the LME would need to consider the establishment of a staggered schedule such that proposals could be reviewed annually throughout the re-bidding period. Invited proposals could be grouped annually based on service or disability designations or other categories.

   The practice of re-bidding contracts could promote enhanced competition among providers, which should lead to improved provider performance. Furthermore, a re-bid process would permit the LME to ascertain if other providers are available that may provide certain existing contract services in a more effective or cost-efficient manner. Finally, it would offer a way for providers that have historically been unable to access the system an opportunity to be considered. (The Guilford Center for Behavioral Health and Disability Services currently has a re-bid process in place, which might serve as a model for Mecklenburg to consider emulating.)

3. The Financial Service Section, whether or not it is assigned management oversight responsibility, needs to assume a much more substantial role in the annual contract review process as well as in relation to a potential re-bid process. This would ensure that providers possess a sound financial foundation before the LME considers the initiation or renewal of a contract. The Financial Services Section has developed a financial review protocol that is currently used when competitive proposals are submitted in response to RFPs. It is quite possible that the same protocol could be expanded for use during annual contract reviews and/or during the re-bid process.

CONCLUSION

The implementation of the organizational changes recommended in this report would result in a major shift in the manner in which the Mecklenburg LME is managed and operated.

Note: Several of the cited recommendations carry with them potential staffing and cost implications. However, this was not considered by the consultant. In addition, the State fully funds the LME functions via a cost allocation methodology. Therefore, as re-organization is considered, decision-makers in the process should collaborate with Financial Services to ensure that the costs of required functions are properly segregated for cost reporting purposes.