Multnomah County – Mental Health and Addictions Services: Consultation on Managed Care and Local Mental Health Authority Functions and Operations

Why ask for consultation?
Managed Care Issues

Financial risk

- Financial risk to County if medical expenses exceed capitation revenue
- Concerns related to development of risk methodology used to develop capitation
- New Medicaid enrollees present an "unknown"

Change in oversight

- Government now being overseen by a private entity (Health Share)
- Health Share Board of Directors composed of providers

Changing healthcare environment

- Oregon's move from paying for volume to paying for value
- Increasing reliance on Medicaid as a funding source – reductions in State funding
- CCOs play a major role in the new healthcare landscape

Does the County have the right systems and structures to operate as a managed care organization in light of these changes?

Why ask for consultation?

Local Mental Health Authority (LMHA) Issues

Changing fiscal environment

- Re-deployment of state funds to support Medicaid expansion is challenging ability to operate the Community Mental Health Program (CMHP)
- Uncertainty of how much additional County support may be necessary to support the LMHA

Implications for the LMHA if no longer the RAE

- Impact on LMHA operations
- Ability to operate an integrated behavioral health system

Emerging concerns over commitment issues

- Increased pressure on ED and inpatient beds
- Lack of residential beds/housing is impacting ability to effectively treat and serve throughout the system
- Insufficient co-occurring disorder treatment
- Pervasive homelessness

What has the impact of health care transformation been on the LMHA?

Consultation Questions

- Should the County continue to as a Risk Accepting Entity (RAE) for Health Share Oregon?
  - What are risks and benefits of continuing or ending the County's contract as the RAE?
- Does the County have the necessary infrastructure to continue to operate as the RAE?
- What changes would be necessary to improve the County's performance as a RAE should the County choose to continue in this role in the future?
- What is the impact on the County's role as the Local Mental Health Authority (LMHA) if the County was no longer serving as the RAE?

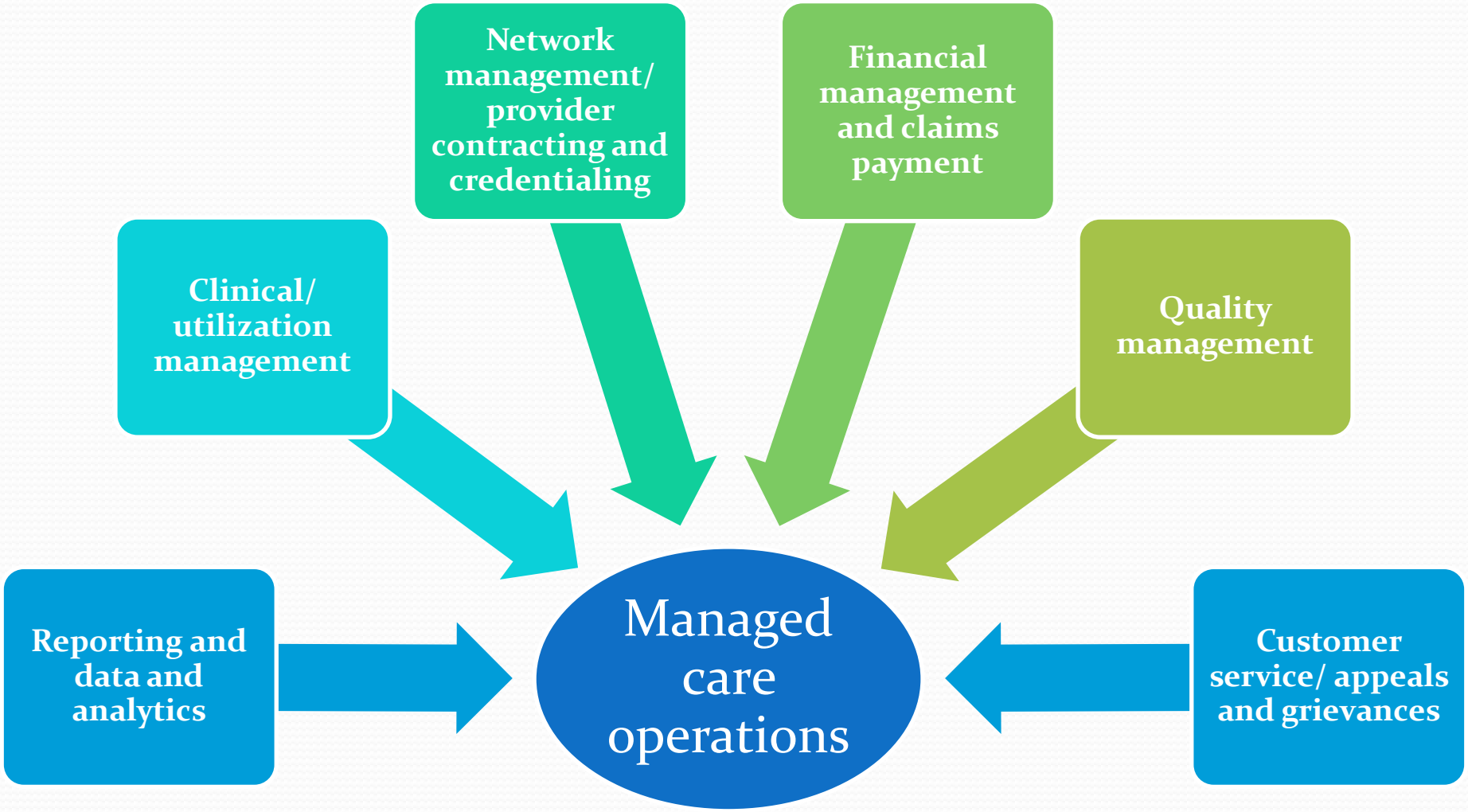
Consultation Questions

- What “possible futures” and options exist for the County?
- What are the implications for the LMHA given reductions in state funding?
- What are the issues impacting involuntary commitment in Multnomah County?

Major findings

Findings Specific to Managed Care Operations

Managed care core responsibilities



Financial systems

System Limitations

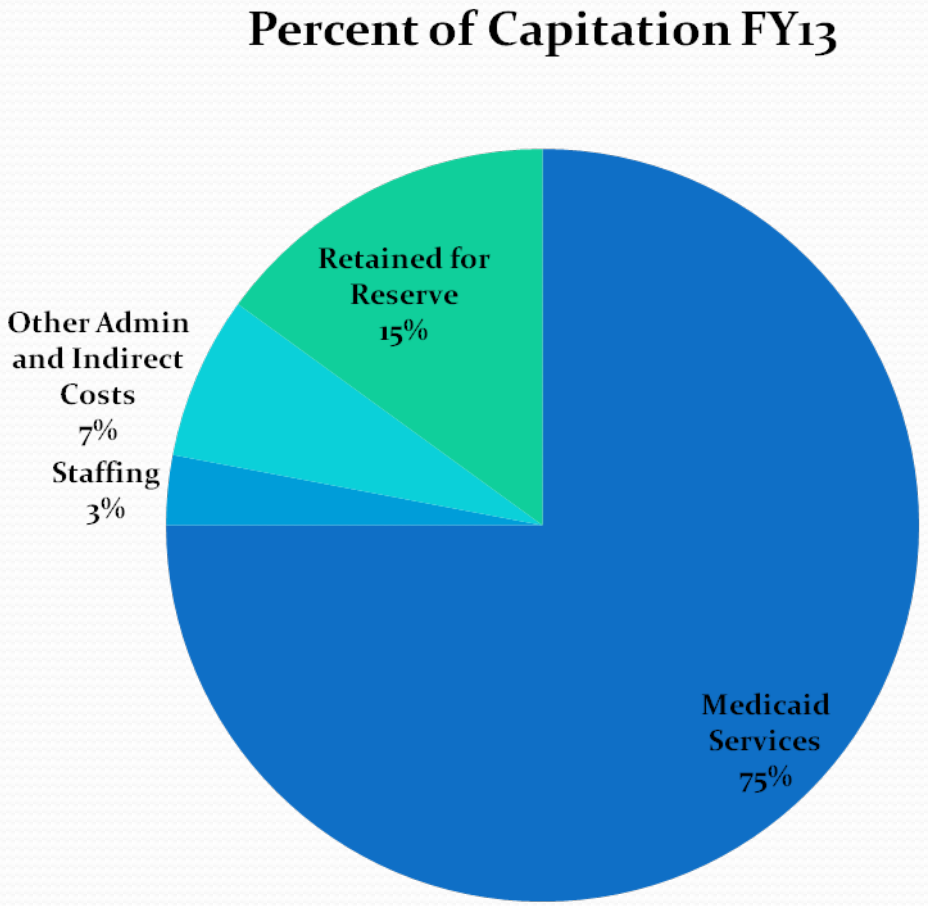
- The claims payment system and the accounting system do not "talk to each other" making reconciliation of claims reports with the accounting system nearly impossible.
- Reporting required for managed care is very difficult with the existing financial system.

Blending of revenues and expenses across programs

- Difficult to tell how staff are allocated across programs and funding sources
- Makes it difficult to analyze financial needs of both managed care function and LMHA

Financial Management

- Difficulty meeting contract requirement that at least **90.5%** of the Health Share funds be spent on behavioral health care services.
- In FY13, only **75%** of the capitation was spent on Medicaid funded services.
- Q1 FY 15 results reflect that the County is meeting the MLR – sustainability over time in question
- The ACA requires at least **85%** of premiums spent on services and quality improvement.



Utilization management

UM Approach

- Rate of denials and appeals higher than what Health Share is comfortable with
- Providers frustrated that services for youth in Wraparound had to go through UM process

Regionalization

- Difficult for the County to be nimble and make changes in its UM approach
- The County's size and difference in population may require them to manage differently

Network management and care coordination

- Providers seeking more contact with the County and would like a single point of contact to direct questions and address issues
  - Move toward global payments and focus on quality improvements suggests need for greater connection with providers
- More resources needed to provide care coordination for high utilizing adult members

Provider payment methodologies

- CCOs are expected to provide leadership for the transformation towards global and bundled payments.
- Differing perceptions of provider community regarding global payments and move to case rates*
  - Some providers unhappy with global budget as it would not allow a provider the opportunity to grow
  - Some were very pleased with global budget approach and do not want to transition to case rates
  - Some providers felt case rates should be individually negotiated to reflect the cost of specific programs

*Not all providers or services moving to a case rate payment

Quality management

Technical Assistance

- Providers need technical assistance and support to monitor their performance on important quality measures.
- A dedicated network manager could help provide this support.

Methodology

- Disagreement regarding the methodology used to calculate 7 day follow-up after psychiatric hospitalization.

Population

- Multnomah County's more complex population may impact performance on quality measures.

Leadership and staffing

- Managed care operations more complex and changing with health care reform.
- Current staffing may not be adequate
  - **Need to <u>hire a Director of Managed Care Program</u> with managed care experience to oversee the managed care contract.**
  - Need to create a position dedicated to network management.
  - Need more resources dedicated to care coordination.

Legal and contractual

- Legal agreement with Health Share is extremely complex which increases legal risk for the County
  - Contract between Health Share and the County frequently refers back to master contract between Health Share and OHP
  - Master contract between Health Share and OHP frequently refers back to OAR and ORS
- New relationship with Health Share with new expectations and requirements

Major findings

Findings Specific to LMHA Operations

Implications for LMHA absent Medicaid support

Funding

- Medicaid managed care comprises about 50% of MHASD funding for services
- Additional County funding to operate the LMHA needed if Medicaid admin funds are lost

Workforce

- A number of MHASD FTEs have shared duties across the Medicaid program and LMHA
- Vacating role as the RAE could mean a reduction in County workforce

Legislative Mandate

- Of $50M budget for non-Medicaid, only $4 M is spent on legislatively mandated County commitment services

Implications for LMHA absent Medicaid support

Influence

- MHASD would lose ability to decide/influence how to reinvest Medicaid funding into service expansion

Fragmentation

- Stakeholders describe system as "fragmented" as is; a stand-alone LMHA increases fragmentation

Implications for LMHA of re-deployment of state funds

Shift to Medicaid	• $20 M in state funding has been shifted from County Mental Health Program (CMHP) to Medicaid effective 1/1/2014
Indigent Support	• While some individuals are newly eligible for Medicaid, on-going demand for indigent support continues (15 new /week).
Non-Medicaid Services	• The CMHP funds many services and supports that are not Medicaid reimburseable
CMHP Capacity Issues	• Providers struggling to meet demand for CMHP funded services

Implications cont.

Funding cuts	• Immediacy of funding cuts while the system is in transition has **multiplied** pressure on the CMHP
Impact on effective utilization of resources at all levels of care	• Individuals leave treatment while waiting for services • Solid treatment plans are less effective when individuals have no place to live

Multnomah County currently contributes $17 M to fund the CMHP, more than any other county

Emerging Commitment issues

Emergency Holds	• The number of emergency holds and investigations has held steady for last 3 years • Public defenders and AG are increasingly challenging decisions
High Bar for Commitment	• The bar for MH commitment is high • Outpatient commitment exists in law but is not used
Overwhelmed EDs	• EDs are reportedly overwhelmed with persons with BH issues • Only 5-9% of visits are “MH” but avg. time spent per visit is 17 hrs
Bifurcated System	• The lack of comprehensive assessment, integrated treatment options and bifurcated funding under Health Share add complexity to appropriate SA/COD case disposition

Emerging Commitment issues cont.

Psych or Safety Holds	• ED physicians often pursue Psych holds when Safety holds would be more appropriate for individuals under the influence
Criminal Justice	• Judges, Police, Probation and Parole, Corrections Health report frequent interface with persons with behavioral health issues
Interventions	• Need for care coordination and more efficient/effective crisis response system or effective disposition to break the cycle of recidivism
Homelessness	• Homelessness is pervasive, including transition age youth and individuals with SMI/SA/COD

Recommendations

Necessary infrastructure investments and improvements to strengthen managed care and Local Mental Health Authority operations

Managed Care Program

Necessary improvements if County decides to continue as a RAE

Financial systems and management

- Invest in an accounting system that is designed to function for a managed care line of business
- Set-up a cost methodology to disaggregate FTE and expenditures by payer and program type
- Review amount of indirect and non-staff administrative costs allocated to managed care
- Work with Health Share to establish common definitions of administrative duties and associated costs.

Financial systems and management cont.

To meet the medical loss ratio (MLR) contract requirement, the County should:

- Reduce expenditures on non-staff administrative costs and increase direct service spending
- Ensure that all costs are being reported in the correct category for an accurate measure of MLR

Consider negotiating a MLR requirement of 85%

- The retained earnings are the County's one protection against the financial risk of the contract

Financial systems and management cont.

Hire an actuary	• This will help the County understand whether the capitation rates offered by Health Share are sufficient.
Seek opportunities to maximize Medicaid revenue	• Review those services funded with state or County general funds only to determine if aspects of those programs could be billed to Medicaid.

Utilization management

- Work with Health Share and Family Care to create solutions and reduce barriers to treatment for people with co-occurring mental heath and addictions issues
- Move forward in changing UM processes for children in Wraparound
- Consider expanding the capacity of the Multnomah Wraparound team
- Explore how to train and certify more providers in Multidimensional Treatment Foster Care

Utilization management cont.

- Take a more global approach to UM by creating a full-time network manager position
- Dedicate more resources to care coordination to help connect high-utilizing members with appropriate services
- Request Health Share evaluate areas such as service utilization and medical necessity criteria to ensure compliance with Mental Health Parity and Addiction Equity Act

Quality management

Review the existing QM plan to ensure it aligns with the goals of OHP

- Improved behavioral health/physical health coordination
- Reducing preventable re-hospitalizations
- Reducing costly services utilization by super-utilizers

Engage the provider network in developing Quality Improvement Projects in order to meet key performance metrics

Provider payment

- Collaborate with Health Share to ensure that solid base data is used in calculating case rates.
- Work to ensure providers understand case rate methodology.
- Ensure providers understand how base data is used, and what benchmarks are used in addition to base data to ensure the right incentives exist in the global budgets.

Leadership and staffing

- Hire a key leadership staff person with managed care experience to lead Health Share Multnomah Mental Health
- Consider creating a managed care operation distinct from the LMHA, possibly a 501-C.3 that can employ staff with appropriate expertise and experience while remaining under the authority of the County
- Create a position dedicated to network management activities.
- Dedicate more resources to care coordination.

Legal and contractual

- Engage legal counsel to ensure the County has a thorough understanding of their contract with Health Share as it relates to:
  - Financial risk,
  - Delegation of UM
  - Provider contracting functions

Local Mental Health Authority

Necessary improvements needed for LMHA, whether or not County continues as RAE

LMHA role and responsibilities

- Need to hire a leader to focus on managed care operations to allow for time and attention to LMHA functions
- Engage key stakeholders to assist in problem solving
  - State MH Director
  - Multnomah County Adult Mental Health and Substance Abuse Advisory Council

Improve Care Continuum to Reduce Need For Commitment

Assessments	• Comprehensive assessments at all points of entry
SBIRT	• Screening, Brief Intervention, Referral to Treatment for Substance Use Disorders
Integrated Treatment	• Continuum of integrated treatment for co-occurring disorders regardless of funding source
Crisis Capacity	• Enhance the capacity of the current crisis system
Care Coordination	• Enhance care coordination for high-end service utilizers, both Medicaid and Non-Medicaid

Other Strategies To Reduce Commitment

- Outpatient commitment
- “Safety holds” versus MH holds for persons under the influence
- Continue to implement strategies identified in the 10-year plan to end homelessness with a focus on effective strategies such as permanent supportive housing

Options and Possible Futures

Continue in current role as a RAE

Investment in Managed Care Infrastructure Required

- Leadership Position, Staffing and Accounting System
- Consider creating managed care operation distinct from LMHA, possibly creating a 501(c) 3 organization

Pros	Cons
• Being a part of health transformation • Maintains accountability at County level • Greater integration of services • Continue to operate an integrated system	• Requires substantial investment in systems and new staffing • Decisions impacting County budget being made by private entity • Financial risk • Differing perspectives of County and Health Share

Form a single behavioral health RAE for the region

Options:

1) Counties could form a quasi public organization to serve as the RAE
2) Multnomah County develops agreements to be the RAE for all 3 counties

Pros

- Distributes risk over a larger pool of individuals
- Creates admin efficiencies
- Reduces admin burden on providers

Cons

- Political feasibility question with other counties
- Decisions impacting County budget/ops being made by a private entity
- Financial risk

Become a RAE for specialized services only

Pros	Cons
• Decreases financial risk • Promotes integration for more people with substance use disorders • Maintains the County's expertise on specialized mental health programming	• Leaves County at risk for high cost services of most needy members • Leads to a more fragmented system • Shifts some dollars from County operations to a private contractor resulting in workforce reductions • Increases potential for cost-shifting

Propose to become an Administrative Services Organization (ASO)

Pros	Cons
• County no longer at risk for Medicaid services • Would allow the County to receive revenues to support operations • Would allow the County to continue to operate a comprehensive mental health and addictions system	• County would be a vendor to Health Share and would have little control or authority over critical decisions impacting UM • Eliminates the County's ability to benefit from effective management of the program • Requires investment in infrastructure improvements

Terminate RAE contract - maintain LMHA role

Strengthen Role as Local Mental Health Authority

- Keep Responsibility for Community Mental Health Program
- Contract with Health Share as a provider of services

Pros	Cons
• Lowers the County's financial risk • Allows the County to generate some Medicaid revenue for services • Allows MHASD to direct focus and resources to "what it does best" • Maintains County investment in its citizens with BH needs • Allows Advisory Council to re-focus attention and efforts	• Accountable to a private entity • Loss of Medicaid funds • County may be subject to cost-shifting from Medicaid • Ability to operate a comprehensive mental health and addictions system diminished • Funding may continue to be reduced/re-directed to CCOs • Likely to require additional County funding for staff/operations

Questions and Discussion