

Analysis

Item 12: Oregon Health Authority

Mental Health Residential Rates

Analyst: Linda Ames

Request: Acknowledge receipt of a report on mental health residential rate standardization.

Analysis: In a budget note established during the 2017 legislative session, the Oregon Health Authority was directed to conduct a rate analysis on mental health adult residential rates, and to report back on “a proposed plan for a standard rate or set of rates, a proposed schedule to move all providers to these rates, analysis of the cost, and plans for funding both the Medicaid and non-Medicaid components.”

The agency provided an update to the interim Joint Committee on Ways and Means in November 2017. A special purpose appropriation of \$2 million was established in the 2018 legislative session to help fund rate increases, if needed. At that time, the agency hoped to distribute funding to a few of the providers with the lowest and most disparate rates by Summer 2018, although data collection was still in its initial stages.

Providers of mental health residential services currently receive reimbursement in several ways. Providers receive a monthly rate for personal care/habilitative services through Medicaid, a monthly rate for General Fund services, and some providers can also bill Medicaid for rehabilitative services. Personal care includes daily life activities such as personal hygiene; habilitative services include life functioning skills such as buying a bus ticket or opening a bank account. Rehabilitative services include those focused on regaining and maintaining lost skills.

Monthly rates for personal care/habilitative service and for General Fund services vary significantly among providers. In general, older programs that negotiated rates years ago have lower rates than newer programs. These rates have little connection to resident acuity levels. In addition, not all providers are certified, or have certified staff, to bill for rehabilitative services, further increasing disparities among providers. Although agency training and assistance have increased the proportion of providers that bill for rehabilitative services from about 50% to 80%.

This lack of a standardized rate or set of rates is a major reason why the mental health residential system has not been transitioned over to the coordinated care organizations. In addition, there is concern that the rates for some providers are so low that the state risks losing capacity in the system, creating access issues for clients that need these services.

The agency has continued to work with the actuarial vendor Optumas to collect and code general ledger data from providers, as well as provide data analysis. In addition, a vendor is in the process of collecting independent resident acuity levels, and that data should be complete by approximately February 2019. This is a major piece of the data that is necessary to set the final rates. The rate standardization will eliminate the rate for General Fund services and will adjust the Medicaid rate for personal care/habilitative services which, based on this new methodology, will include program costs

except room and board, which is not an allowable Medicaid cost. The rehabilitative rate is outside of this standardization work, although adjustments may be made to that billing process.

OHA is currently in the process of finalizing rate adjustments for the 10 providers that have the lowest rates. The data collection and analysis for this group is now complete. The agency will use the questions and concerns raised by these 10 providers to validate the rates resulting from the methodology, or to identify areas of concern that may need more work. The latest estimate of cost for these 10 providers is between \$2.4 million and \$2.9 million total funds (\$0.5 million and \$0.6 million General Fund). The agency intends to fund these rate increases from its current budget.

These changes are dependent on federal approval of a State Plan Amendment that incorporates the new rates and methodology. The agency hopes to make the rate adjustments for the 10 providers by March 2019, retroactive to January 1, 2019.

Final rates may be available for the remaining 103 providers in time for a July 1, 2019 implementation, partly depending on how many issues are raised during the earlier process. Until final acuity data are available, it is not possible to estimate the final cost, and implementation will depend on funding. Final implementation will also include decisions on how to handle provider rates that go down as a result of the new methodology.

While the agency has been keeping the various provider organizations, county mental health programs, and Community Care Organizations (CCOs) informed about the high-level process, a more complete communication plan started the week of November 5th with communications to the 10 providers, as well as webinars on details of the methodology. OHA plans to continue to engage in implementation planning through rate simulations with providers, review of related draft rule changes with stakeholders, and training, webinars, and technical assistance on billing and rate changes.

Legislative Fiscal Office Recommendation: Acknowledge receipt of the report.

Request: Report on the Oregon Health Authority's progress on the standardization of mental health residential rates.

Recommendation: Acknowledge receipt of the report.

Discussion: This report represents the Oregon Health Authority's (OHA's) third update this biennium on the agency's progress to standardize mental health residential rates. The standardization of rates used by OHA to reimburse mental health residential facilities for both Medicaid and non-Medicaid services has grown increasingly important given the impact rate variances across providers and services could have on access to mental health treatment.

The underlying reasons for the existing rate discrepancies include: lower rates for providers with long-standing contracts compared to providers with newer contracts; lack of connection between rate levels and patient acuity; and differences between Medicaid and non-Medicaid rate structures. OHA provided a high-level report on this issue in November 2017 and again in January 2018 with a more detailed course of action to reach a standardized rate model. During February 2018, the Legislature appropriated \$152,500 General Fund for actuarial services and technical support to help develop the new rate model and established a \$2 million special purpose appropriation (SPA) to increase rates for certain providers, if needed.

The current update shows meaningful progress over the past several months in terms of completing an analysis of provider cost and claims data, advancing an analysis of patient acuity levels, and movement toward implementing a new rate structure. OHA's current focus is on 10 providers currently receiving the lowest rates. OHA and its actuary have now completed a new rate methodology for these providers, which will effectively serve as a proxy before expanding a new rate structure to all providers. The proposed rate methodology for the 10 providers includes adjustments based on client acuity, as well as demographic and geographic variation to account for wage, housing and transportation variances.

OHA anticipates most of the 10 providers will experience a rate increase based on the new methodology, resulting in an estimated increase in total costs ranging from \$1.8 million to \$2.4 million in 2017-19 assuming the rates take effect January 1, 2019. A significant portion of these costs will be eligible for federal Medicaid match. Since OHA has already identified sufficient funding within its existing budget for this purpose, OHA does not intend to request funding from the SPA to support the revised rates in 2017-19.

Next Steps: To implement the new rates for the 10 providers, OHA must submit a Medicaid state plan amendment for federal review and approval. Before doing this, the agency must complete a consultation with Oregon's tribal communities. If all goes according to plan, OHA will have the state plan amendment in place this winter, with the new rates for the 10 providers effective as of January 1, 2019. Before finalizing and rolling out new rates for the remaining providers, OHA will evaluate the impact of the rates for the 10 providers, as well as complete its analysis of patient acuity across the broader provider community. The analysis of patient acuity is imperative given its strong correlation to treatment costs. The earliest likely date a new rate structure could be implemented for all providers is July 1, 2019.

Throughout each of these steps are two critical ongoing actions OHA will take: communicating with providers and assessing the state budget impact. In terms of communication, OHA continues engaging providers, community mental health programs, coordinated care organizations and other stakeholders to identify potential challenges and ensure all parties are aware of and agree to the proposed rate changes. OHA's report further outlines the agency's plan to conduct a rate simulation with providers, review draft rule changes with stakeholders and provide training, webinars and technical assistance.

Evaluating the financial impact throughout the process is critical not only from a state budget standpoint, but also due to the potential for a new rate model to have both upward and downward impacts on providers' rates. Regarding the potential impact on providers, OHA is exploring ways to ensure services are not impaired during the rate adoption period. OHA might have flexibility to mitigate potential issues if savings are achieved by shifting certain costs currently supported with General Fund dollars to allowable Medicaid reimbursement, which OHA intends to maximize as part of this process. Conversely, scaling the rate model beyond the 10 low-rate providers could be challenged by budgetary constraints given the approximately 125 providers across the state. At this time, the potential impact on the state budget for doing this remains unknown.



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October 31, 2018

The Honorable Senator Peter Courtney, Co-Chair
The Honorable Representative Tina Kotek, Co-Chair
State Emergency Board
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Dear Co-Chairpersons:

NATURE OF REQUEST

The Oregon Health Authority (OHA), in response to the budget note included in House Bill 5026 (2017), and to report on the related designated special purpose appropriations funding in HB 5201 (February 2018 session), requests acknowledgement of this report, which includes:

- An update on the special purpose appropriation and transition of adult mental health residential providers in the lowest quartile of rates to a standardized rate methodology.
- Update on the standardized rate methodology for all adult mental health residential and implementation.
- Possible budget implications as the new rate methodology is implemented.

HB 5026 (2017) Budget Note:

The Oregon Health Authority shall conduct a rate analysis, including but not limited to provider costs as well as expected revenues from billing for rehabilitative services. The agency shall report to the Interim Joint Committee on Ways and Means by November 30, 2017 with a proposed plan for a standard rate or set of rates, a proposed schedule to move all providers to these rates, an analysis of the cost, and plans for funding both the Medicaid and non-Medicaid components. The plan should prioritize increasing rates for providers with the greatest disparity in rates, that is, providers who receive the lowest rates compare to more recent providers who typically receive higher rates. Contingent on available funding, the agency will implement at least the first phase of the plan beginning January 1, 2018. If the agency is unable to fully fund the plan within their existing budget, they should request additional funding during the 2018 legislative session.

HB 5201 (2018) Budget Note:

A special purpose appropriation was established for the Emergency Board of \$2 million to be available for rate increases for certain residential mental health service providers, if needed. Another \$152,500 General Fund was provided to OHA for actuarial services and to provide technical assistance to providers with data collection and billing.

AGENCY ACTION

Historically, OHA negotiated provider rates on an individual basis, based upon provider-submitted costs, with little connection to resident acuity. In 2007, a partial rate standardization effort resulted in two groups of providers, each paid according to a different rate methodology. Neither rate methodology is risk-adjusted nor tied to patient acuity.

Past Legislative Reports

OHA reported to the Joint Ways and Means Committee on October 16, 2017, related to an initial plan and proposed schedule to collect provider cost allocation plan (“CAP”) data, KEPRO individual assessments of consumers, community-based care rate reports and provider operating budgets.

OHA provided an update to the Joint Ways and Means Committee on January 12, 2018. During the three-month intervening period, October 2017-January 2018, OHA engaged the actuarial vendor Optumas to analyze collected cost allocation plans from cooperating providers, claims, and client assessment data for data analysis and rate development. OHA reported at that time on the initial trends identified by Optumas but found that additional data collection would be necessary. OHA requested additional funding to review for interim rate adjustment for providers with the lowest and most disparate rates, and funding for additional technical assistance with rate analyses.

Implementation

To provide additional provider revenue while OHA proceeded with the rate standardization analysis, OHA provided training and assistance related to Medicaid billing for rehabilitation services on a per diem basis. Eighty percent of mental health residential providers can now perform and bill for rehabilitation services.

OHA has continued working with Optumas on data collection and analysis since the January report. The lack of correlation between acuity of residents and provider cost presented a barrier to building a rate methodology based on initial data.

As a result, the vendor proceeded with an analysis of all general ledger data from providers. Data collection for the interim provider group and the overall standard rate analysis included provider engagement and interviews to clarify general ledger and budget submissions.

Additionally, independent assessments of residents' level of service needs had not been conducted in mental health residential settings until February 2018. That process began at that time and continues.

The development of the rate methodology continued through Optumas during the data collection and analysis of the lowest rates, such that OHA is recommending that the provider group with the lowest rates proceed with an early adoption of standardized rates, subject to State Plan Amendment approval by CMS.

Rate Methodology

The rate methodology has been developed with the overarching goal of consistent, equitable rates based upon client acuity and level of care needs. The tiered rate structure based upon client acuity includes adjustments for demographic or geographic variation to address wage, housing, and transportation pressures. OHA has also requested an add-on for clients with complex medical needs which significantly impact treatment and self-care.

Tying the rate structure to level of care needs determined through an independent process will allow the system to maximize personal choice, incentivize providers that serve individuals with complex needs, and incentivize positive outcomes like transitions to community-based treatment.

Additionally, the use of actuarially sound rates will facilitate future transition of residential services to CCOs.

Ten Lowest Rate Providers: Initial Transition to New Rates

During October 2018, OHA worked with Optumas on the projected fiscal impact of the new rate methodology on the ten providers. The impact of the standard rate on an individual provider's budget will vary based upon the clients' acuity levels. Based on our current understanding of resident acuity, level of care needs, regional rate adjustments and provider costs, the majority of the ten providers will receive an increase in funding.

Before implementing the rates for these ten providers, OHA must:

- Complete tribal consultation (initiated 9/19/18) on the draft State Plan Amendments (SPAs) for the standardized rate methodology; the SPA cannot be effective prior to January 1, 2019.
- Publish draft rates for SPA submission; and
- Assess feasibility of MMIS, vendor, county and contract changes.

The rate standardization, including implementation with the first ten providers, will include OHA discontinuing the General Fund dollars to the counties for OHP eligible clients and shifting Medicaid allowable program operations dollars currently paid through the General Fund county contract passthroughs to the Medicaid standardized rate. General Fund county contracts will continue to cover Non-OHP eligible residents who are served under the OHA Behavioral Health safety net.

The estimated 2017-19 budget impact to implement the new rate methodology for the ten providers effective January 1, 2019, is:

Low Estimate: \$1,813,626 Total Funds (\$132,876 General Fund and \$1,680,750 Federal Funds)

High Estimate: \$2,440,752 Total Funds (\$322,913 General Fund and \$2,117,839 Federal Funds)

Because of this relatively small General Fund impact, OHA is not requesting funds from the special purpose appropriation.

Application to All Residential Providers

The independent qualified agent is completing an annual review cycle of independent client assessments. As this data is collected, OHA is working with the actuarial vendor and Budget to refine a lower and upper bound range for the system wide rate standardization 19-21 cost. OHA will maximize allowable Medicaid match for the standard rates and will transition from the rehabilitation services per diem back to the individual procedure code billing.

In addition to continued rate analysis, OHA will continue to engage in collaborative implementation planning with county CMHPs and residential providers, including:

- Rate structure overview with vendors;
- Rate simulation with providers;
- Review of related draft rule changes and discussions how to improve client outcomes and support providers supporting clients with more complex behavioral issues as well as medical complexities for an aging population; and
- Provider training, webinars and technical assistance on billing and rate changes.

OHA will continue to update the Legislative Fiscal Office and Department of Administrative Services on its progress.

ACTION REQUESTED

Acknowledge the receipt of OHA's report.

LEGISLATION AFFECTED

None.

Sincerely,



Patrick Allen
Director

CC: Linda Ames, Legislative Fiscal Office
Ken Rocco, Legislative Fiscal Office
Tom MacDonald, Department of Administrative Services
George Naughton, Department of Administrative Services