Analysis

Item 4: Oregon Health Authority

Mental Health Residential Rates

Analyst: Linda Ames

Request: Acknowledge receipt of a report on mental health residential services rates.

Recommendation: Acknowledge receipt of the report.

Analysis: In a budget note, the Oregon Health Authority was directed to conduct a rate analysis on mental health 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."

Providers of mental health residential services 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 a lost skill. General Fund is used to help fund the residential program operating budgets for things that Medicaid does not fund.

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. In addition, only about half of providers are certified, or have certified staff, to bill for rehabilitative services, further increasing disparities among providers.

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, and creating access issues for clients that need these services.

In order to conduct a rate analysis, the agency developed a cost allocation plan template and distributed it to all mental health residential providers to collect data on home/facilities expenses, staffing expenses, service utilization, and revenues. Nearly 70%, or 87 out of 125 providers submitted their data over the summer. The agency is now in the process of analyzing this data, as well as incorporating other information such as payment information from the Medicaid Management Information System (MMIS). Ultimately this work will result in an integrated Medicaid and non-Medicaid expenditure model that can compare current expenditures with projected expenditure levels based on possible rate proposals and scenarios, aimed at a solution that will ensure the stability of the system for both clients and providers.

Over the next 1-2 months, the agency expects to have a proposal for a rate or set of rates, and the associated fiscal impact, that will address the range of providers delivering Medicaid and non-Medicaid services, and account for different levels of care due to client acuity levels. The agency

plans to keep providers updated on the process, and engage volunteer providers to model the preliminary rates for their specific operations, to further validate the model. The final implementation is expected to be phased in over time, and will prioritize providers with the greatest rate disparity, as well as demonstrated operational risk.

Depending on the results of the analysis, the agency may need to ask for additional funding during the 2018 legislative session.

The Legislative Fiscal Office recommends acknowledging receipt of the report.

Request: Report on mental health residential rates.

Recommendation: Acknowledge receipt of the report.

Discussion: Several issues have caused discrepancies among the rates the Oregon Health Authority (OHA) uses to reimburse the state's network of mental health residential facilities for the Medicaid and non-Medicaid services they provide. These issues include: insufficient growth of rate levels over time in comparison to increasing costs of services; differences between Medicaid and non-Medicaid rate structures; lack of certification for some facilities to provide Medicaid services; and lower rates for long-standing contracted providers versus the rates for newer contracts.

The rate discrepancies serve as one of the reasons the residential mental health benefit is paid on a fee-for-service basis as opposed to being part of the capitated payment structure of the Coordinated Care Organization (CCO) benefit package. The rate discrepancies also increase the risk of problems with access to care for those needing residential mental health services. OHA has addressed part of this risk in the short-term by providing technical assistance for those with qualified staff to bill Medicaid for the provision of rehabilitative services. Yet there continues to be a need to establish a sustainable, long-term standardized rate methodology to adequately and equitably fund residential service providers across Oregon. This is critical for access to care to be preserved for those needing residential mental health services.

Current Status of Rate Standardization Process

OHA began a cost analysis of the mental health residential facilities in the 2015-17 biennium and has submitted a report to the legislature pursuant to the following budget note in House Bill 5026 (2017):

> *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 compared 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.*

OHA has made progress on the provider cost analysis process by submitting cost allocation plan templates to its provider community of 125 residential homes and facilities to capture the necessary expenditure data. Of these entities, 87, or approximately 70 percent, provided feedback. The analysis of this expenditure data, as well as expenditure data from other sources, such as the Medicaid Management Information System, is on-going and will result in an integrated Medicaid and non-Medicaid expenditure model that compares existing expenditures

with an estimated expenditure level necessary to ensure stability in the mental health residential system. Due to the volume of complex work involved, OHA will need the assistance of an actuarial firm to complete the expenditure model, but will work to minimize the scope of work completed by outside help as much as possible. OHA anticipates completion of the cost data analysis sometime in November 2017.

Next Steps and Potential Costs
Most of the other required reporting elements identified in the budget note will have a longer track given the complexity of the issue and the length of time required for the agency to develop and propose a comprehensive standardized rate plan. The estimated completion dates of the other components of the work are as follows:

- November 2017 – options for standard rate or set of rates
- January 2018 – estimated fiscal impact and proposed schedule to move all providers to the new rates
- February 2018 – request for additional resources (if necessary)

The estimated fiscal impact and potential request for additional funding should indicate the extent to which the rate discrepancies can be resolved within the current level of Medicaid and non-Medicaid payments while ensuring each provider is sufficiently paid for services and access to care can be maintained. It will also be crucial for the fiscal impact to be estimated beyond the 2017-19 biennium in order to adequately assess the costs of any rate implementation plan considered for adoption.

Since the work on a standardized rate plan remains on-going, OHA's current report submission effectively serves as an initial status report, with additional updates to be provided in the future as the rate standardization process takes shape. The agency intends to provide additional details when it presents its report to the Interim Joint Ways and Means Subcommittee on Human Services.

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October 17, 2017

The Honorable Senator Richard Devlin, Co-Chair
The Honorable Representative Nancy Nathanson, Co-Chair
Interim Joint Committee on Ways and Means
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Dear Co-Chairpersons:

Nature of the Report

As requested in the budget note for House Bill 5026-A (2017 Regular Session), this report presents the Oregon Health Authority's (OHA) proposed plan for standardizing reimbursement rates for adult mental health residential services and the work completed so far to build the plan.

HB 5026-A 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 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 compared 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.*"

Agency Action

Background

Current residential reimbursement

As shown in the following chart, residential providers receive reimbursement in several ways, and the rate of funding varies across providers.

- **Medicaid** pays for personal care services to Oregon Health Plan members in adult residential settings. Under personal care rates, certified facilities may bill habilitation and personal care services. Mental health rehabilitation Medicaid services are billed separately.
- **General Fund** funds the residential program operating budgets, as well as rent subsidies for facility operations. OHA contracts with counties to coordinate residential programs that pay individual facilities for facility operations and in some counties, rent subsidies. OHA also has some direct contracts with individual facilities.

Per Person Per Month Rates

			Medicaid			General Fund					
			Personal Care Rates			Operating Costs			Rent Subsidies		
Provider Type	Total	Beds	Min.	Max.	Avg.	Min.	Max.	Avg.	Min.	Max.	Avg.
Residential Treatment Facility	44	449	$1,164	$8,563	$4,115	$0	$8,808	$1,011	$0	$1,475	$454
Residential Treatment House	57	253	$2,458	$10,240	$4,040	$0	$25,715	$6,005	$70	$1,564	$570
Residential Treatment House/Young Adult Program	4	19	$3,000	$6,696	$4,676	$0	$10,146	$4,550	N/A	N/A	N/A
Secure Residential Treatment Facility	21	205	$6,144	$20,649	$11,485	$0	$6,566	$1,378	$354	$1,060	$742

Residential entities also receive other revenue, such as room and board payments from the residents; Supplemental Security Income (SSI); and Supplemental Nutritional Assistance Program (SNAP) payments. Depending on the eligibility of their residents, providers may not receive some of these payment types.

Causes of residential rate disparities

For Medicaid-covered services, disparities exist because:

- Only certified providers are allowed to bill for rehabilitation.
- Almost half of all residential facilities are certified to also provide Medicaid-covered mental health rehabilitative services, but may not regularly access this funding, either due to lack of training on how to bill Medicaid[1] or because they do not have staff certified to provide these services.
- A few providers have personal care/habilitation rates that are bundled with rehabilitation rates, so they cannot currently bill rehabilitation separately.

Other reasons for reimbursement disparities among residential providers include:

- Individual client needs determine the service intensity. Service intensity directly affects payment rates and provider costs. This is true for both Medicaid and General Fund services.
- Some providers who can bill Medicaid for personal care/habilitation or rehabilitation do not receive GF payments for operating costs or personal care/habilitation.

Rate standardization will address the inconsistent rate methodology applied to programs as the residential system developed over time.

- Older programs that negotiated rates when the system began have lower rates than newer programs.
- In addition, older programs have bundled rates that preclude additional billing.
- Different rates between older and newer residential programs, especially if older providers have not requested a rate review in recent years. Providers without a recent review tend to have lower rates.

Rate standardization would allow OHA to further consider transitioning these services to coordinated care organizations.

[1] In October 2016, the Authority provided training on Medicaid billing to help certified facilities access additional revenue. OHA continues to provide technical assistance to individual facilities.

Status Summary

The following table shows the OHA's progress on each piece of the requested standardization plan.

Standard rate or set of rates	**Est. Nov. 2017**
Develop Cost Allocation Plan (CAP)	Complete
Collect CAP data: 87 of 125 providers submitted CAPs	Complete
Collect data from other sources	Complete
Proposed schedule to move all providers to these rates	**Est. Jan. 2018**
Analysis of the cost	**Est. Nov. 2017**
Perform preliminary data analysis	In progress
Create integrated expenditure model	In progress
Build models of rate methodology options, including fiscal impact	Est. Nov. 2017
Determine fiscal impact analysis	Est. Jan. 2018
Plans for funding both the Medicaid and non-Medicaid components	**Est. Nov. 2017**
Identify current Medicaid and non-Medicaid total expenditures	Complete
Examine Medicaid allowable expenditures	In progress
Request additional funding (if required)	Est. Feb. 2018

Collection of provider cost allocation plan (CAP) data

For the rate analysis, OHA sought to gather data about the operational expenditures of all residential providers for a common time period (*i.e.*, the most recent audited financial period).

- In June 2017, OHA developed and distributed a CAP template to residential providers to collect data about home/facilities expenses, staffing expenses, service utilization, and revenue, as well as a cost allocation time study for a week in April 2017.
- 87 of 125, or nearly 70% of provider homes/facilities submitted their CAP responses by the August 1, 2017 due date.
- OHA developed validation tests and applied them to the 87 submissions.

Data analysis to construct new rates

In order to come up with possible rate proposals, OHA is examining data from the CAPs and other sources. Other data sources include:

- Kepro, OHA's Independent and Qualified Agent responsible for authorizing 1915(i) services
- The Medicaid Management Information System
- Community Based Care Rate Reports
- Provider operating budgets

Next Steps

Developing integrated expenditure model

To test the fiscal impact of possible rate proposals, OHA is developing an expenditure model based on total Medicaid and non-Medicaid expenditures to residential providers. OHA will then compare current expenditures with projected expenditures based on possible rate proposals and scenarios. This model will ensure stability of the delivery system for both clients and providers.

Current expenditures include:

- Non-Medicaid payments: Contracted and invoiced services
- Medicaid payments: Personal Care and Habilitation; Mental Health Rehabilitation

The rate scenarios will address:

- The range of providers delivering Medicaid and non-Medicaid services
- Different levels of care due to client acuity levels

In addition, OHA plans to:

- Engage provider volunteers to similarly model preliminary rates in their operational budgets, concurrent with internal OHA modeling.
- Use the model to effectively manage residential payments and monitor rate standardization impacts on providers and the overall delivery system.

OHA is seeking help from an actuarial services contractor (Optumas) to provide independent review of:

- Rate methodology options
- High-level fiscal impact of those options
- Oregon's rate options as compared to other states

OHA will determine the fiscal impact of rate standardization efforts based on the completed analyses from OHA and Optumas. OHA expects to complete this work in time for the 2018 legislative session in order to present the fiscal impact, and request additional funding, if needed.

Phased implementation plan

Based upon simulation and validation of the proposed standardized rates, OHA will develop a phased implementation of the rates. The implementation will:

- Prioritize providers with greatest rate disparity; bundled rates; and demonstrated operational risk
- Include training providers on how to bill MMIS using the revised Medicaid rates; submit CAPs; and document allowable Medicaid expenditures.

This phased transition will require monitoring to ensure provider stability and quality client care. OHA will begin monitoring with the integrated financial model, and explore other areas to monitor as appropriate.

Action Requested

Acknowledge the receipt of OHA's report.

Legislation Affected

None.

Sincerely,

Patrick Allen
Director

CC: Linda Ames, Legislative Fiscal Office
Tom MacDonald, Department of Administrative Services