

Montana's History with Managed Mental Health Care

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Background

Montana moved into and out of a managed care mental health system in the 1990s, starting in 1993 with planning and legislative efforts that laid the groundwork for managed care and ending in mid-1999 with cancellation of a problem-plagued managed care contract.

The 1999 Legislature essentially forced cancellation of the contract with Magellan Behavioral Health, which had failed to make payments to providers as scheduled, sought to cut provider rates, and -- based on an agreement with the state -- changed service offerings and premiums.

Magellan, for its part, said it lost \$15.7 million in its first year of operation in Montana and was losing \$1 million a month on the contract.¹ The Atlanta-based Magellan inherited the \$400 million, 5-year managed care contract when it bought Merit Behavioral. Merit had acquired the original contractor, CMG Health, just months after CMG started operating the managed care program in April 1997.

The Vision for Managed Care

Before the state moved to the managed care model, it provided mental health services to Medicaid recipients on a "fee-for-service" basis, meaning providers billed the state for any eligible service provided to a patient. It also used state general funds and federal block grants to contract with a limited group of providers, primarily community mental health centers, to serve low-income consumers who did not meet Medicaid eligibility requirements.

As Medicaid expenses rose, the state looked for ways to control the costs. In April 1993, the state began talking with consumers, advocates, and providers about the managed care option. During a budget-cutting special session in November and December 1993, lawmakers approved House Bill 33. The bill allowed for capitated health care, or health care provided by an entity that receives a fixed payment to design and provide services to a target population. HB 33 also gave the state the ability to contract for management of mental health services and created an advisory group to work on a managed care plan.

The 1995 Legislature enacted further provisions, through Senate Bill 223, to allow managed care to go into effect for mental health services,

Meanwhile, DPHHS sought and received a Medicaid waiver that allowed it to put a managed care program in place. A Medicaid waiver allows a state more flexibility in how it provides services to a targeted group of people, as long as the costs of the services offered under the waiver costs are the same as they would have been for services provided under the traditional Medicaid rules.

¹Kathleen McLaughlin, "Magellan, Care Coalition Compromise," *Missoulian*, Sept. 17, 1998 [online]; available at <http://www.missoulian.com/articles/1998/09/17/export57401.txt>; accessed Oct. 6, 2008.

The department then issued a Request for Proposals (RFP) in October 1996 that laid out its vision for a managed care mental health program -- a vision that sounded much like the goals voiced by advocates and administrators today: to provide services to eligible individuals "in a manner which will increase access to a flexible, consumer-centered array of high-quality, cost-effective mental health services."²

However, the services were to be provided "through an integrated, risk-based system of managed care"³

The RFP said the move to managed care was prompted by a growth in Medicaid mental health expenditures and a perception among legislators, consumers, state agencies, and providers that the existing system was not meeting needs or expectations.

Under the managed care model, the successful bidder would be paid a fixed amount and would assume all financial risks for providing or arranging for the necessary services. In return, the company could keep up to 7.5% of the profits it made, depending on which targets it met for paying providers of services in a timely manner. Profits above the various targets for performance would be returned to the state. The RFP emphasized that the company receiving the contract "**should endeavor to avoid the possibility of profits in excess of established maximums by reinvesting revenues in service development and improved quality of services.**" (Emphasis original to the RFP.)

The contract was awarded to CMG Health, which began operating the managed care program in April 1997. Within months, Merit Behavioral acquired CMG and shortly thereafter, was itself acquired by Magellan.

The Promise Fades

While managed care for the mental health system was ushered in with the hopes it would improve services, spur creativity in service development, and better manage the state's costs, problems with the system surfaced within months. And barely a year after managed care went into effect, a financial audit of Magellan raised red flags about the firm's continued operations in Montana.

The audit said the company lost \$15.7 million in its first year of operations and faced numerous complaints from health care providers and patients. Shortly after that news came out, Magellan proposed to cut provider rates in order to reduce its costs, threatened to cancel the contract, and eventually negotiated with the state for changes designed to control costs. The changes required some clients to pay premiums and eliminated some services.⁴

Despite the changes, provider and consumer complaints mounted, and Magellan was unable to consistently meet the contractually set targets for paying providers on time.

In February 1999, the Joint Appropriations Subcommittee on Human Services eliminated funding for a managed care contract. As a result, the state and Magellan agreed to terminate the contract effective June 30, 1999.

²State of Montana Request for Proposal, Managed Mental Health Care, Oct. 8, 1996, P. 100-1.

³Ibid.

⁴Kathleen McLaughlin, "Montana, Magellan Make Peace," *Missoulian*, Oct. 24, 1998 [online]; available at <http://www.missoulian.com/articles/1998/10/24/export58091.txt>; accessed Oct. 6, 2008.

Recommendations

- ▶ Review and develop plans for pay for performance options in Medicaid and begin a planning process to implement them. This process will need to include key purchaser, consumer and ultimately provider stakeholders, and content experts in performance measurement and improvement. Develop a strategy for a small pilot.
- ▶ Designate a small pool of state general funds to be used for a pilot of performance contracting. Establish incentives for performance and/or tie them to attaining desirable client outcomes. Implement, measure (monthly or quarterly) and revise as needed over the next two or more years.
- ▶ Implement other quality improvement projects to create action on important performance improvement areas. These should be voluntary and intended to promote professional development as well as performance improvement. They should follow the Quality Improvement (QI) models proposed by the Network for Improvement of Addiction Treatment or the Institute for Healthcare Improvement.
- ▶ Develop provider reporting that includes key performance measures of client outcomes and can inform quality improvement with specific and periodic measures.
- ▶ Develop more specific contract and licensing service standards and performance requirements, and monitor provider performance more closely, with regular performance based contract reporting measures such as length of stay, re-admission rates, etc.

B. Options for Major System Reorganization

DMA has identified two major options for organizing the administration of public mental health services differently. One involves considering consolidation of many functions for CMHB, CHIP and AMDD services. The other involves the development of Medicaid waiver options for better coordination of care.

1. Options for Coordination among CMHB, CHIP and AMDD

Currently, AMDD is its own Division, with responsibility for adult mental health and substance abuse services. CMHB is a bureau within the Health Resources Division, and a sister to the Health Care Resources Bureau that includes CHIP. CHIP and CMHB frequently collaborate to assist in administering CHIP mental health services. For the implementation of the CHIP Extended Benefit, CHIP does not have mental health professionals on its staff, so CMHB clinical staff are available to CHIP for consultation when significant clinical issues arise. Children's Medicaid and the CHIP Basic and Extended Benefit Plan for children with SED are administered through three separate processes and personnel: CMHB, Blue Cross Blue Shield and the Health Care Resources Bureau that includes CHIP.

With similar benefits and serving some of the same families, there would be advantages to consolidating certain administrative aspects of CHIP and children's Medicaid mental health services. This could be accomplished by assigning responsibility for oversight of CHIP mental health directly to CMHB or making significant improvements in reporting that break out mental health utilization and spending. This would allow for greater attention to CHIP mental health services. Because children's mental health is a relatively small part of total health care, mental health gets relatively little attention in the general health world. This is part of the reason why the CHIP Extended benefit is administered by HRD staff, rather than Blue Cross. CMHB

experience with managing high cost services and experience with local systems of care can be helpful for the care of children receiving the Extended CHIP benefit.

In the past, adult and children's mental health were managed by the same Division. Operating as separate entities and in different locations cannot help but increase the division between child and adult services. While our analysis has shown that there are significant differences between the child and the adult systems in financing, scope of eligibility and provider networks, it is important for children to make an effective transition to the adult system at 18, and for both systems to work collaboratively to serve families that have both children and adults with mental health problems. A number of stakeholders identified the transition into the adult system as a problematic and difficult transition that should be improved. Shared administrative functions between AMDD and CMHB could lead to some savings and both divisions might end up functioning better. Efficiencies and improvements could be realized in consolidated regional planning, contracting and quality improvement. This could create savings and benefit both the child and adult entities. At the same time it is important that children's services not find themselves subsumed under the "weight" of the adult system, something that many state children's mental health agencies experience.

We considered the option of merging Children's Mental Health Bureau and AMDD again, which might increase efficiencies in certain administrative functions and facilitate the ability of both groups of staff to better plan for services to transition age youth. However, a disadvantage is that it would move CMHB away from CHIP which covers a large number of youth. Some of the advantages of a merger of CMHB and AMDD could be achieved simply by co-locating the staff and leadership, increasing the opportunity for more frequent communication, requiring joint local planning frameworks and approaches and creating a cross-agency effort to identify and better serve shared families. The creation of the CCO, even with separate Child and Adult divisions would accomplish these same objectives.

Recommendations

The state can achieve improvements by reorganizing administration of its mental health agencies to consolidate certain functions

- ▶ Give CMHB more authority over the mental health benefit and the coordination of care within CHIP and for the CHIP extended benefit.
- ▶ Co-locate AMDD and CMHB management staff and share certain administrative functions. These shared functions should include purchasing, network management, revenue and TPL functions, among other functions. This should not be a merger.
- ▶ Give CMHB more authority over the mental health benefit and the coordination of care within CHIP and for the CHIP extended benefit.
- ▶ Co-locate management staff and share administrative functions between AMDD and CMHB. These shared functions should include purchasing, network management, revenue and TPL functions, among other functions.

2. Care Coordination through Section 1915b Managed Care/Freedom of Choice and 1115 Research and Demonstration Waivers

The Center for Medicare and Medicaid Services (CMS) allows states to develop and operate waivers to implement delivery systems designed to better coordinate care, control costs, and limit individuals' choice of providers under Medicaid. States may request Section 1915b Waiver authority to operate programs that impact the delivery system for some or all of the individuals

eligible for Medicaid in a state. Section 1915(b) Waiver programs may be implemented in regions; they do not have to be operated statewide. Recipient eligibility must be consistent with the approved state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan through the 1915(b)(3) Waiver. Some 1915(b) waivers are voluntary programs and some have the option for fee-for-service or managed care. There must be assurance that the Medicaid recipient has a choice of at least two providers.

There are nearly 100 1915b Waivers in operation with one or more in most states. Under a 1915b authority, States are permitted to waive "state wideness", comparability of services, and freedom of choice. There are four types of 1915b Freedom of Choice Waivers:

- ▶ 1915(b) (1) Mandates Medicaid enrollment into managed care.
- ▶ 1915(b)(2) Utilizes a "central broker".
- ▶ 1915(b)(3) Uses cost savings to provide additional services.
- ▶ 1915(b)(4) Limits the number of providers for services.

States that have implemented 1915b Waivers have generally had two sometimes competing goals: increasing the effectiveness of services, and controlling expenditures for behavioral health services. In their Waiver application, states must provide information to CMS on their goals to maintain or increase access to services, while maintaining or reducing costs. They must also outline their strategies to achieve these goals. The solution to this apparent conflict lies in increasing access to outpatient and support services while reducing the length of stay and use of high cost inpatient, residential and other costly services.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas that show policy merit including all the options possible under the more limited 1915(b) waiver authority. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. There are two types of Medicaid authority that may be requested under Section 1115:

- ▶ Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
- ▶ Section 1115(a)(2) – allows the Secretary to provide Federal Medicaid Assistance Percentage (FMAP) for costs that otherwise cannot be matched under Section 1903.

The differences between the 1915b and 1115 Waivers are significant. States have much more flexibility under a 1115 Waiver. The 1915b can only waive provisions of Section 1902 of the Social Security Act, including freedom of choice (1902(a)(23)), State wideness (1902(a)(1)), and comparability of services (1902(a)(10)). Provisions of Title XIX other than 1902 provisions may not be waived. The 1115 Waiver can waive other sections of the Act. Both the 1915b and 1115 Waiver would allow the state to reinvest savings into the mental health system. However, under capitation rate²⁶ setting rules for the 1915b, savings can only be reinvested in services

²⁶ Note that "capitation rates" refer to rates paid to a health insuring organization or similar entity to provide coverage for a set of defined services. In Medicaid, these are generally expressed as per member per month rates. As with personal health or other types of insurance, they are paid for everyone who is eligible in the rate category regardless of whether they need services or of

that are part of the current state plan in order to be included in future capitation rates. This is an important distinction, while savings can be used to pay for services not typically provided under the state plan, this usage will lead to lower capitation rates in future years of the 1915b Waiver.

States that have 1915b or 1115 Waivers often contract with a Prepaid Inpatient Health Plan (PIHP) or a Prepaid Ambulatory Health Plan (PAHP) to implement and administer their managed care programs. A PIHP is an entity that provides, arranges for or otherwise has responsibility for the provision of any inpatient or institutional services for its enrollees. A PAHP does not provide or arrange for (and is not otherwise responsible for) the provision of any inpatient hospital or institutional services for its enrollees. PIHPs and PAHPs often receive pre-paid capitation payments or other payment arrangements to provide services to enrollees. PIHPs and PAHPs are generally private companies (profit and non-profit). However, some PIHPs and PAHPs are administered by state or local governments (e.g. Hawaii Child and Adolescent Mental Health Division and Philadelphia County).

From 1997 to 1999 the State of Montana used the 1915b Waiver authority for mental health services. The state no longer operates the mental health 1915b Waiver program. A number of factors led to the demise of the program, including but not limited to the following: multiple changes in ownership of the contractor, a poorly constructed contract which left far too much discretion to the contractor, weak contract oversight initially, provider and consumer resistance and lack of trust, and perhaps most importantly, rates that were set too low as a result of the state pulling funding from the program.

Montana does, however, currently perform certain "managed care functions" through its contract with First Health. Specifically, First Health provides Medicaid utilization review services for the State of Montana. This includes prior authorization, continued stay and retrospective review of the medical necessity of the following services:

- ▶ Adult and Children's Outpatient Therapy Services
- ▶ Adult Acute Inpatient Services – Prior Authorization and Continued Stay for Out of State services only. (In state services are reimbursed with Diagnostic Related Groups)
- ▶ Adult Acute State Hospital Services for individuals under 21 and 65 years of age or older.
- ▶ Adult Intensive Outpatient services
- ▶ Adult Crisis Stabilization
- ▶ Youth Residential Treatment
- ▶ Therapeutic Home Visits
- ▶ Therapeutic Living Services
- ▶ Targeted Youth Case Management Services

In addition to the prior authorization and continuing stay review services, First Health also provides regional care coordination services for youth receiving Mental Health services under Medicaid. These staff facilitate treatment planning, communicate with the various parties involved in the care, and they provide liaison to First Health clinical reviewers, physicians and state and provider case managers.

the level of need. Rate categories can be established to break the population into subsets and to control the risk. For instance in Medicaid this is often done in categories for individuals eligible under Temporary Assistance for Needy Families (TANF) rules; aged, blind or disabled individuals (SSI) and perhaps children in state custody.

Finally, First Health provides retrospective review services of selected providers, reviewing medical records and documentation for a range of Medicaid services provided by a sample of providers selected according to criteria determined by DPHHS.

Nationwide, Montana has one of only two 1915c Home and Community Based Services Waivers for adults covering a planned 120 people who would otherwise be receiving nursing home level of care. The waiver is unique and unusually broad in eligibility, covering a range of rehabilitative services, including respite and adult foster care among other services. In addition, Montana applied for and received a CMS PRTF Demonstration grant that serves up to 100 children per year. These are examples of the state's creativity and forward looking approach.

The sections below summarize our observations and recommendations on Organizational Structure and Reimbursement.

a) Organizational Structure.

Over the year and a half prior to this study, beginning in August 2006, a number of state officials and other interested parties met on at least four occasions to develop a set of recommendations for the state to consider in restructuring its operations to achieve the goals outlined by the President's New Freedom Commission (NFC). The major goals in this report were that:

- ▶ American understand that mental health is essential to overall health
- ▶ Mental health care is consumer and family driven
- ▶ Disparities in mental health services are eliminated
- ▶ Early mental health screening, assessment and referral to services are common practice
- ▶ Excellent mental health care is delivered and research is accelerated
- ▶ Technology is used to access mental health care and information

There was widespread agreement on these goals and a strong feeling that system reorganization was needed to accomplish some of the major goals of the NFC. Three different approaches were suggested. These include:

- ▶ Contracting with a specialized Managed Behavioral Healthcare Organization (MBHO) to provide managed care functions. This would be similar in some ways to the state's previous managed care initiative and its contract with Magellan Health Services. It could include features such as braided funding similar to the work in New Mexico²⁷. Contract terms and conditions will need to be quite specific and detailed for it to address the likely fears and concerns of many other stakeholders based on Montana's earlier experience with managed mental health care.
- ▶ Developing a quasi-public Coordinated Care Organization (CCO) to administer a managed care program under a 1915b or 1115 Waiver authority. The CCO has been proposed as a quasi-public authority under the auspices of state government and would have a Board of Directors comprised of leadership from the various state agencies and stakeholders including consumers and providers. The CCO would hire a chief executive officer and authorize spending levels for the CEO, staff and infrastructure. The CCO would be

²⁷ Braided funding is an approach that a number of states have used to try to provide greater integration of services for consumers. New Mexico is the best example of the work nationally. In this approach, states use an intermediary organization (a managed care organization, a provider or the state or county itself) to provide open access to services across several different federal and state funding streams. The goal is to create a system where the restrictions and limits on a service associated with a funding stream are hidden from the consumer but the unique eligibility and reporting requirements are retained for reporting and accounting purposes.

responsible for purchasing and overseeing all mental health services. The CCO could be paid on a risk based, partially risk based or administrative fee contract. Under a risk arrangement, savings generated by the CCO would be reinvested in mental health services.

- ▶ Using existing or reorganized state agencies for the management of care. This approach is best suited to incremental improvements and retains many of the negative features of the current system, including annual financing, spending restrictions, hiring restrictions, etc. Under effective leadership and with a clear mandate, public agencies can transform themselves. Unfortunately leadership and mandates in the public sector are too often subject to changes in administrations and changing priorities to be effective in sustaining systems transformation over time.

Table V-1 summarizes potential advantages and disadvantages of different managed care organization structures.

<p align="center">Table V-1 Potential Managed Care Organizational Structures: Advantages and Disadvantages</p>		
Org. Structure	Advantages	Disadvantages
Private Contractor	<ul style="list-style-type: none"> • National managed care companies would compete for the services • May allow more rapid start up from organizations with experience in the field • Larger national firms can potentially bring more talented employees to Montana • Highly flexible in compensating employees • Profit motive spurs change • Potential to braid funds more easily and defragment the system 	<ul style="list-style-type: none"> • Increased administrative costs and profit • Procurement process is burdensome • Risk of appeal and litigation if process not run carefully • Still requires extensive oversight and public administrative support in agencies • May reduce access to services as less funding would likely be available for services • Easy to become politically charged • Montana history with managed care is traumatic • Changes the nature of the relationships with providers – more difficult to make the goal be about public benefit • Difficulty for the Legislature in directly impacting managed care decisions
Quasi-Public Authority or Non-Profit Corporation	<ul style="list-style-type: none"> • May offset concerns regarding previous managed care experience—it may be viewed as closer aligned with the mission of state agencies • Higher level of initial perceived public trust • Profit is reinvested back into system • Lower level of oversight needed for a “public” CCO • Several positive examples of public or quasi-public systems managing care (Philadelphia, Wraparound Milwaukee, Piedmont Behavioral Health (NC), and CAMHD (Hawaii)) • Can potentially by-pass public hiring and procurement rules to reduce costs • Would allow for more flexible financing and retained savings • Could have bonding authority to finance housing for mentally ill • Could develop a risk pool • Potential to braid funds more easily and defragment the system • “Authority” could contract for the technical expertise it needs. 	<ul style="list-style-type: none"> • Enabling legislation is required and negotiating the details will result in suboptimal decisions on many items • Separate bonding and financial authority is risky and requires separate oversight structures • Over time public “authorities” can become highly political and not necessarily more productive than state agencies. • Less legislative and executive branch control though some of this can be worked out in enabling legislation or through governance • Transition to quasi-public entity would be more difficult than people believe, though not more difficult than a private contractor • Difficulty in getting federal approval for some initiatives and the quasi-public nature of this may raise some questions • Requires legislative authority to retain revenue
Use Existing or Reorganized Public Agencies	<ul style="list-style-type: none"> • Marginal increases in costs • Known processes for administration • May be easier to create incremental change • Can be effective if there is a strong public mandate for change • Strong leadership is needed in any of the scenarios. Public agencies can be just as effective when the leadership is there, e.g. Goal 189 success and recent successes in reducing out of state placements for youth • Reorganizing staff within existing public agencies may help to initiate major change 	<ul style="list-style-type: none"> • Budgeting and hiring processes are restrictive • Little flexibility in compensation • Can be harder to accomplish transformative objectives • Political distractions • Status quo is often the path of least resistance • More difficult (though not impossible) to roll over savings

Any managed care plan in Medicaid requires a waiver. Whether delivered through a public or quasi-public agency or a contracted BHO, the waiver provides states with tools that are not available otherwise to control mental health care costs, coordinate care, and control utilization. These tools include the ability to implement:

- ▶ Selective contracting in the provider network rather than any willing and qualified provider;
- ▶ Assignment of recipients to providers for the coordination of care; and
- ▶ Capitated rate setting methods.

In addition, the use of an 1115 or 1915(b) waivers allow states to structure contracts with organizations to jointly administer Medicaid and state general funds. In Montana this would permit the consolidation of a number of administrative resources from several divisions that purchase and manage these services. The managed care entity can achieve this in many ways because it is a third party with a focus on implementation and execution. In our opinion, particularly in mental health services, the public purchaser should retain the responsibility of planning and responding to the public, other agencies and elected officials.

A risk based contract also provides an opportunity to obtain additional FMAP for administrative functions that may be currently funded with state general funds or that are reimbursed by Medicaid at the administrative match rate of 50%. Our review did not uncover any significant areas missing from the state's allocation and administrative cost plan for Medicaid. However, the added federal matching rate that would result from including administrative functions as a part of a capitation rate compared to the current administrative rate could conservatively amount to \$300,000 to \$400,000 in additional federal revenue. Calculation of this is as follows: The difference between the capitation rate (matched at 68%) compared to the current administrative rate (50% for most functions; higher for some functions such as IT and Quality which are matched at 90% and 75% respectively) is approximately 18%. Multiplying this 18% difference in FMAP rate times an estimated \$2M in eligible administrative costs equals roughly \$300K - \$400K. This estimate may understate the administrative costs for both adult and child divisions.

The CCO model assumes that a quasi-public organization would have many of the reimbursement and financing related advantages of a contractor, but that public trust would be higher, transition to the new entity would be easier and a lesser degree of oversight would be required of the public authority. The CCO model also assumes that most if not all of the functions performed by AMDD and CMHB would transition over to the new entity. This is a significant undertaking that will require detailed planning for both state staff and contractors (such as First Health).

There are a number of examples of quasi-public authorities that have been quite successful in administering mental health services. These include Philadelphia Community Behavioral Health (CBH), Hawaii's Child and Adolescent Mental Health Division, and Wraparound Milwaukee. In Philadelphia's case, the city created a non-profit organization, CBH, to manage the behavioral (mental health and substance abuse treatment services) health benefit for the city. Wraparound Milwaukee and Hawaii are both run by a county or state division. There are also several California counties that manage capitated mental health services as integrated delivery systems. All of these organizations have been in existence for five or more years; a decade in the case of Wraparound Milwaukee. None of them have chosen to contract out administrative functions to a managed care organization. They all have developed their own claims and IT

solutions. While all of them had challenges in their implementation, as a group they have been surprisingly free of problems.

New Mexico has undertaken a compelling approach in many ways, attempting to consolidate the administration of mental health and substance abuse funding streams across all state agencies. However, we do not recommend the governance and oversight strategy that New Mexico has established, because it has resulted in oversight by committee. The state created a large purchasing group (the "Behavioral Health Purchasing Collaborative"), a statewide Behavioral Health Planning Council and disparate local advisory groups called "Local Collaboratives". Decision making and staffing of these groups have been very resource intensive and overly time-consuming, and the quality and timing of decision making has been sub-optimal.

In any managed care scenario, the state must structure payment incentives so that they are aligned with its goals, which must be clearly specified as part of the contract or enabling language for the CCO. For instance, will the state use a risk based contract to achieve its goals of increased access, or will the state consider an administrative services-only contract with performance incentives to manage enrollees' services? Risk based contracts use capitation or case rate payments to provide incentives to an organization to maximize efficiency of services, yet these are not always the best ways to improve effectiveness. Administrative service contracts generally use an administrative fee with some form of incentive payment to meet goals and objectives of increased access and improved outcomes.

b) Reimbursement.

The table below presents a framework for considering reimbursement options for a managed care organization under a 1915b or 1115 Waiver authority in Montana. It outlines advantages and disadvantages of each approach and should be viewed independently from the organizational or contracting design.

Table V-2 Managed Care Reimbursement Options: Advantages and Disadvantages		
Reimbursement Options	Advantages	Disadvantages
Non-Risk, Administrative Services Organization Contract	<ul style="list-style-type: none"> • Matching federal funds for administrative services would be included in ASO contract (50% of all administrative costs) • The PIHP or PAHP may need less financial reserves for a risk pool 	<ul style="list-style-type: none"> • State of Montana would continue to hold the risk for all service expenditures • State may have to expend additional resources to develop or contract for needed managed care functions
Risk Based Managed Care Contract	<ul style="list-style-type: none"> • Matching federal funds for administrative services would be included in the risk based managed care contract (68% of all administrative costs). This marginal increase might result in \$300-400K in additional revenue. • State of Montana would have less risk for service expenditures. • Can negotiate rates that differ from Medicaid rates. Could pay a premium for services in underserved areas. 	<ul style="list-style-type: none"> • Managed care administrative costs come out of service funding unless the state makes up the difference • State will still need to maintain oversight functions • There will be rate setting difficulties and likely added costs of incorporating the HCBS waiver and the PRTF Demonstration

Managed care initiatives are often undertaken when a state believes that the patterns of care being used are unnecessarily intensive and expensive. Utilization management controls, selective contracting, and resetting prices of service can all be implemented by a managed care contractor to drive changes that keep care closer to the community whenever possible. Montana already has a utilization review organization (First Health) to help reduce use of residential facilities for children and to manage authorization for some of the more intensive adult services. These same "controls" are not possible under current admission and commitment rules for Montana State Hospital. The state resources for the PRTF Demonstration and the Home and Community Based Services Waivers are explicitly focused on substituting community resources for residential and nursing home levels of care wherever possible. These waivers provide considerable flexibility in using Medicaid funds in non-traditional ways. It would be challenging (though not impossible) to incorporate these services in the managed care approach; alternatively these waivers could be terminated.

On both the child and adult side, Montana lacks enough current providers to benefit from selective contracting or from increased competition. As a result, Montana's strategy should be to build and maintain effective partnerships with its "suppliers". This partnership should find effective ways to foster a focus on recovery among its provider network and to ensure that providers make the changes in practice necessary to implement it. An enhanced focus on recovery is sorely needed, according to many of the comments we received from stakeholders.

An optimal strategy for Montana depends upon a number of factors including the perceived capacity of the public organization to effect change, whether authority for the needed financing strategies can be obtained in the public agency (e.g. retention of reserves for reinvestment), contracting and hiring flexibility, and ultimately the availability of leadership and experience. Public sector compensation levels are often the barrier to these last two attributes.

Recommendations

DPHHS should develop and hold a public review process of a detailed plan for a public Care Coordination Organization (CCO) to manage mental health services to children and adults under a 1915(b) or 1115 Waiver. A detailed design and plan for the waiver and, ultimately, procurement will require considerable effort by the state and is beyond the scope of this paper. An 1115 Research and Demonstration Waiver would allow the state to consolidate its HIFA Waiver terms into the managed care approach. The CCO should consolidate all children's and adult mental health services and administrative activities. The state should consider whether to include substance abuse services also.

Montana agencies have demonstrated their abilities to accomplish needed system changes through their various efforts over the past years. Reducing out of state residential placements for youth and reducing the Montana State Hospital census are examples of agency capabilities. The challenge for these agencies is to maintain their attention and focus on transformation and cost management. This takes sustained leadership and cooperation throughout the administration. The use of a third party to manage care can change the dynamics of the system markedly. Splitting planning and implementation functions between the state and the managed care entity, consolidating administrative functions across the several agencies, and creating an effective non-profit governance strategy for a statewide quasi-public entity are important elements of success. The added federal revenue will permit the state to fund certain needed administrative functions.

If the state ultimately does not decide to pursue this plan, many of the same goals can be achieved by AMDD and CMHB with effective leadership, new financing rules and other changes. This will require a firm commitment by the administration and strong project management and leadership within the state agencies.

c) Implementation Plan

While the state should continue its many current efforts to improve the existing service system during the implementation process, the following activities are essential to plan for and implement the CCO:

- ▶ Create an internal working group to undertake the detailed planning and analysis needed to implement the effort.
- ▶ Develop and seek input on a detailed workplan. Ensure that there are some dedicated resources to the efforts and a realistic timeline developed for start up. It is not likely that anything could happen sooner than 2012 despite the best wishes of many in the system.
- ▶ Study the current mental health positions in AMDD, CMHB, and Extended CHIP. Identify the functions, current staffing and costs of all subcontractors including ACS (the Medicaid claims payment subcontractor), Blue Cross and First Health. This should include an assessment of capacity of existing staff.
- ▶ Collect data on other mental health administrative costs in AMDD, CMHB, First Health Services and the CHIP contract with Blue Cross. Evaluate where there may be savings or efficiencies in consolidating staff and contractor functions into a quasi-public CCO. To minimize disruption during the transition, the state should ensure that current employees will continue to have a job either in the new entity or will be placed in a comparable position. There needs to be an overlap in the start up and wind down of the work of any contractor. This will incur start up costs.
- ▶ Review the options for governance and legal organization of the CCO. The basic options include: 1) establishing a non-profit corporation (subject to IRS approval) with shared governance, similar to what Philadelphia has established; 2) creating a public authority as a separate governmental entity; or 3) designating a division within one of the agencies, similar to what Hawaii or Wrap Around Milwaukee have established at the state and county levels. The central issues will revolve around the flow of funds from the Medicaid agency and the legal, governance and reporting relationship between the new entity, DPHHS and the Legislature. Care should be taken to avoid the appearance of inter-governmental transfers since those have been under scrutiny at CMS. With respect to non-profit governance issues, the details of the board composition and oversight functions in Philadelphia and in other sites can provide some guidance for Montana officials. However, there is no template for Montana to follow. Planning will require considerable discussion and negotiation and it should include public hearings, since the concerns about any form of managed care are likely to be strong. If the state's plans call for a separate non-profit, it will require IRS approval for federal tax exemption. Legislative authorization and clear enabling language about the public purposes and mission of the new entity may be necessary to ensure that IRS approval or tax-exempt status is received.²⁸
- ▶ Develop a plan to identify and define the scope of services to be included in the CCO. We have assumed that it would include all AMDD contracted services; however, there will surely be a debate over how to handle Montana State Hospital and the Montana Mental

²⁸ In the late 1990's the IRS was concerned about the legitimacy of tax exempt status of many non-profit managed care organizations. While the concerns of attorneys and others seem to have relaxed on this in recent years, the public benefit and purpose of the organization needs to be very clear.

Health Nursing Care Center costs. The choices are that the cost of MSH and MMHNCC be either 1) excluded from the CCO benefit; 2) paid for on a capacity, grant type basis with annual capacity; 3) covered through some form of risk adjusted case rate; or 4) purchased on a fee for service basis.

- ▶ Develop financial estimates for the costs of the transition including estimation (based upon existing expenditures) of capitated rates or premiums, any additional cash flow requirements for fee for service claims incurred but not reported, the potentially overlapping capitation payments, and other one-time expenses.
- ▶ Develop publicly accountable and responsible procedures to retain revenue in the CCO. These would be used initially to fund needed risk reserves within the CCO, and second be reinvested in services. Initially, the state would have to retain risk. Over the first several years of CCO operation, however, savings must be retained to build the required reserves. Once an appropriate level of reserves is achieved (consider one or two months of operations and service expenses at a minimum), the savings would be captured by the state. These should be reserves based upon a full accrual method of accounting (after an allowance is made for claims incurred but not yet reported and pending but not yet paid).
- ▶ Review the HIFA application and other changes needed for the design of a more comprehensive 1115 Waiver that incorporates the adult eligibility expansion in the current HIFA Waiver and brings the administration of existing children's mental health benefits and substance abuse services into a more comprehensive and coordinated Medicaid initiative. At a minimum, the waiver document should incorporate the plans for a capitated benefit and CCO administration.
- ▶ Draft and submit the waiver for approval to the new administration.
- ▶ Develop legal documents including any needed organizational papers and memoranda of understanding.
- ▶ Establish financial mechanisms, including banking arrangements for cash management, billing and claims processing procedures. DPHHS' contract with ACS will likely need modification to ensure that reporting for mental health utilization and expenditures is discrete and separate, both organizationally and financially. There are at least three acceptable ways to handle this: 1) Establishing separate check runs and using separate bank accounts; 2) Establishing completely separate check runs for the CCO as a separate legal entity or Org. Code (accounting code); and 3) Processing a consolidated check run with separate Org. Code financial accounting for all mental health checks. The check registers and claims reports should be accessible for the CCO independently of DPHHS. To ensure appropriate separation of powers and internal controls, CCO checks should not be run without explicit authorization of the CCO leadership. As a result, Options 1 or 2 are likely the preferred approach.
- ▶ Develop a comprehensive organizational plan for the new entity with positions and reporting structure clearly laid out.
- ▶ Develop and implement a detailed plan for the transfer all existing contracts and provider relationships.
- ▶ Establish and hold initial meetings of the Board.
- ▶ Implement a formal hiring process, particularly for the senior staff positions. Ensure that some key positions are hired prior to the transition in order to focus on some of the critical project tasks.

Additional steps will become clearer as the planning process expands to involve others, and after the strategy and direction has been set by the Legislature and administration. Leadership on the planning teams and within the administration will be key to success. With several recent

and future retirements, this may be a factor that needs to be considered. Strong project management skills will be needed as will strong group facilitation skills. A transparent planning process will be critically important to build and maintain trust. We hope that this study has set a tone which will be helpful going forward.

d) Potential Costs of the CCO

In implementing managed care approaches, there is a general assumption that the staff and services needed to accomplish the care coordination goals will come from restructuring existing staff, efficiencies achieved by eliminating redundancy, and possibly increased revenue from increased federal match for administrative costs. While increasing resources for the better coordination of services can improve consumer outcomes, given the gaps in services that we have documented, the state of Montana should not develop a plan that seeks to reduce overall service costs. In our experience, any savings from these areas are often/usually offset by the costs of the additional functions needed to achieve the improvement, increased capital outlays for new technology, one-time costs for the transition, risk reserves and what economists call risk premiums (the additional percentage point or more to cover the "costs" of taking on risk), and profits. Advocates and others always fear that reductions in services to consumers and families will finance profits for the managed care entity. The CCO proposal, using either a non-profit Montana corporation or organized within a state agency, avoids some of these concerns about profit making.

There will be certain one-time costs associated with the transition. These may include actuarial and consulting costs, legal costs, costs of moving staff and changing functions between agencies. With a conservative approach, assuming that the waiver application can be completed by DPHHS staff, these functions can be accomplished for \$250,000 to 300,000. In addition to one-time costs, there are certain new or incremental functions that can and should be performed by the CCO. These include increased activities in contract management and oversight for providers, added staff for provider reporting and new technology investments in reporting and internet functionality. These are likely to cost \$300,000 for 3-4 FTEs (salaries, benefits and some allowance for increased overhead) and the technology.

The costs of most other administrative functions can be addressed as the state consolidates staff from AMDD, CMHB, those staff from CHIP Extended Benefit, and First Health Services. If the final decision is that the CCO should be a separate non-profit organization, some level of administrative oversight will need to be retained in DPHHS. At its simplest level, an individual in the administration must be designated as the Single State Agency Director for SAMHSA Block Grant planning and oversight. Similarly, a clear designation should be made of the unit or staff responsible for oversight of mental health services and expenditures in Medicaid. Philadelphia and Wraparound Milwaukee have addressed this by separating the planning functions and keeping them in the County agency. The implementation and care coordination functions were moved to CBH. This separation of functions may have some cost implications for Montana although there may be some creative ways to handle these requirements.

Total first year costs incremental costs are likely to be from \$550,000 to \$600,000. Subsequent additional costs are estimated at \$300,000. These can be offset by the savings from the added federal match that we have estimated for a shift from administrative to service match rates. We have not projected savings in service premiums, since we believe that all savings should be reinvested in filling service gaps and making other system improvements.

We are cognizant that we are making these projections and assumption at a time of potentially dramatic changes in state revenues given the national financial crisis. If state revenues are going to be dramatically affected and cuts will be needed, it is important that the cuts take place before any of the restructuring. Great care should be taken that the two issues are not confused in the minds of providers or consumers and families.