

Washington Medicaid Integration Partnership

Snohomish County Pilot

Addendum to the WMIP White Paper

June 14, 2004

Overview

The North Sound Mental Health Administration (NSMHA/NSRSN) commissioned the January 2004 WMIP White Paper for two purposes:

- 1) To bring together current information regarding how the integration of behavioral health (mental health and substance abuse) services with medical services can improve the care and health status of the Medicaid and priority populations; and
- 2) To assess the potential impact that a dually managed system (NSRSN and WMIP) would have on the Snohomish County residents receiving these services.

This Addendum updates the paper based on additional information provided since the original drafting, covering the following areas:

- Per Member and Per Client Formula Correction
- Revenue and Cost Updates
- Target Populations
- Inpatient Risk at the NSRSN
- Clinical Integration Efforts
- Impact of the Balanced Budget Amendment of 1997

The addendum also includes a revised set of Recommended Next Steps.

White Paper Updates

One of the objectives of the White Paper was to estimate whether the revenue moving from the NSRSN to the WMIP vendor would match the expenses for the NSRSN clients being assigned to the WMIP. Three scenarios were developed and each projected a transfer of net revenue from the NSRSN to the WMIP vendor. In the June 2, 2004 Questions and Answers document posted on the WMIP website Dr. David Mancuso provided an analysis of the White Paper's financial projections, addressing the following areas:

1. **Per Member and Per Client Formula Correction:** Dr. Mancuso noted that our cost calculations were based on expenditures per eligible enrollee when they should have been based on expenditure per served client. The formula resulted in an understatement of costs for clients that would be transferred to the WMIP vendor.

This is an accurate critique. To quantify the impact of this correction we have updated our analysis in Table 1 below, comparing the original formula to the corrected formula that uses expenditure per served client. Note that Table 1 is computed prior to adjustments that remove Inpatient Costs, per item 2 below.

The results are Net Revenue Transfer decreases from \$4.5 million to \$4.0 million in Scenario 1, \$2.7 million to \$1.6 million in Scenario 2, and \$3.4 million to \$2.5 million in Scenario 3. This represents a significant reduction. The new figures also reflect a substantial proportion of Net Revenue Transfer for the three scenarios – 39%, 16% and 24% respectively – when Inpatient and Outpatient services are moved into the WMIP pilot.

Table 1: Cost per Enrollee to Cost per Client Correction

	White Paper Original ⁽¹⁾	White Paper Corrections ⁽²⁾
Scenario 1		
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$4,553,782	\$4,553,782
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$62,998	\$466,454
Net Revenue Transfer	\$4,490,784	\$4,087,327
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	43%	39%
Scenario 2		
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$4,553,782	\$4,553,782
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$1,887,375	\$2,911,143
Net Revenue Transfer	\$2,666,407	\$1,642,639
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	26%	16%
Scenario 3		
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$7,105,586	\$7,105,586
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$3,671,589	\$4,635,479
Net Revenue Transfer	\$3,433,997	\$2,470,106
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	33%	24%

2. **Revenue and Cost Updates:** Dr. Mancuso noted that the White Paper projected WMIP revenues and costs by including inpatient and outpatient services, 2003 expenses and 2005 revenue. After the White Paper was written DSHS revised the design of the WMIP pilot to move only mental health outpatient services to the WMIP vendor. Dr. Mancuso and Milliman USA completed an analysis of the resulting revenues and expenses based on this change, creating new 2005 per member per month revenue rates based on the Milliman USA mental health actuarial calculations.

In this update we revised our calculations to reflect only outpatient services and projected forward the NSRSN's FY2003 expenditures, applying a 3.5% trend factor for two years. Table 2 compares the two sets of figures and suggests two conclusions:

- Revising the scenario analysis to include only outpatient services dramatically changes the Net Revenue Transfer calculations in both sets of scenarios, bringing the costs much closer to the revenues. This change reflects a better matching of revenue with outpatient services costs by Milliman USA.
- MCPP calculations, based on NSRSN data for Snohomish County, project a small Net Cost Transfer in two of the three scenarios, where more costs than revenue shift to the WMIP vendor. The differences in the two sets of numbers may be due to Milliman USA's use of statewide cost data (versus MCPP's use of Snohomish County data) as well as different costing methodologies. These differences underscore the need for additional rigor when costing for a subset of the population in a single county.

Table 2: Inpatient and Outpatient Costs

	White Paper Update ⁽³⁾	Mancuso Calculations ⁽⁴⁾
Scenario 1		
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$1,702,902	\$1,702,902
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$281,904	\$338,739
Net Revenue Transfer	\$1,420,998	\$1,364,163
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	14%	13%
Scenario 2		
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$1,702,902	\$1,702,902
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$1,915,961	\$1,702,057
Net Revenue Transfer	-\$213,059	\$845
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	-2%	0%
Scenario 3		
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$2,584,143	\$2,584,362
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$3,133,302	\$2,585,125
Net Revenue Transfer	-\$549,159	-\$763
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	-5%	0%

Note: Attachment A combines Tables 1 and 2 with additional comments.

3. **Target Populations:** Dr. Mancuso took issue with our conclusion that higher cost offset would be available for Medicaid enrollees with low to moderate behavioral health risks and complexity and that this population would be a natural target for the WMIP vendor if their goal was to expand mental health care and achieve cost offsets.

He stated in the Q&A that the December 2003 Cost Offsets and Client Outcomes Technical Report, co-authored by Dr. Mancuso, found that there were large medical cost offsets when mental health services were provided to DSHS clients with serious mental illness and also noted that DSHS planning for the WMIP project has centered on clients with serious mental illnesses.

We found the Technical Report extremely valuable and applaud the importance of using the Medicaid data base to inform policy decisions. We also continue to have questions about the differences between a person with a DSM-IV diagnosis and low to moderate behavioral health risk and complexity, and individuals with a DSM-IV diagnosis and high behavioral health risk and complexity. Because of Dr. Mancuso's role in both projects we suggest that next steps related to this item should include a discussion of two issues:

- Are there medical cost offset differences between individuals with a DSM-IV diagnosis with low to moderate behavioral health risk and complexity, who are not the primary target for the NSRSN; and individuals with behavioral health risk and complexity that require higher levels of care and are part of the NSRSN target population?
- What is the target population for the WMIP pilot and how does this crosswalk to current NSRSN clients? Will the identified WMIP target population result in a higher proportion of high need individuals currently served through the NSRSN, a lower proportion (as we postulated in the White Paper), or a proportional distribution of NSRSN clients and non-clients. Is one of the policy intents of the WMIP pilot to expand access to behavioral health services for those Medicaid enrollees not currently receiving treatment services?

4. **Inpatient Risk at the RSN:** The shift of outpatient dollars, but retention of inpatient dollars, from the NSRSN to the WMIP vendor continues to present a serious risk to the NSRSN – even with the projection of a Net Cost Transfer in Scenarios 2 and 3 of Table 2. As we stated in the White Paper:

Basic managed care principles and decades of claims experience dictate that:

- Parties holding outpatient risk only have the lowest probability of catastrophic claims experience (WMIP contractor).
- Parties holding both inpatient and outpatient risk have the greatest ability to manage inpatient utilization through prevention, disease management, and diversion to inpatient alternatives (current NSRSN arrangement).
- Parties holding inpatient risk only have the little control over what occurs both pre and post-admission and are subject to cost shifting from other parties (NSRSN under the proposed design change).

This continues to be a major concern that has been acknowledged but not addressed in WMIP policy or funding decisions.

5. **Clinical Integration Efforts:** Since the White Paper was written in January 2004, we have seen very limited WMIP activity related to leveraging best practices in the area of clinical integration of medical and behavioral health services. This includes discussion of the Four Quadrant Clinical Integration Model, the Chronic Care Model, and the several national and regional initiatives described in the White Paper.

We continue to believe that this is the most important aspect of the project and has the greatest potential to improve the health status of participants in the WMIP pilot. We encourage DSHS to focus on the details of the clinical design as described in the recommendations section of the White Paper:

- The exciting opportunity to *create a new clinical service model shared by the behavioral health system and the healthcare system should move forward*. DSHS should clarify the intended target population and develop a service model appropriate to the specific needs of that group. The WMIP project should focus on creating this service model and learning from that model regarding the impact on medical service costs and the implications for RSN services and populations.

6. **Impact of the Balanced Budget Amendment (BBA) and CMS Terms and Conditions:** Since the White Paper was written, the Mental Health Division has completed waiver negotiations with the Centers for Medicare and Medicaid. The result is a set of dramatic changes that will be required to bring the Washington State public mental health system into compliance with the final rules for the Balanced Budget Act of 1997, which went into effect August 13, 2003.

The implementation of the new rules poses significant threats to the system in general and the NSRSN in specific.

- CMS now requires the State, RSNs and providers to stop using Medicaid savings to meet the needs of non-Medicaid persons.
- CMS will not allow Medicaid funds to be used for non-approved services to Medicaid beneficiaries, including those in IMD-type facilities.
- The State is required to set up a Community Reinvestment fund for Medicaid savings. These funds can only be spent after pre-approval by CMS. If the monies are not spent within a year they must be returned to the Federal Government.

It is estimated that \$10.6 million of the NSRSN's FY2003 budget of \$51.6 million was used for non-Medicaid persons or non-Medicaid covered services. This compares with only \$2.2 million of funding for these services. This \$8.4 million gap, which is over 16% of the total NSRSN budget, poses the most serious financial threat to the NSRSN since the managed care waiver was implemented over ten years ago. These changes and the resulting threats to the system must become part of the WMIP planning process.

Recommended Next Steps

Recommendation 1: WMIP Funding Calculations: The Net Revenue Transfer of funds from the NSRSN to the WMIP vendor should be “taken off the table” as a “show stopping” issue. Efforts in this area should focus on developing a final per member per month mental health capitation rate based on the actual costs of the Snohomish County aged, blind and disabled population to ensure that neither the NSRSN nor the WMIP vendor is disadvantaged by the program. NSRSN officials should be provided with the detailed actuarial calculations for review and analysis prior to the finalizing of the PMPM rates for the WMIP pilot.

Recommendation 2: Target Populations and Adverse Selection: DSHS, NSRSN, the apparently successful WMIP vendor, and the Community Advisory Committee should work together to clarify the outstanding medical cost offset questions described in item 3 above, and identify the target populations that will be served within the aged, blind and disabled Medicaid Eligibility Groups. This work should be used to develop the WMIP enrollment strategy which is scheduled to begin November 2004.

Recommendation 3: Mitigation of Inpatient Risk: DSHS should work with the NSRSN and the Community Advisory Committee to mitigate the risk that has is being retained by the NSRSN by assigning the management of the Inpatient and Outpatient systems to two parties. We recommend that DSHS implement a stop-loss mechanism to hold the NSRSN harmless if state hospital and community psychiatric inpatient expenditures increase for the WMIP pilot enrollees after the start of the program.

Recommendation 4: Clinical Design: DSHS should work with the NSRSN and the Community Advisory Committee to convene a structured process to develop and formally adopt a clinical design for the WMIP pilot. This design should be based on available and emerging Evidence-Based Practices relevant to the project. The process should include a stakeholder involvement process that produces a set of detailed design documents. The results should become the basis for how clients are served in the WMIP pilot.

Recommendation 5: Reconciling the WMIP Pilot and the BBA-Driven Changes: The WMIP Implementation Committee and Community Advisory Committee should work with the appropriate resources to develop a Risk and Feasibility Assessment that examines the impact of starting a WMIP Pilot in Snohomish at the same time the new BBA rules become fully effective. This study should examine the risks to both parties –WMIP vendor and NSRSN, including an identification and quantification of the potential for loss of federal funds and financial viability threats to both projects. If a contract is executed with the WMIP vendor prior to the completion of this study, contract language should be included that allows for contract cancellation by either party should the financial viability of either the NSRSN or the WMIP Pilot be seriously threatened.

Washington Medicaid Integration Partnership/Snohomish County Pilot

Attachment A: White Paper Data Update and Comparisons

Section A: Data Comparisons

	White Paper Original ⁽¹⁾	White Paper Corrections ⁽²⁾	White Paper Update ⁽³⁾	Mancuso Calculations ⁽⁴⁾
Scenario 1 – WMIP Selection of Enrollees with High Potential for Medical Cost Offset				
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$4,553,782	\$4,553,782	\$1,702,902	\$1,702,902
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$62,998	\$466,454	\$281,904	\$338,739
Net Revenue Transfer	<u>\$4,490,784</u>	<u>\$4,087,327</u>	<u>\$1,420,998</u>	<u>\$1,364,163</u>
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	43%	39%	14%	13%
Scenario 2 – WMIP Selection of Enrollees with High Potential for Medical Cost Offset, but Proportional Selection of NSRSN Clients				
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$4,553,782	\$4,553,782	\$1,702,902	\$1,702,902
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$1,887,375	\$2,911,143	\$1,915,961	\$1,702,057
Net Revenue Transfer	<u>\$2,666,407</u>	<u>\$1,642,639</u>	<u>-\$213,059</u>	<u>\$845</u>
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	26%	16%	-2%	0%
Scenario 3 – WMIP Selection of Enrollees is Proportionate to Current NSRSN Clients and Non-Clients				
Medicaid Mental Health PMPM Revenue from RSN to WMIP	\$7,105,586	\$7,105,586	\$2,584,143	\$2,584,362
Corresponding Cost Estimates for Clients Transferred from RSN to WMIP	\$3,671,589	\$4,635,479	\$3,133,302	\$2,585,125
Net Revenue Transfer	<u>\$3,433,997</u>	<u>\$2,470,106</u>	<u>-\$549,159</u>	<u>-\$763</u>
Percentage of RSN FY2003 Expenditures on Aged, Blind, Disabled 21+	33%	24%	-5%	0%

Section B: Explanatory Comments

Note ⁽¹⁾ The White Paper was completed prior to WMIP design change to shift only Outpatient Services funding and responsibility to the WMIP vendor. David Mancuso in the 6/2/2004 Q&A document correctly pointed out that the White Paper calculations incorrectly used Per Member Per Month costs when Per Served Client Per Month calculations should have been used.

Note ⁽²⁾ This column corrects the "Per Member" to "Per Served Client" formula. This column is an intermediate step that continues to move Inpatient and Outpatient to the WMIP vendor. Although the corrected figures show a decrease in the net transfer from the RSN to the WMIP vendor, all three scenarios project a substantial transfer as projected in the White Paper.

Note ⁽³⁾ This column builds on the corrections made in column 2 and, using FY2005 cost estimates, projects the RSN impact where only Outpatient Services are shifted to the WMIP vendor.

Note ⁽⁴⁾ This column presents Dr. David Mancuso's projections of the RSN impact where only Outpatient Services are shifted to the WMIP vendor. The reader will note that a significant shift occurs only in scenario 1; scenarios 2 and 3 become cost neutral.