FINAL REPORT

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

Report No. SR-CMH-08

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

February
2009

Report Highlights

OPEGA Report No. SR-CMH-08

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

What questions was this OPEGA review intended to answer?

- How much of the funding for outpatient services for children is expended on the administrative costs of DHHS and providers versus direct delivery of services?
- What are the primary factors driving the administrative costs?

What was OPEGA's overall conclusion?

Of the approximately $18.5 million spent on outpatient children's mental health services (CMH services) in FY 2008, we estimate about 73%, or $13.5 million is associated with the cost of directly delivering the services to children. Approximately 19% ($3.4 million) can be attributed to providers' administrative costs, and the remaining 8% ($1.4 million) represents the administrative cost of program management performed by the Department and its contracted Administrative Service Organization (ASO).

Primary drivers of administrative costs for DHHS are the contract with the ASO and costs incurred by the Office of MaineCare Services in processing provider claims. Providers surveyed reported that certain administrative requirements imposed upon them by the State, and the ASO in particular, represented significant efforts for them.

The State has moved to standardized reimbursement rates for CMH outpatient services and providers are working to adapt by managing their costs to a supportable level. By lowering or raising the standard rate, the State affects the level of costs providers can afford to bear.

The provider network will continue to adapt to the implementation of care management efforts and standardized rates. We encourage DHHS and the Legislature to closely monitor whether the current standard rate, or administrative requirements on providers, should be further adjusted to achieve additional savings or to address any unintended changes in the availability and quality of services.

What actions has OPEGA suggested?

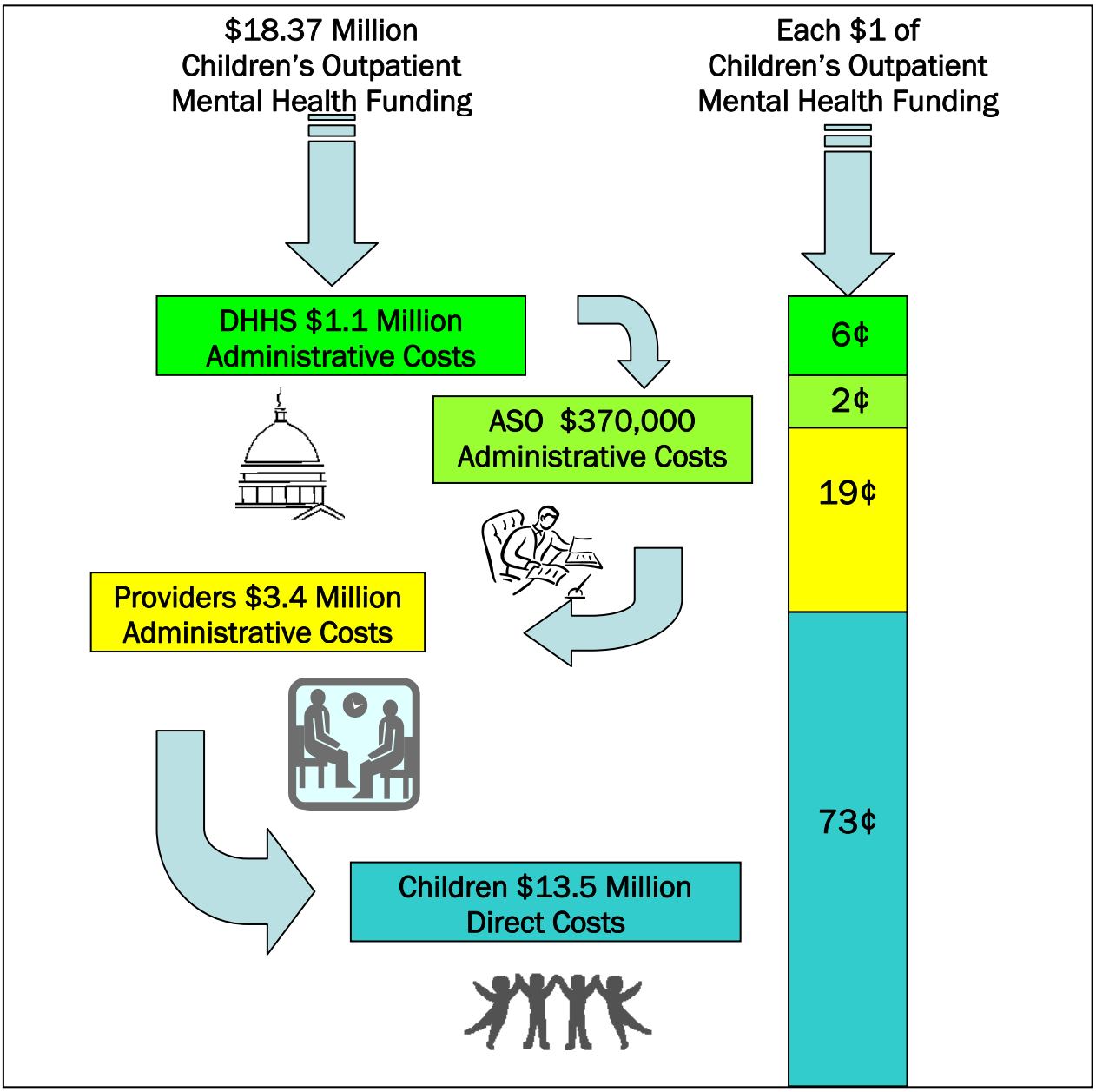
OPEGA suggested the Legislature consider taking action to:

- ⇨ Assess the cost-effectiveness of the contract DHHS has entered with the ASO, APS Healthcare.
- ⇨ Formally monitor the effects of the current standard rate and administrative requirements of the care management effort on the CMH network to ensure any unintended changes in the availability or quality of services can be addressed promptly.
- ⇨ Determine whether to revive the currently inactive Children's Mental Health Oversight Committee authorized by 34-B MRSA §15004-2.
- ⇨ Monitor developing actions by DHHS and the Service Center to begin collecting federal reimbursement for appropriate costs not reimbursed in prior years.

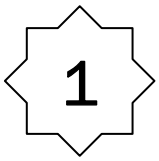
To get a copy of the full report, or for more information visit the website listed at the bottom of this page or contact OPEGA at (207)287-1901.

February 2009

Estimated Portion of Each FY 2008 Dollar that Went to Direct Services and Administrative Costs for MaineCare Children's Outpatient Services



Recommendations



More Detailed Review of Contract with APS Would be Prudent

When the 123rd Legislature passed PL 2007, Chapter 240, Part CC, it expected estimated savings of $6 million in General Fund and just over $16 million total during FY 2008. Expected savings for FY 2009 were $8.5 million in General Fund and about $23 million total. Table 7 shows the detail of savings booked as part of that public law. We also note that the Governor's Proposed Biennial Budget for 2010 – 2011 includes several budget initiatives related to PL 2007, Chapter 240, Part CC.

Table 7. Savings Estimates Excerpted from PL 2007, Chapter 240, Part CC

SECTION TOTALS	2007-08	2008-09
GENERAL FUND	($6,000,000)	($8,500,000)
FEDERAL EXPENDITURES FUND	($10,348,774)	($14,732,479)
SECTION TOTAL - ALL FUNDS	($16,348,774)	($23,232,479)

DHHS has contracted with APS Healthcare to serve as the ASO. The contract became effective September 1, 2007 and ends on July 31, 2009 unless extended. The cost of the contract for all services is approximately $3.6 million in FY08, $5 million in FY09 and $406,688 in FY10. Seventy-five percent of the contract is paid for with Federal funds with the State funding the other 25%.

OPEGA inquired about whether and how actual savings realized from APS's contract were being tracked. DHHS provided a Cost Impact Analysis for the ASO prepared for DHHS by the Muskie School of Public Service. This analysis bases cost savings on changes in trends in MaineCare spending for behavioral services as a whole and by individual services. We note that there are a number of factors that could contribute to changes in the total cost of behavioral services, and outpatient CMH services specifically, from one year to another including:

- changes in MaineCare eligibility that may affect how much outpatient treatment children may receive annually;
- changes in the number of MaineCare eligible children seeking outpatient services;
- implementation of standardized rates; and
- changes in provider requirements or environmental factors that may affect the number of providers willing to offer the services.

Consequently, savings shown in this analysis cannot be directly attributed to the efforts of the ASO.

In addition, our survey of providers indicated that many providers have concerns about the administrative burdens imposed by APS, not just related to outpatient services, but for all behavioral health services. These concerns may be mostly the frustrations of dealing with new procedures, but they do raise the question of whether the benefits (cost savings and improved outcomes) of the contract with

APS actually exceed the total costs associated with their work: not just their contract costs, but also the costs imposed on the provider network.

Given the cost of the APS contract, the significant savings expected from the ASO and providers' concerns about associated administrative burdens (which OPEGA has not validated), we believe it would be prudent to conduct a more detailed review of the contract to assure that the State's desired outcomes for the care management effort are being achieved in the most cost-effective manner possible.

Recommendation for Legislative Action:

The Legislature should consider directing OPEGA (or some other entity) to perform an in depth evaluation of the contract and services provided by APS. Such an evaluation should review the detail of results APS has achieved, the administration of the contract with APS, and the costs that the provider network has absorbed as a result of APS's requirements.

Outpatient Provider Network Needs Ongoing Monitoring

Maine's relatively recent move to a standard rate for outpatient services has changed the interaction between the State and the provider network. There is no longer negotiation to ensure that individual providers' rates are adequate to cover their specific expenses. With this new dynamic, it will be increasingly important for the State to actively and consistently monitor the health of the provider network: following the evolution of the network, staying alert for any access or quality issues, and monitoring the implementation of efforts to improve efficiencies and reduce administrative burdens.

In our discussions with DHHS, they mentioned several avenues that currently exist for monitoring the quality of services provided – some of them more objectively based than others. Adequately assessing the geographic availability of outpatient services for children, however, is currently a difficult task due to a lack of objective data and processes for collecting it.

Recommendation for Legislative Action:

The Legislature should consider two potential approaches for monitoring the health of the outpatient provider network, the quality of service children are receiving and on-going efforts to increase efficiencies in providers' administrative requirements. One would be for the Joint Standing Committee on Health and Human Services to establish a formal and regular process specifically focused on monitoring these items. As an alternative, the Legislature could assign this formal oversight to the now inactive Children's Mental Health Oversight Committee. Although the Committee has been inactive for some time (see Finding 3), its statutorily set membership seems well suited to carry out this sort of monitoring.

With either approach, the Health and Human Services Committee and DHHS should agree upon the data to be collected and reported that will allow for a sufficient understanding of changes in the provider network and meaningful,

objective measures of availability and quality of services. Data collection processes and procedures should have adequate controls built in to assure that data collected is complete and reliable.

Continued Need for Children's Mental Health Oversight Committee Should be Determined

The Children's Mental Health Oversight Committee required by 34-B MRSA §15004-2 appears to have stopped meeting and no longer receives reports or makes reports to joint standing committees of the Legislature as required in statute. It appears that a number of the Committee's seats have not received legislative appointments for some time, and as a result the Committee has ceased to function. Statute contains a number of specific duties for the Committee, some of which no longer appear relevant.

Recommendation for Legislative Action:

The Legislature may want to consider either removing the Children's Mental Health Oversight Committee from statute, or else taking steps to revive the Committee and ensure its effectiveness. An active Oversight Committee could potentially assist the Department and the Legislature in monitoring how changes in the newly standardized rates are impacting the provider network and tracking the implementation of initiatives to reduce administrative burdens on providers.

If the Legislature decides to reactivate the Committee it should review, and update as appropriate, the Committee's current statutory responsibilities. The Legislature should also consider adding the Committee to the list of committees in 5 MRSA Chapter 379 so that the Secretary of State's office can monitor and report on the Committee's annual activity and vacant seats as it does for all other committees listed in that chapter.

DHHS Cost Allocation Plan Should Include Rate Setting Unit

The DHHS Rate Setting Unit performs work related to federal programs but had none of their costs allocated to Medicaid in the Department's FY 2008 Cost Allocation Plan. This results in less federal matching dollars for the Department and requires the Unit to be fully funded by the General Fund. Issues with the CAP have been noted previously by the Department of Audit, and the DHHS Service Center has been working actively over the past few years to make improvements to the plan and maximize federal reimbursements. The Service Center estimates that allocating the Rate Setting Unit's applicable costs to Medicaid could result in additional federal reimbursement of approximately $110,000, but not more than $148,000 annually.

Recommendation for Legislative Action:

DHHS and the Service Center are taking steps to ensure the Rate Setting Unit's costs are allocated to federal programs as appropriate to maximize federal revenue in future fiscal years. The Joint Standing Committee on Health and Human Services (HHS) may want to follow up on the status of this action during the second session of the 124th Legislature to make sure the State has collected all appropriate federal reimbursement associated with the Rate Setting Unit. In addition, by the second session the State Department of Audit will likely have completed its thorough audit of DHHS's new CAP plan. Although that audit may not touch on the Rate Setting Unit specifically, the HHS Committee may want to invite the State Auditor before the Committee to report on the Department's new CAP as a whole.

Agency Response

In accordance with 3 MRSA §996, OPEGA provided the Department of Health and Human Services an opportunity to submit comments on the draft of this report. The response letter can be found at the end of this report.

Acknowledgements

OPEGA would like to thank the management and staff of the Department of Health and Human Services and the DHHS Service Center who worked with us throughout this audit. We would also like to thank:

- the providers and family advocates who took the time to share their perspectives with us;
- the APS Healthcare representatives who willingly shared output data and information about their processes;
- the legislative Office of Fiscal and Program Review and the Office of Policy and Legal Analysis for assisting us in understanding the context and legislative history associated with children's mental health; and
- the State Auditor's Office for providing additional context on relevant Single Audit findings and the related federal programs.

Department of Health and Human Services
Maine People Living
Safe, Healthy and Productive Lives

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax (207) 287-3005
TTY: 1-800-606-0215

February 23, 2009

Beth Ashcroft, Director
Office of Program Evaluation and Government Accountability
#82 State House Station
Augusta, ME 04333-0082

Dear Ms. Ashcroft:

The Department of Health and Human Services appreciates having the opportunity to respond to the Office of Program Evaluation and Government Accountability's report entitled "MaineCare Children's Outpatient Mental Health Services – An Assessment of Administrative Costs and Their Drivers". The Department was given the opportunity to comment on a preliminary draft of the report, and we were pleased to note that some revisions were made as a result of the Department's comments. We appreciate the courtesy and professionalism which OPEGA brings to their work, and we hope the comments we are providing here will provide additional information and perspective that will be helpful to legislators.

On page 14 of the report, OPEGA states: "there are some differences in perspectives between providers and DHHS on the administrative burdens and this is not entirely unexpected given the cultural shift that a care management effort creates. However, we have not researched the specific points made to us by either group and are not in a position to validate them." We think it is unfortunate that OPEGA has adopted this stance, and we believe it diminishes the value of the report. In several instances, the Department provided information and documentation that would have enabled OPEGA to make a determination concerning specific issues identified in the report. For example:

- OPEGA has reported (on page 13) the providers' contention that the "multiple" pages of information required for continuing stay reviews of children's outpatient services is extremely burdensome, even after the Department provided a copy of the actual one-page form that is required. It is impossible to perform a utilization review function without requiring some information from providers, and a minimal amount of information is currently being required.
- The report contains the allegation that "changes to MaineCare requirements mean providers are constantly asking administrative and technical staff to update data submission forms, codes and processes." There have been two instances of such changes in MaineCare requirements for outpatient services that were necessitated by the need to replace local codes with HIPAA-compliant billing codes (as part of the conversion to a new claims processing system). We do not mean to understate the significance of these changes for providers, but two instances certainly do not amount to a "constant" problem. We believe this may be a view held by providers of multiple services and is outside the scope of this review.

- Regarding rates for children's outpatient services, the report notes that the Department contracted with Deloitte to assess the reasonableness of MaineCare reimbursement rates for behavioral health services. Further, the report correctly points out that Deloitte's analysis supported the reasonableness of the cost-based standard rates that were originally developed and proposed by the Department in 2007. However, in the face of all the data that has been developed, the extensive and well documented process of discussion with providers that has occurred, and the comprehensive analysis that was done by a firm with national scope and expertise in the area of rate-setting, the report concludes (on page 11) that OPEGA "did not participate in [Deloitte's] effort, or in their meetings with providers, so we can not evaluate the validity of their work or the extent to which they considered providers' input about actual costs providers were experiencing."

It is difficult to understand why OPEGA has been willing to report subjective provider concerns that excessive administrative burdens are being imposed or that rates may be either too high or too low, and reluctant to draw a conclusion based on the voluminous objective data that is available on the issues that have been raised. It is not enough to say (as the report does on page 19) that OPEGA has not validated provider concerns about administrative burdens when there is clear evidence that at least some of the most prominent concerns described in the report are certainly not valid. Without validating claims and counter-claims, the OPEGA report gives unwarranted credibility to assertions and allegations that are not supported by facts.

The Department does not object to the recommendations contained in the report, but we would offer the following comments regarding those recommendations:

- Recommendation 1 calls for a more detailed review of the contract with the Administrative Services Organization (ASO). While such a review may help to answer questions raised in the report, the primary reasons that OPEGA has presented for recommending this review is to assess the costs and benefits of this initiative in light of provider concerns about the administrative burdens it imposes. In response to this recommendation, we would note that the decision to implement a utilization management initiative for behavioral health services was a policy decision made by the Legislature based on the need to control escalating costs. It only began operating in December of 2007. For the first three months providers registered their clients and services and received automatic authorizations. Actual clinical reviews generally began 3 to 12 months (depending on the service) after the initial registration became effective (less for inpatient and PNMI services). Claims for services are generally submitted and processed one to three months after the service is provided. In other words, the initial year of operation is an implementation period and the impact of an ASO initiative manifests itself over time. We therefore suggest that it is too soon to effectively evaluate the ASO initiative, and that such an evaluation should wait until the initiative has been fully operational for a reasonable period of time and more data is available.

  On the other hand, we would welcome a review if the Legislative Committee would like to focus on the question of administrative burdens, how the burdens imposed by the Maine ASO compare to burdens imposed by other utilization management programs in the public and private sectors, and what the Department and the ASO have done to mitigate administrative burdens on Maine providers.

- Recommendation 2 calls for monitoring of the outpatient provider network. In response to this recommendation, the Department would note that the Children's Cabinet already exists and has general responsibility for monitoring children's services. If the Children's Mental Health Oversight Committee is to be re-activated, it will be important to coordinate roles and functions in order to prevent duplication.

  In addition, the recommendation calls for collecting complete and reliable data to support monitoring of the availability and quality of services. The lack of waiting list data for children's outpatient services is one of the specific issues mentioned earlier in the report. We would note that collecting waiting list data from the large number of outpatient service providers in Maine would only result in the compilation of duplicated, inaccurate and outdated data. In order for waiting list data to be meaningful, it must be collected and maintained in a central location on a "real time" basis. Doing this requires a substantial commitment of resources and imposes significant burdens on providers. Our only point here is that before imposing new data collection requirements, there should be a determination that there is a clearly identified problem or need to be addressed. In this instance, the report itself notes (on page 15) that "no systemic issues with either availability or quality of children's outpatient services were brought to OPEGA's attention".

Thank you for the consideration of our comments.

Sincerely,

Brenda M. Harvey
Commissioner

BMH/klv

cc: Geoff Green, Deputy Commissioner, DHHS
Muriel Littlefield, Deputy Commissioner, DHHS
Russ Begin, Deputy Commissioner, DHHS
Jim Beougher, Director, Office of Child and Family Services, DHHS
Joan Smyski, Office of Child and Family Services, DHHS
Lucky Hollander, Legislative Liaison, DHHS