Multnomah County – Mental Health and Addictions Services: Consultation on Managed Care and Local Mental Health Authority Roles

June 2014

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Executive Summary

Summary of Findings and Recommendations

The Multnomah County Department of Human Services, Mental Health and Addiction Services Division (MHASD) engaged the Technical Assistance Collaborative (TAC) and its partner, the University of Massachusetts Medical School, Center for Health Law and Economics, (CHLE) to conduct an analysis of its dual role as the Local Mental Health Authority (LMHA) and a Risk Accepting Entity (RAE) as part of Health Share, one of the two Coordinated Care Organizations (CCOs) serving Multnomah County residents. The purpose of this engagement was to provide MHASD with an analysis of its local mental health authority and managed care functions in order to assist the County in making decisions regarding efficient management of resources and provision and/or administration of mental health services for Multnomah County residents. Additionally, TAC/CHLE was asked to help the County evaluate the risks and opportunities of continuing as a RAE in this evolving healthcare environment and what changes would be necessary to improve the County's performance as a RAE should the County choose to continue in this role in the future.

The following recommendations resulted from this consultation:

Managed Care Recommendations

Financial systems and management

- If the County wants to remain as a RAE it will be critical that it invest in an accounting system that is designed to function for a managed care line of business.
- Accounting should set up a cost methodology to disaggregate full-time equivalent (FTE) positions and expenditures by payer and program type and a system to track each line of business.
- The amount of indirect and non-staff administrative costs allocated to managed care operations should be reviewed.
- The County should work with Health Share to establish common definitions of administrative duties and associated costs for clear tracking and reporting.
- Opportunities to maximize Medicaid revenue should be sought where possible by identifying those services currently being funded with state or county general fund dollars that could become Medicaid reimbursable.
- The County should consider using existing resources to hire an actuary to review its utilization data, and develop an adequate capitation rate. This would help the County understand whether the capitation rates offered by Health Share are sufficient.
- To meet the contracted Medical Loss Ratio (MLR) requirement, the County should reduce non-staff administrative costs and retained revenue, re-directing amounts toward funding of appropriate medical services.
- The County should consider negotiating for a MLR requirement of 85%, which is closer to industry standard, especially since the retained earnings are the County's one protection against the financial risk of the contract.

Utilization management

- The County should engage Health Share in discussions about whether or not the substance use benefit should remain in the capitation of the physical health plans. Given that the substance use residential benefit is now being managed by the behavioral health RAEs and the high co-occurrence of mental health and substance use disorders, moving the substance use benefit into the capitation of the behavioral health RAEs may help improve coordination of care and more integrated community-based treatment options for these individuals, while reducing inappropriate utilization of psychiatric inpatient care.

- The County should move forward in the process of changing its UM processes for children enrolled in Wraparound so that the care coordinator will have the responsibility for authorizing care. This type of approach to care management and authorization for youth participating in high fidelity Wraparound is more consistent with best practice nationally.

- The capacity of the County's Wraparound team should be expanded. The County should also work with Health Share and the Department of Human Services to explore how to train and certify more providers in Multidimensional Treatment Foster Care (MTFC) to help ensure that youth with mental health challenges involved with the child welfare system have access to alternatives to residential care. The County may want to collaborate with the Oregon Social Learning Center on these efforts.

- The County may want to consider taking a more global approach to UM by creating a full-time network manager position with responsibility for meeting with providers to review certain quality metrics and focusing more on overall provider performance for the different contracted services they provide.

- Additional resources should be dedicated to identifying and coordinating care for high utilizing members. Using a more global approach to a member's care through an increased emphasis on care coordination rather than service specific UM again aligns more closely with the purpose and intent of healthcare transformation.

- The County should request that Health Share evaluate areas such as service utilization limitations and the medical necessity criteria of all of its RAEs to ensure compliance with the federal Mental Health Parity and Addiction Equity Act.

Provider payment

- Health Share and Multnomah County should ensure that solid base data is used in calculating case rates, and should be transparent with providers about how these rates are being developed. Opportunity for provider input should be incorporated into the process.

Leadership and staffing:

- A key leadership staff person should be hired or assigned to be fully dedicated to managing the Medicaid program. This person needs to understand both the financial and operational aspects of running a Medicaid managed care plan.

- Positions dedicated to network management and care coordination should be created.

Legal and contractual

- County leadership should engage with their legal counsel to ensure they have a thorough understanding of their contract with Health Share particularly as it relates to financial risk, delegation of utilization management and provider contracting functions.

Local Mental Health Authority Recommendations

- Given the substantial challenges of funding cuts and ongoing demands for the safety net, MHASD leadership needs the time to focus its attention on fulfilling the LMHA mandated duties and on the effective operation of the Community Mental Health Program (CMHP). As suggested earlier, hiring a key leader to focus on the managed care operations will hopefully allow MHASD leadership to refocus their attention on the work of developing and maintaining the critical services the County provides under the auspices of the LMHA.

- The County should strengthen their relationship with new State Mental Health Director so as to improve communication and engage in problem-solving.

- The County should work with key partners to develop strategies to reduce the reliance on hospital emergency departments for people in psychiatric crisis. Strategies to consider including enhancing the Crisis Assessment and Treatment Center or the Urgent Walk-in Center to provide 24/7 availability and exploring the Alameda County, California model which has proven successful in drastically reducing hospital emergency department (ED) “boarding times” and inpatient hospitalization rates for people in behavioral health crisis.

- Educating hospital emergency department physicians about the use of Safety Holds when substance abuse appears to be at play, and establishing a payment mechanism for the holds would alleviate demands for mental health resources and result in better disposition for the clients.

- In its role as the LMHA, the County should engage Health Share and Family Care as the two CCOs serving Multnomah County Medicaid members to help create solutions and reduce barriers to treatment for people with co-occurring disorders to reduce inappropriate utilization of hospital emergency departments and inpatient mental health care.

- Increasing access to and availability of care coordination for people not eligible for Medicaid (including facilitating enrollment in Medicaid) to help them transition between levels of care could improve the system’s ability to more easily move individuals through a continuum of care and supports.

- Continue to monitor and improve access to outpatient treatment and community support services as more people seek care as a result of Medicaid expansion.

- Multnomah County may be better served by reestablishing dialogue with involved stakeholders to determine how to facilitate use of inpatient and jail diversion services, and the existing involuntary outpatient commitment criteria.

- Together with their partners, the County should continue to implement its 10-year plan to end homelessness with a specific focus on promoting effective strategies such as permanent supportive housing for people with serious mental illness.

Introduction

Purpose of Engagement

The Multnomah County Department of Human Services, Mental Health and Addiction Services Division (MHASD) engaged the Technical Assistance Collaborative (TAC) and its partner, the University of Massachusetts Medical School, Center for Health Law and Economics, (CHLE) to conduct an analysis of its dual role as the Local Mental Health Authority (LMHA) and as a Risk Accepting Entity (RAE) as part of Health Share, one of the two Coordinated Care Organizations (CCOs) serving Multnomah County residents. The purpose of this engagement was to provide MHASD with an analysis of its local mental health authority and managed care functions in order to make decisions regarding efficient management of resources and provision and/or administration of mental health services for Multnomah County residents.

As part of the Oregon Health Plan's (OHP) ambitious effort to transform its health care delivery system, OHP selected a network of 15 CCOs, and charged them with helping the state achieve the "triple-aim" of reducing the cost of care and improving health care quality and population health. The Multnomah County MHASD, in its role as a behavioral health RAE as part of Health Share, is a key partner in the state's transformation efforts. While serving as a Medicaid mental health managed care organization is not a new role for the County – the MHASD operated Verity, the County's Medicaid mental health organization for many years – health care reform, a changing fiscal environment, and the County's new relationship as a subcontractor to a CCO have presented the County with a wealth of potential opportunities to improve the health and well-being of people with mental health and addiction issues, but has also presented some challenges and risks. As part of the consultation on the County's role as the RAE, TAC/CHLE was asked to help the County evaluate:

- The risks and opportunities of continuing as a RAE in this evolving healthcare environment.
- What changes would be necessary to improve the County's performance as a RAE should the County choose to continue in this role in the future.
- Whether the County has the necessary infrastructure to continue to operate as a RAE.
- What options exist for the County's continuing role in the behavioral health system.

As part of the consultation on the County's LMHA role, TAC/CHLE was asked to help the County evaluate:

- The implications on the LMHA should the County no longer serve as the RAE.
- The impact on the County of the re-deployment of state funds to the Medicaid program.
- The County's role in the civil commitment process.

Methodology

As part of the work evaluating the County's managed care operations and functions, TAC/CHLE reviewed existing documentation including:

- Summary of Oregon's 1115 Demonstration Waiver
- Oregon Health Plan Services Contract,
- RAE Participation Agreement between Health Share and Multnomah County
- Memorandum of Understanding between Health Share and Multnomah County
- Health Share Multnomah Mental Health Specialized Services Provider Manual
- Health Share Provider Manual
- Adult and Child Level of Care Utilization Management Guidelines
- Wakely risk adjustment methodology

- Health Share Mental Health Provider Boot Camp
- Financial reports, both prior to contract with Health Share, and since the contract with Health Share
- Utilization reports
- Statistics on appeals and grievances

TAC/CHLE also conducted a two day site visit focused on Multnomah County's managed care role and functions that included:

- Interviews with Multnomah County staff and leadership
- Interviews with five of the County's contracted behavioral health providers
- Interviews with Health Share leadership team.

The second phase of the work focused on the County's role as the LMHA. While it is critical to allocate and track costs separately according to the appropriate funding stream, the roles of managing the Medicaid managed behavioral healthcare program and serving as the LMHA intersect. Review of the LMHA included assessing whether the County is better served by taking full advantage of opportunities to build on the strengths of each role in creating a unified behavioral health system for Multnomah County, or if the County would be better served by relinquishing responsibility for the Medicaid program and re-directing its full attention and resources to operating the LMHA. Evaluation of the LMHA included review of:

- MHASD Tables of Organization
- County Financial Assistance Contract/Flex Funding and AMHI Amendments
- AMH Funding Memos
- LMHA/CMHP Biennial Implementation Plan 2013-15
- MHASD Board Presentation
- MHASD summaries on Crisis Intervention Services, Direct Clinical Services, Behavioral Health System of Care and LMHA/CMHP Commitment Services
- Department of Justice letter re: Investigation of Portland Police Bureau
- Interim Report Regarding United States Investigation of Oregon's Mental Health system

TAC conducted a second two-day site visit focused on the role of the LMHA and the Multnomah County community behavioral health system conducting interviews with:

- Multnomah County MHASD staff and leadership
- Providers of Crisis Intervention Services, behavioral health inpatient and community-based services
- Advisory Committee Co-Chairs
- Various stakeholders from the criminal justice system including the Presiding Judge, the Portland Police Behavioral Health Unit, the Parole and Probation Mental Health Unit, Corrections Health and Mental Health Court/Commitment staff.

Major Findings

Managed Care

Financial Systems Management

The County is facing significant challenges in managing the fiscal side of the managed care program. Most notably, while the former managed care program, Verity, had operated in deficit (after an 11% reduction from the state) in fiscal year FY12, in calendar year 2013 the County operated in a surplus, with a medical loss ratio (MLR) of 75%. This means that 75% of the capitation payment paid for behavioral health care services and activities that improve the quality of care. The contract with Health Share requires a 90.5% MLR, and the Affordable Care Act (ACA) has a minimum standard of an 85% MLR. Though the County has under spent its capitation revenue in 2013, it operated the managed care function under a constrained basis as if it were still in deficit. In the first quarter of 2014, the County has paid over 90% of the capitation to providers.

According to the financial reports for 2013, 3% of the capitation funded administrative staff positions, 7% funded other administrative costs including indirect costs, and 15% of the capitation was retained as earnings.

In interviews with the financial management leadership staff at the County, it became clear that the financial accounting systems that the County uses to manage the plan are inadequate for the task. The SAP accounting system was not designed for either government or managed care, and is not flexible enough to meet the needs of this line of business.

The financial system does not link directly to the claims payment data, and the financial management staff work with multiple downloads of data from differing systems, some with duplicative data, making reconciliation between the financial system and the claims system very time consuming. It is not clear that the financial system is able to provide accurate numbers on a timely basis.

The financial system is not able to produce reports by varying time frames, critical when some reporting needs to be done by fiscal year and other by calendar year. Health Share has asked for additional in-depth financial reports that are typical of managed care plans, but the systems used at Multnomah County currently cannot produce these reports.

Utilization Management

Utilization Management (UM) has been an area of considerable tension and concern from the perspective of the leadership of both the MHASD and Health Share. County UM staff expressed concerns that they are receiving pressure to authorize care that does not meet their established medical necessity criteria and/or is not within their capitation, in the case of substance use treatment. County staff also expressed frustration that Health Share is circumventing the County's policies and procedures related to appeals and grievances and is intruding in its UM processes, undermining the County's ability to appropriately manage care. Health Share staff expressed concern about the high number of denials issued, appealed and overturned compared to the other two behavioral health RAEs and worries that their members are not receiving requested services. See Table 1 for summarized data on appeals received and upheld for both initial denials, and discontinuation of care for 2013. Two areas stand out as sources of particular disagreement: authorization of inpatient care for individuals under the influence of substances and access to intensive treatment services for children.

TABLE 1: SUMMARIZED DATA FOR 2013 OF NOTICES OF ACTION AND APPEALS

Quarter	Notice of actions	Appeals	% Actions appealed	# Upheld	% Appeals upheld	# Over-turned	# Partial denial	# Partially or fully over-turned	% Over-turned or partial denial
Jan - Mar	182	42	23%	22	52%	20	0	20	48%
April - June	131	28	21%	19	68%	9	0	9	32%
July - Sept	138	60	43%	28	47%	9	11	20	33%
Oct - Dec	104	34	33%	22	65%	5	5	10	29%
2013	555	164	30%	91	55%	43	16	59	36%

Inpatient Authorizations for Members with Co-Occurring Mental Health and Substance Use Disorders

Until recently, the County had been denying authorization requests for inpatient psychiatric care to people presenting for inpatient mental health care while under the influence of drugs or alcohol. The rationale for this is that when substance abuse is the primary factor causing the "behavioral concerns" the symptoms do often disappear in less than 24-hours and the appropriate disorder needing treatment can be properly assessed. County staff thought these requests should be considered addiction services covered by the physical health RAE's; however if the individual does not require medically monitored detoxification (detox) to manage withdrawal symptoms, which is covered by the physical health RAE, but does require intervention to assure that the initial assessment is accurate and to prevent dangerous behavior such as suicide, a Safety Hold[1] or mental health hospitalization may be appropriate.

The County recently agreed to authorize the first day of the psychiatric inpatient stay in such situations, and then conduct a clinical review to determine the appropriate level of care for the member. Once the individual is no longer under the influence, an appropriate diagnosis and treatment referral can be made. This is an improved approach. It should be noted, however, that the current fiscal arrangement, which has detox and outpatient substance use treatment benefits in the capitation of the physical health RAEs and the mental health benefit in the capitation for the behavioral health RAEs, has contributed to the cost-shifting and lack of continuity of care and integrated treatment options for people with co-occurring disorders. The bifurcated funding under Health Share does not support proper assessment and disposition for its members. In addition, the LMHA pays for Mental Health Holds for the indigent, but not Safety Holds. As currently designed, the system provides an incentive for providers to identify a person as having a mental health disorder rather than a substance abuse or co-occurring mental health and substance use disorder. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), nationally 8.9 million adults are estimated to have a co-occurring disorder, but only 7.4% receive treatment for both conditions and almost 56% receive no treatment at all.[2] The County's Medical Director has legitimate clinical concerns about how members with a co-occurring mental health and substance use disorder (COD) tend to cycle through multiple short psychiatric admissions without getting connected to treatment that could help them recover.

[1] Safety Holds provide for limited retention of individuals who appear to be under the influence of drugs and/or alcohol.
[2] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009

Authorization of Children's Services

Concerns regarding the County's approach to authorizing care for youth enrolled in Multnomah Wraparound were mentioned by numerous stakeholders. Multnomah Wraparound utilizes a high fidelity Wraparound approach to coordinating care for youth with the most complex and intensive needs. For children enrolled in Wraparound, child and family care plan team meetings are convened where team members, in collaboration with the youth and family, develop a plan of care including recommendations for mental health treatment services, based on the unique strengths, needs, and circumstances of the youth and his/her family. The Wraparound care coordinators, however do not currently have the authority to authorize the services recommended by the planning team, and must seek authorization from the County's utilization review team. This has led to instances where services recommended by the care planning team have been denied. Further, this process is duplicative and appears to be an inefficient use of resources.

The County is currently in the process of changing their UM process for children enrolled in Wraparound so that the care coordinator will have the responsibility for authorizing care. As part of this change in UM approach, care coordinators will need to help members of the care planning teams understand the medical necessity criteria for the Medicaid services they are recommending. This type of approach to care management and authorization for youth participating in high fidelity Wraparound is more consistent with best practice nationally.

An additional concern raised by numerous stakeholders regarded requests for residential treatment for youth involved with the child welfare system. In some instances County staff members believe that the requests for residential care are being sought due to a dearth of treatment foster homes, rather than the clinical need for residential care. Given the high-cost and poor-outcomes often associated with residential care, County UM staff members are correct to question whether the youth's needs could be more appropriately met through community-based services.

Provider Payment Methodologies

The progression from fee-for-service, to global budgets, to case rates for behavioral health providers[3] is forward thinking, and the direction that provides most promise in achieving the triple aim. Most providers were supportive of the general direction of moving away from fee-for-services arrangements.

However, each provider had a different take on whether the implementation was working well or not, and most did not feel that they were being well informed of the process. Some providers thought the current global budget model was a very good model, and thought that the planned move toward case rates was moving backwards.

Other providers were unhappy with the use of the global budget rather than case rates, with the overall concern that a global budget would not allow a provider the opportunity to grow, as the global budget was based on data from a prior year, rather than the members being served currently. Providers agreed that the process for establishing the global budget appeared to be flawed, with some providers receiving budgets that were favorable for them, while other received budgets that were challenging. There was some concern among providers that the case rates may prove inadequate depending upon what base data is used to create the rates. Some providers felt that case rates should be individually negotiated to reflect the costs of specific programs.

[3] Not all providers or services are moving to a global budget or case rate approach.

Quality Management

Multnomah County has a fairly large Quality Management (QM) staff, but it is not clear whether the quality management efforts have been successful. Health Share was concerned that the plan was not able to meet their target on their 7 day follow-up after hospitalization quality metric.[4] The target rate of 68% of members receiving care within 7 days of discharge from a psychiatric hospitalization was the 90th percentile of all Medicaid managed care plans in the country who report the measure in 2012 HEDIS Reporting.[5] It is not surprising that the County, with its high concentration of individuals with serious mental illness and people experiencing homelessness would have a lower rate than the other counties. However, providers and County staff persons described a quality metric process that was flawed in implementation. The County provided information on the metrics, but did not engage the providers in technical assistance that may have enabled them to meet the goal. Additionally, there is concern with Health Share's method for calculating this measure: a follow-up visit on the day of discharge, which is a best practice, is not counted as meeting the measure.

Leadership and Staffing

Most providers acknowledged the long history of support and good relationships with the County, especially in developing the structural integrity of the system of care. The County has built a strong foundation of the mental health safety net in Multnomah County. However, now that most of the services are run through the managed care program, the providers were not clear that the management of the health plan function has the same level of leadership. Managed care operations under health care reform have become more complex, with the increasing insured population, changing payment models and quality improvement incentives. The providers expressed a desire to have a single point of contact with the County for health plan questions, especially during this time of health care transformation.

In reviewing the staffing 46.63 FTE are assigned to managed care functions, out of a total 172.54 FTE in MHASD. Because it is difficult to separate out staffing roles in the County structure, it is hard to tell whether the staffing assigned to the contract is sufficient to support the managed care function. 46.63 FTE is a lean staffing structure for a $56,000,000 Managed Care program. The administrative staffing costs are just 3% of the capitation. The County's desire to use their human resources efficiently across its managed care and LMHA functions, staff are not organized into clearly defined functional units to support typical managed care functions such as: UM, care management, credentialing and contracting, grievances and appeals, compliance and fraud prevention, member and community relations, network management, quality management, IT and analytics, and finance. Missing from the organization charts were care management, credentialing and contracting, compliance and fraud prevention, member and community relations and network management. With many staff roles covering multiple functions, standardized work processes and systems seemed lacking.

While discreet staffing for the managed care work seems low, the MHASD leadership team appears to focus a considerable amount of time on the managed care program which is detracting from their ability to tend to the challenges faced by the LMHA and operation of the Community Mental Health Program. The responsibilities of operating a risk-assuming managed care program are very different than the responsibilities of administering the LMHA which requires a different skill-set and expertise.

Legal and Contractual Issues

The legal agreement with Health Share is complicated, as the agreement appears to be non-customized to the County and includes provisions that are pertinent only to the medical RAE's. The contract frequently refers back to the contract between Health Share and OHP which refers back to Oregon state regulation.

[4] The County met and received performance payments for the two other mental health plan metrics.
[5] Oregon Health Authority 2013 Benchmarks; http://www.oregon.gov/oha/CCOData/2013%20Benchmarks.pdf

Given Health Share's concern related to the County's application of medical necessity criteria, it is critical that the County and Health Share both understand who is taking the financial risk for both over and under-spending. The County and Health Share should have a common understanding of the level of authority the County has and what level of authority Health Share has on setting rates, reimbursement policies, provider contracting, and utilization management policies.

The composition of the Health Share board, with participating providers sitting on the board of the plan, is unusual for a managed care entity. While it is desirable for providers to have a process for input into, and feedback on, the plan in which they participate, provider forums and a complaint and grievance process typically provide these opportunities. If provider participation on the board continues, the County may want to have its legal counsel review the appropriateness of this board composition and whether there are rules in place that govern how providers may participate in voting on issues that pertain to their agency/operations.

Local Mental Health Authority

Multnomah County contains 19% of Oregon's population; the majority of the County's residents live in Portland the 28th most populace city in the United States. Based on the SAMHSA's estimate of prevalence 18.6% of the County's population is estimated to have a mental health disorder.

Mental health and substance abuse disorder services in Oregon are de-centralized, delegated to 36 county authorities. LMHAs are legislatively mandated to protect the most vulnerable mentally ill and addicted persons in the community through the provision of crisis intervention services, involuntary commitment services and a safety net of services and supports for person who do not qualify for Medicaid but do not have the income or other insurance to provide for their care. Multnomah County administers the largest LMHA in Oregon. Approximately 25% of the state's licensed residential beds for people with serious mental illness are located in Multnomah County. These beds are available to anyone in the state. In addition, 1/3 of the state's Psychiatric Security Review Board beds are in Multnomah County.

Multnomah County provides a broad continuum of treatment options based on individual need. Services include school-based mental health, clinic-based outpatient services, intensive care management, chemical dependency residential treatment, transitional housing, supported employment, wraparound, supportive housing, forensic diversion and specialty courts. The Community Court at Bud Clark Commons which provides an opportunity for people who commit misdemeanor crimes such as petty theft, drinking in public, and trespassing to perform community service or participate in treatment services to address the underlying issues that led to the crime, is the first of its kind in the nation. In FY 14 the County contributed $16.5 million[6] to enhance the availability of treatment and to provide services not available elsewhere in Oregon such as a crisis assessment and treatment center for sub-acute care and specialty providers such as Outside In which provides assistance to homeless youth and marginalized people to move towards improved health and self sufficiency.

Key services administered by the County include:

Crisis and respite services

Multnomah County maintains a mental health crisis infrastructure that includes urgent walk-in, mobile crisis, crisis assessment and treatment center, crisis respite, inpatient hospitalization, and a 24/7 call center that acts as the 'hub' of the system. In addition to taking crisis calls from the community, the call center staff

[6] The approved budget for FY 15 is $17.3 million of County General Funds.

answers lines dedicated to the police and 9-1-1. Staffed 24 hours a day, seven days a week by Multnomah County mental health professionals, the **Call Center** is a crisis line and a dispatcher for the **Mobile Crisis Outreach Team**. In 2013, they responded to more than 70,702 callers. The county's **Urgent Walk-in Clinic** is open seven days a week from 7:00 a.m. to 10:30 p.m. to see individuals and families who are in crisis and need an urgent appointment with a mental health professional; the clinic saw 3,603 individuals in FY 13, diverting 97% from a trip to the ED. For individuals not appropriate for crisis respite but not ill enough for hospitalization, the **Crisis Assessment and Treatment Center (CATC**) is available for crisis stabilization in a secure setting. Peers, medical and mental health professionals are on staff at the site. It should be noted here that many of the County's crisis safety net services are available to all County residents, regardless of insurance type and ability to pay. Medicaid funds through Health Share help support the crisis system operation, however the other CCO that operates in the County, Family Care, does not contribute to the operation of the crisis system despite the fact that its members access these services.

Court/Diversion Services

The LMHA performs **Involuntary Commitment Investigations** on more than 4,900 people on emergency psychiatric holds each year; in 2013 only 6% were subsequently committed. **Forensic Diversion programs** reduced the number of individuals with mental illness in jails, the court system and the Oregon State Hospital, serving 270 severely ill individuals in the first 6 months of 2013.

Early Assessment and Support Alliance (EASA)

This multidisciplinary early intervention program is targeted to young people ages 15 to 25 experiencing their first symptoms of psychosis. Family members and friends are engaged as part of the team. Approximately 26% of EASA clients have jobs after a year in the program and hospitalizations decreased by 79%. The EASA program model has been shown to prevent longer term consequences and costs associated with severe mental illness (SMI). It is being used nationally and internationally as a best practice to support young adults with SMI.

Multnomah Treatment Fund (Indigent Care)

The MHASD's original annual budget for FY 21013/14 was $99,716,689: Oregon Health Plan represented 46% of funding, State/Federal/Other represented 37.5% and the County General Fund represented the remaining 16.5%. Effective January 1, 2014 Oregon implemented health care reform per the ACA providing for Medicaid Expansion and subsidized health care coverage for more than 360,000 residents statewide. The increase in coverage is intended to result in fewer indigent persons relying on the LMHA safety net. The state authority reduced county mental health adult non-residential and acute care services funding by 50 and 65%, and substance abuse funding by 86%, re-directing $20 million in state General Funds to Medicaid expansion. The state estimates that an additional 54,400 Multnomah County residents will be covered by the OHP by 2016.

While enrollment for the Multnomah Treatment Fund had declined by 34.5% since January 1st, the County continues to see about 15 new indigent persons a week in need of services. The County estimates that a significant number of its residents will remain without coverage/insurance and will rely on the safety net of services/funding.

Multnomah County retains responsibility as payor of last resort for mandated functions like emergency holds and commitment services for all County residents.

Culturally Specific Mental Health Services

In response to the changing demographics of the County, the desire to ensure that mental health care is accessible to underserved populations and reflects the diversity of its population, the County has committed

to supporting providers that serve people from a broad array of cultural groups. Specifically, the County has contracted with providers that have the expertise and competencies in working with: people migrating from Eastern Europe, African-Americans, Asian-Americans, Latinos, and Native Americans. In FY 12-13 culturally specific mental health services were provided to approximately 713 individuals.

Implications for the LMHA if the County is no longer a RAE

A primary concern with MHASD relinquishing administration of the Medicaid managed care program is the impact on the larger behavioral health system. While Health Share currently influences decisions made by MHASD, the County still maintains responsibility for both the Medicaid and non-Medicaid programs. MHASD can determine how to best direct resources for service development and expansion. Another entity would make these decisions regarding Medicaid funded services if MHASD is no longer involved. Another potential result would be the reinforcement of "silos" within the system. Most stakeholders interviewed expressed concern about the fragmentation that already exists within the system. Removing the Medicaid program from MHASD would surely add to the separation of the systems and how they are used to support consumers and their families.

In addition, the impact on the County's staffing and certain services must be considered. MHASD currently employs 172.54 full-time equivalent (FTE) staff. Some staff have duties strictly associated with the LMHA, such as those who conduct hold investigations or perform Protective Services. Others have shared duties which cross both the Medicaid managed care and Community Mental Health Programs. The County is able to allocate a portion of the costs and operations for the shared FTEs to Medicaid administration, and would lose the administrative funding support if the County were to relinquish responsibility for the Medicaid managed care program. It is not clear what the exact financial impact would be but there would likely be a loss of revenue to support the existing staffing structure. The County may find it necessary to contribute additional funding to insure the effective and efficient operation of the LMHA. For example, the County operated Crisis Intervention services benefit from Medicaid support.

Of course, there would be potential benefits for Multnomah County to operate the LMHA without the distractions of administering the Medicaid managed care program. Given the introduction of CCOs, MHASD leadership is directing considerable time and attention tending to its relationship with Health Share and navigating a regional approach with its neighboring counties. In the mean time, challenges within the County are emerging that need MHASD attention such as Commitment issues discussed further below.

Impact of the Re-directing of Funding from the LMHA to Medicaid

While the expansion of Medicaid and the provision of subsidized health insurance through the Exchange is expected to provide some relief to the LMHA administered safety net, the immediate re-direction of funding has exacerbated the strain to an already under-funded community behavioral health system. Oregon has made significant reductions to the non-Medicaid funded behavioral health program effective the date of Medicaid expansion. Most states realize that there will be a lag in Medicaid enrollment as individuals learn about their eligibility for health care coverage and how to access preventative and maintenance care. This may be especially true for individuals with behavioral health needs. The issue is evident in that MHASD estimates that in spite of Medicaid expansion they continue to see an average of 15 new individuals present each week in need of treatment who lack Medicaid or insurance coverage. These individuals receive care funded by the reduced safety-net.

Not only does the LMHA provide coverage for the indigent, the funding provides many critical services and supports that do not qualify for Medicaid or private insurance reimbursement. Dollars spent on mental health and substance abuse treatment are not well spent if recipients lack basic supports such as housing, and supported employment; services which rely on County safety net funding. The Department of Justice's Interim

Report stated that "…Oregon's health transformation will have a positive impact *if* it includes a focus on helping people with serious mental illness achieve positive outcomes through the provision of critical community services."[7]

Multiple stakeholders identified that "through-put" is an issue in the system – service capacity is so limited that at times when individuals present for community treatment they either deteriorate or lose interest while waiting for an appointment, resulting in the need for crisis intervention, and often, inpatient services. Individuals leave inpatient with an aftercare plan and treatment referral but without adequate community supports and care coordination and often re-cycle back into crisis; dollars spent on stabilizing the episode are ineffective for sustaining long-term outcomes. While the Medicaid expansion will help many people who were previously uninsured gain access to needed services and supports, there will continue to be people who are not eligible for Medicaid and important services that are not covered by Medicaid; thus the County will need continued support to maintain its critical safety net services.

Issues with Commitment in Multnomah County

A secondary focus of the LMHA review involved examination of what MHASD described as an "emerging concern" over commitment issues in Multnomah County. In Oregon, a physician can initiate an Emergency Hold/Notice of Mental Illness which detains a person for up to five working days. On day three a decision is made whether to hold a hearing for commitment which can last up to 180 days. Multnomah County staff investigates all involuntary holds placed in Oregon on Multnomah County residents regardless of their insurance coverage and regardless of state funding; Multnomah County must cover the costs of all uninsured involuntary holds as payor of last resort. If the investigation determines the individual does not meet criteria for a hearing, or as a result of the hearing the person is determined to not meet criteria for commitment, the individual is released from the hospital and the social worker assists them with discharge. If the person is found to meet criteria for a hearing and subsequently for commitment, the individual can be held in the acute care hospital for up to 180 days of treatment or be transferred to a state hospital bed for long-term treatment/stabilization.

An initial review of data on Involuntary Holds and Investigations did not identify an upward trend; in fact it appears that there may be a slight decrease in events as shown below.

TABLE 2: INVOLUNTARY HOLDS, HEARINGS, & INVESTIGATIONS

Timeframe	Holds	Hearings	Commitments
FY 2011/12	5,009	271	236
FY 2012/13	5,053	297	252
7/1/13-5/12/14	4,179	214	194

While the numbers of events do not appear to be growing, stakeholders report that the time spent on disposition for individuals presenting to the ED is increasing. The Director of Behavioral Health Services for Legacy Health identified that while individuals presenting at the ED account for only 5-9% of all admissions, the average time spent in the ED is 17 hours.

Stress on Emergency Departments

There are a number of factors gleaned from various stakeholder interviews that appear to be contributing to the ED dilemma. Absent the availability of a 24/7 Crisis Triage Center and/or increased Mobile Crisis

[7] US DOJ Interim Report to the State of Oregon, Integration of Community Mental Health and Compliance with Title II of the Americans with Disabilities Act, January 2,2014

Outreach capacity, the Portland area EDs have become the place where individuals with concerning behavior are taken. As described earlier in this report, Multnomah County has a fairly robust array of crisis intervention services, however demand for such services outpaces the existing capacity of the system. The Urgent Walk-in Clinic operates 7 days a week, but is closed from 10:30 p.m. to 7 a.m., a period of variable demand for behavioral health triage and assessment, only the Call Center and the Mobile Crisis Outreach Team are available 24/7. The Walk-In Clinic does not have the ability to detain individuals if they choose to leave. The Crisis Assessment and Treatment Center (CATC) has mental health and medical staff on-site and offers a secure setting but the process for admission is cumbersome and time-consuming, making CATC of limited benefit to the Portland Police Department (PPD). Rather than wait for an authorization from the County which may be denied, police officers tend to drop the individuals off at the ED so they can quickly return to their duties.

Once at the ED, proper identification of the individual's disorder and treatment need is a problem. Like their peers nationwide, ED physicians in Portland are described as "overwhelmed" and ill-prepared to deal with behavioral health issues. While the OHA has identified the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care settings as a goal of health care reform, SBIRT is not being utilized consistently in EDs. Legacy Hospital is planning to invest its own resources into creating a crisis stabilization unit based on the model implemented in Alameda County, California to alleviate strain on their ED. The County staff also suggested that ED physicians lack education about the availability of Safety Holds for individuals presenting under the influence of drugs and/or alcohol. The use of Safety Holds would assist in proper treatment disposition and reduced denials of requests for inpatient psychiatric admissions. Unfortunately there is no current payment mechanism for Safety Holds which creates an incentive for ED physicians to utilize a mental health hold even when a Safety Hold would be more appropriate.

"Throughput," the ability to move an individual through a continuum of care and supports, was described as a problem by every stakeholder. Many of the individuals encountered by the PPD and/or presenting at the EDs have a COD. As described earlier, the bifurcated funding for treatment offers no incentive for the development of COD treatment. Nor is there a seamless transition or hand-off between levels of care, for both Medicaid and non-Medicaid eligibles. The lack of a continuum of integrated, or at least coordinated, mental health and substance abuse treatment results in a repeated cycle of crisis/police interface, ED presentation, stabilization, discharge, decompensation and crisis/police interface. Even when there is an appropriate service for after-care, the waiting time for an appointment can be long for specific levels of care or programs that the individual decompensates before they can be seen, again resulting in the repeated cycle. A stakeholder commented that the availability of after-care has actually gotten worse since Medicaid expansion; enrollment in the Medicaid program in Oregon has been higher than originally estimated, placing additional demands on the already stressed system. Aware that Medicaid expansion would lead to an increased demand for services, since January 2014 the County has allocated additional funds to providers to help them build their capacity to meet the demand.

Criteria for Commitment

Another concern expressed by stakeholders is the "high bar" for Commitment. County staff acknowledged that commitments are becoming more difficult to obtain. County staff identified the following as contributing factors:

1. Commitments are being questioned and overturned by the Public Defenders and the Attorney General's Office. Witnesses, including physicians, are being required to attend hearings and physicians are reluctant to do so.
2. Perceived lack of inpatient bed capacity.

3. The volume of “concerning behaviors” in a large, urban setting with limited funding dictates that only the individuals with the greatest acuity/complex needs have access to the most intensive/restrictive levels of care.

County staff identified the assignment of a regular District Attorney to handle Commitments and the access to electronic medical records as positive. They also recognized several hospitals are triaging Holds to determine the best use of County Investigations. When asked about Assisted Outpatient Treatment (AOT) legislation, which appears to be before the Oregon Legislature, staff responded that similar legislation has been presented twice before but without funding has, and will again, “go nowhere.” Staff also pointed out that Oregon’s current law allows for Involuntary Outpatient Commitment but the provider community will not pursue IOCs as they are cumbersome to implement and difficult to enforce.

Pervasive Homelessness

The final factor which contributes to, and is indicative of, the challenges facing the Multnomah County behavioral health system is the pervasive homelessness. Oregon has one of the highest rates of homelessness in the United States[8], with a high concentration in Portland. Many of the people experiencing homelessness in Portland are young (estimated between 1,500 and 2,000), and many suffer with mental health, substance abuse and medical conditions. There are many factors which contribute to individuals migrating to Portland; the liberal environment and availability of a wide array of service and supports likely draws people living in other parts of Oregon to Portland. Also the number of residential and forensic beds in Multnomah County likely results in those individuals admitted from out-of-county choosing to stay. The resources available, however, are not nearly sufficient to meet the demand. Of particular concern is the lack of affordable housing, and particularly permanent, supportive housing for people with behavioral health disorders.

All stakeholders identified the lack of housing options as a major problem which contributes to involvement with the police, stress on the EDs, involvement with the courts, jail demand, involvement of Probation and Parole, and ineffective aftercare from inpatient treatment. As one stakeholder pointed out, “the best-written treatment plan is useless if the client has no place to live.” The state of Oregon is allocating and re-directing resources to ensure that its citizens have health care, but the question remains how health care outcomes will improve for people who are homeless. The issue of homelessness in Portland has spread beyond the legal and health care systems; a stakeholder pointed out that the City’s downtown businesses and tourism are suffering as a result of the amount and visibility.

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[8] Department of Housing and Urban Development, The 2010 Annual Homeless Report at 22, www.hudhre.info/documents/2010 HomelessAssessmentReport.pdf

Recommendations

Managed Care Program Recommendations

Financial Systems Management

Invest in an accounting system designed for managed care operations

If the County wants to remain as a RAE it will be critical that it invest in an accounting system that is designed to function for a managed care line of business. The system used for this purpose should be easily able to comply with the detailed financial reporting specifications as outlined by Health Share, which based on our review contain metrics typical for managed care. We understand that the County contracts with a Third Party Administrator to pay claims and to capture third party revenues. Encounters must be aligned with the service authorizations and claims submitted by the providers. As claims are paid the system must immediately reconcile the payment with revenues available from the capitation payments. Currently, County staff receive multiple downloads which are cumbersome to reconcile. This is inefficient and creates opportunity for error. Absent an information system that can capture these data sets, integrate the information, and generate reports on a real-time basis, the County is managing the program with a lag in information.

Disaggregate financial accounting to report separately for each line of business

Accounting should set up systems to disaggregate full-time equivalent (FTE) positions and expenditures by payer and program type. While it is feasible to have the same staff assigned to more than one business line, it must be possible to accurately report on revenues, payments and administrative expenses by funding source and program. While time studies may be preferable, they can be time-consuming and a data-driven proration of time/activity may be necessary at least as an interim strategy. The County should work with Health Share to establish common definitions of Administrative duties and associated costs for clear tracking and reporting. The County should also review the allocation of non-staff administrative costs allocated to the Health Share contract, and the method for calculating indirect costs, which are substantially higher than the administrative staff costs.

Maximize Medicaid revenue

The County should identify those services currently being funded with state or county general fund dollars that could become Medicaid reimbursable. For example, certain activities performed as part of the County's jail diversion program may be Medicaid reimbursable.

A full review of services provided to Medicaid eligible members paid for with state and/or County general fund dollars should be undertaken to determine which services could be billed as Medicaid services and which services could be proposed to the State as services that they should consider adding to the Medicaid benefit for CMS review.

Hire an actuary

County financial and leadership staff expressed concerns that the capitation rate they were receiving was not adequate to support their program. As discussed above, the risk methodology employed by Health Share to adjust rates by county did not incorporate the variation in risk factors for Multnomah County residents that may not be apparent from simply considering diagnosis and medication history: issues such as homelessness, and the migration of people with serious mental illness to Portland from across Oregon for access to mental health facilities or other social services. Because individuals with serious mental illness often require more intensive services including care coordination, not readily apparent from a diagnosis code alone, the risk method used to set rates may not adequately incorporate acuity.

However, despite the County's concern about its financial risk and potential inadequacy of the capitation, its medical spending in FY 13 has been lower than its capitation revenue, and the County had a 15% surplus, after accounting for direct and indirect administrative costs. In the first quarter of 2014, the financial picture has changed, with the County spending over 90% of revenue on services.

Investing resources in hiring an actuary to review its utilization data and develop an adequate capitation rate would help the County understand whether the capitation rates offered by Health Share are sufficient. It will also help the County to understand the extent to which it needs to manage utilization to have sufficient reserves. In order to meet the current medical loss ratio contract requirements, the County should work to reduce non-staff administrative costs and the amount of retained revenue, re-directing funding to cover appropriate medical services. This will put the County in a stronger position in its negotiations with Health Share, as it will have a better sense of what capitation ranges will be an acceptable level of financial risk for the County. The County should consider negotiating for a MLR of 85%, as the retained earnings are the County's one protection against the financial risk of the contract, and an 85% MLR is industry standard.

Utilization Management

Evaluate financing of the Medicaid substance use benefit

The County should engage Health Share in discussions about whether or not the substance use benefit should remain in the capitation of the physical health plans. Given that the substance use residential benefit is now being managed by the behavioral health RAEs and the high co-occurrence of mental health and substance use disorders, moving the substance use benefit into the capitation of the behavioral health RAEs may help improve coordination of care for these individuals. If individuals with substance use issues were receiving appropriate treatment, their presentations to area EDs and subsequent inpatient hospitalization may be reduced. This would be a better outcome not only for these individuals but also for the system as a whole. Absent the ability to move the benefits into the behavioral health capitation, there should be processes required for information sharing and care coordination before the member leaves the inpatient setting.

Improve access to community-based treatment alternatives for youth

The County should move forward in the process of changing its UM processes for children enrolled in Wraparound so that the care coordinator will have the responsibility for authorizing care. This type of approach to care management and authorization for youth participating in high fidelity Wraparound is more consistent with best practice nationally.

The County may have correctly drawn the line by not authorizing residential treatment, when the primary need driving the request for residential care is a child welfare placement. However, the County will want to ensure that youth in the child welfare system with mental health challenges have community-based services and supports available to them that can help them remain in their foster homes and community schools. One possibility might be for the County to expand the capacity of its Multnomah Wraparound team. As an evidenced-based practice, Wraparound has proven effective in other states and counties across the country in reducing the need for out-of-home placement for youth with serious emotional disturbance.[9] Another strategy might be to work with Health Share and the Department of Human Services to explore how to train and certify more providers in Multidimensional Treatment Foster Care (MTFC). MTFC has proven effective at reducing foster care placement disruption and the need for out-of-home placement.

[9] Painter, K. (2012). Outcomes for Youth with Severe Emotional Disturbance: A Repeated Measures Longitudinal Study of a Wraparound Approach of Service Delivery in Systems of Care. *Child & Youth Care Forum, 41*(4), 407-425.

Seek alternative strategies for UM which align more closely with the changes Health Share is making related to global payments and case rates

The County has appropriately delegated outpatient utilization management to the providers, so that the providers themselves authorize their own services based on medical necessity. The County audits a sample of outpatient records to ensure that these service levels are appropriately used. This UM approach appears to result in an appropriate mix of services with an emphasis on community based rather than inpatient care. This approach is consistent with Health Share's move toward global payments and case rates and is one that should continue in the future.

With the regional approach to UM, where all three counties have agreed to the same UM criteria, the county has less latitude in designing its own UM strategy. While the medical necessity guidelines and review processes should be similar across the counties, the County may have latitude to shift its provider management focus from traditional UM to network management by creating a full-time network manager position. This position would be dedicated to meeting regularly with providers to review certain quality metrics such as access to care, and follow-up after hospitalization; focusing more on overall provider performance for the different contracted services they provide. Such meetings could be done collaboratively with the other counties. This approach is more consistent with Oregon's healthcare transformation efforts. This person could also be the "face" of the County providing "on the ground" customer service and technical assistance to the provider community. Good network management is transparent, and gives the provider community confidence that the managed care organization is a partner in providing care to their members. This function appears to be missing from the Multnomah County Health Share contract. Several providers mentioned that they would like a single point of contact at the County, someone they could consistently interface with when issues or problems occur. The County can consider analyzing whether any existing staff members can be re-deployed to network management to make more effective use of health plan dollars and improve the provider community's relationship with Multnomah County.

In addition, redeploying resources currently dedicated to service specific UM to identifying and coordinating care for high utilizing members should be considered. Care managers at the plan could be responsible for facilitating and monitoring follow-up for members who are psychiatrically hospitalized or who frequently present to hospital EDs and connecting those high utilizing members with appropriate services and supports. County staff noted that they have two staff members responsible for identifying and working to coordinate care for high utilizing members. This is a key function of a managed care organization, and is a role highly valued by Health Share. Two FTE to serve over 100,000 members is not sufficient for effective coordination of care for highest utilizing members. A more global approach to a member's care through an increased emphasis on care coordination rather than service specific UM again aligns more closely with the purpose and intent of healthcare transformation. Indeed one of the quality improvement metrics of Oregon's 1115 waiver is reducing preventable and unnecessarily costly utilization by so called "super users." Care coordination for these high utilizing members is one way to help achieve that goal.

Monitor and assess compliance with federal mental health and addiction parity regulations

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally requires group health plans and health insurance issuers that cover mental health and addictions treatment to provide the same level of benefits that they do for general medical treatment. A final regulation implementing MHPAEA was published in the Federal Register on November 13, 2013 and went into effect on January 13, 2014.[10] Health Share will need to evaluate areas such as service utilization

[10] Retrieved on April 16th, 2014 from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

limitations and the medical necessity criteria of all of its RAEs to ensure compliance with this regulation and will need to issue guidance to its RAEs on any required changes in UM practices as a result of this review. For example, if the physical health RAEs do not require prior authorization for someone to see a specialist such as a cardiologist then the behavioral health RAEs should not require prior authorization for someone to see a psychiatrist.

It should be noted here that mental health inpatient treatment and youth residential care, while sometimes necessary, are not optimal treatment settings. They are highly restrictive, costly, and frequently do not result in a better outcome for the individual. Community-based treatment alternatives that can help people with mental health challenges safely remain in the community are preferable to inpatient or residential care in most cases. In this way, employing UM approaches, that consider if the person could be better served in a less restrictive and more normative community-setting first (if those settings do indeed exist in the service array and can be readily accessed by the individual), are appropriate. Alternatives for treatment of someone experiencing a heart attack or stroke do not exist outside of a hospital setting; the same is not the case for people in mental health crisis where community alternatives such as mobile crisis teams, intensive in-home services, Assertive Community Treatment, crisis respite, and high-fidelity Wraparound are reasonable and often preferable alternatives to hospital or residential care.

Provider Payment

Health Share and Multnomah County should ensure that a solid base data is used in calculating case rates, and should be transparent with providers about how these rates are being developed. Opportunity for provider input should be incorporated into the process. We recommend ongoing dialogue with providers to continue identifying relevant issues and strategies for addressing them. This could be accomplished in part through the network management process described above.

Quality Management

Health Share will be assessed for how well it performs in achieving OHP goals as well as how it performs compared to the other CCOs. Similarly, the County will be assessed for the leadership taken to move the behavioral health providers forward with transformation of delivery and payment systems.

The quality management functions should serve to assess how well the CCO and its provider network are meeting the goals of the OHP, to control the rate of growth in Medicaid expenditures while improving the quality of care and the health of the population(s) served. OHP has identified seven quality improvement focus areas, including behavioral health/physical health coordination, reducing preventable re-hospitalizations and reducing costly services utilization by super-utilizers. The County should be adopting strategies to identify how well providers are performing in these areas, and if improvement is necessary, work with providers to identify barriers to optimal performance and strategies that may address those barriers.

Behavioral health providers and service recipients should be included in developing plans for meeting quality metrics early in the process. Performance measurement should occur often and with target timeframes for improvement, while allowing enough time for quality improvement projects to have results.

It appears in 2014, OHP has set two ways for plans to meet benchmarks: meeting the set benchmark, or meeting an improvement target. Multnomah County should begin working immediately with its providers to develop Quality Improvement plans to meet the improvement targets.

Leadership and Staffing

The County should review its staffing functions, and reassign or hire staff to functions appropriate to staffing a managed behavioral healthcare organization. Staff should be organized into functional units that are assigned

to support the health plan. Network management and care coordination for high utilizing members in particular are key functions that need dedicated staffing.

It will be important that a staff person should be hired or assigned to be fully dedicated to managing the health plan. This person needs to be experienced in managed care and understand both the financial and operational aspects of a Medicaid managed care plan. The time and attention that current MHASD leadership has dedicated to the managed care plan has diverted attention from the many issues facing the LMHA. By hiring a key person to lead the managed care plan, the leadership of the MHASD can more effectively oversee both of these critical functions.

The County should work with Health Share to establish common definitions of administrative duties and associated costs for tracking and reporting purposes.

Legal and Contractual Issues

County leadership should engage with their legal counsel to ensure they have a thorough understanding of these issues as outlined in the contract; and if the contract is not specific enough on these issues; legal counsel should advise on whether there are any items that should be addressed in future contract amendments.[11]

Local Mental Health Authority Recommendations

Focus attention on the LMHA

Given the substantial challenges of funding cuts and ongoing demands for the safety net it is critical for MHASD leadership to focus its attention on fulfilling the LMHA mandated duties and on the effective operation of the CMHP. As discussed above, the amount of time and attention required to operate the managed care program has diverted MHASD's attention from focusing on its role as the LMHA. Hiring a key leader to focus on the managed care operations will hopefully allow MHASD leadership to refocus their attention on the work of developing and maintaining the critical services the County provides under the auspices of the LMHA. Not only are MHASD staff impacted, but the Multnomah County Adult Mental Health and Substance Abuse Advisory Council has an expanded role that includes the managed care program across the region, diluting its ability to focus time or attention on furthering its important work related to the CMHP. The Council which is comprised of more than 50% consumers and families has on-the-ground insight into the needs of the community and ideas for how to address some of the challenges. The Council could provide a much-needed source of support for the LMHA but requires a leader at the County to move the work of the group forward, giving them a clear charge and purpose.

Engage the State Mental Health Authority

A number of stakeholders commented about the tenuous relationship between the "state" and Multnomah County. Responsibility for the behavioral health system may be de-centralized but the state still places numerous requirements on the counties and attaches strings to state and federal funding as evidenced by the 200+ page County Financial Assistance Contract. The County is likely to benefit from strengthening its relationship with the new State Mental Health Director so as to improve communication and engage in problem-solving.

[11] Nothing in this report should be construed as legal advice.

Reduce reliance on Emergency Departments

Absent a readily accessible and secure alternative the PPD will continue to rely on the EDs as a drop-off for individuals with concerning behaviors. MHADS has identified a cost of $5 million to operate a drop-off center. Without additional funding the resources for the center would need to come from the system which is already seriously underfunded. Creating the drop-off center without adequate resources for effective disposition upon release would not be an effective use of funding. A better option would be to enhance CATC or the Urgent Walk-in Center to provide 24/7 availability and the level of security needed to make it a viable option.

In addition, MHASD should work with the CCOs, the other counties, the County's contracted crisis services provider, and area hospitals to explore creative strategies such as the Alameda County, California model which has proven successful in drastically reducing hospital ED "boarding times" and inpatient hospitalization rates for people in behavioral health crisis.[12]

Improve integration of care for people with mental health and substance use disorders

There is need for a more integrated and coordinated approach to treating people with a COD across the County. Individuals should not have to go to the ED for a comprehensive assessment of their mental health or substance abuse disorder. In its role as the LMHA, the County should engage Health Share and Family Care as the two CCOs serving Multnomah County Medicaid members to help create solutions and reduce barriers to treatment for people with COD to reduce inappropriate utilization of hospital emergency departments and inpatient mental health care. For example the CCOs could take the lead on engaging the area hospitals, the physical health RAEs, and the behavioral health RAEs in discussions about how to finance and implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) in local emergency departments and primary care.

In addition, educating ED physicians about the use of Safety Holds when substance abuse appears to be at play, and establishing a payment mechanism for the holds, would alleviate demands for mental health resources and result in better disposition for the clients.

Facilitate throughput with effective use of resources

As discussed earlier in this report, "throughput," the ability to move an individual through a continuum of care and supports, was described as a problem by every stakeholder. The increasing gaps in the community support system and the safety net are spilling over into other parts of the community including EDs and the criminal justice system including the courts, jails, Probation and Parole and the PPD. Increasing care coordination for non-Medicaid eligibles to help them transition between levels of care is one strategy that could assist with this. The time and resources spent on adult wrap-around support could go a long way in reducing decompensation and recidivism and be more cost effective to the system overall. The Presiding Judge suggested that the provision of adult wrap-around services and supports would help decrease the number of individuals with behavioral health disorders interfacing with the legal system.

Finally, access to outpatient treatment and community support services must be addressed. Re-directing resources to the Medicaid program may result in coverage for treatment and health care but coverage in the absence of community based services and supports will not result in better health outcomes and is shifting costs to other Human/Public services.

[12] Zeller, S., Calma, N. & Stone, A. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West Journal of Emergency Medicine, 15*(1): 1-6.

Commitments

New State hospital beds will soon be opening, but these will be in replacement of beds being closed in an older institution and are not likely to be a more accessible option. While Assisted Outpatient Treatment (AOT) may be viewed by some as a potential solution (NAMI chapters' nationwide support the legislation) absent additional funding, once again resources would be re-directed from an already under-funded system to fulfill AOT requirements. Multnomah County may be better served by opening dialogue with involved stakeholders to determine how to facilitate use of inpatient and jail diversion services, and the existing involuntary outpatient commitment criteria. Finally, implementation of the recommendations to enhance the capacity of the crisis system and promoting access to outpatient treatment and community support services will help reduce the burden on the civil commitment system.

Addressing homelessness

Multnomah County should be commended for developing a wide array of services and supports for people with behavioral health challenges; however this has likely contributed to the migration of individuals from other parts of the state. The County is not receiving additional funding support to account for the increased demand for services, including housing, which has increased demand on the County's service system. MHASD alone cannot solve the challenges of homelessness in Portland. Together with their partners, the County should continue to implement its 10-year plan to end homelessness with a specific focus on promoting effective strategies such as permanent supportive housing for people with serious mental illness.

Alternative Arrangements and Possible Futures

As part of the consultation, the County asked TAC/CHLE to prepare a summary of alternative arrangements and possible futures for consideration. A discussion of possible options and pros and cons of each are presented below.

Option 1: Continue as a RAE as part of Health Share

The benefit of continuing as a RAE as part of Health Share is that it allows the County to continue being a part of Oregon's in health system transformation and potentially achieving the "Triple Aim" of: improving the health of individuals with mental health and addictions, increasing the quality, accessibility and reliability of their care, and lowering or containing costs.

Further, by remaining a RAE, Multnomah County retains its accountability for the mental health and addictions service system. This approach will provide greater integration of Medicaid and non-Medicaid mental health services, and maintains the County's ability to operate a comprehensive mental health and addictions service delivery system. If the County forgoes its role as a RAE, it will be left with only County General Funds and state allocated dollars to manage, leading to a potentially more fragmented system. The CCOs are becoming a major player in the health care delivery system in Oregon. Increasingly the state is using the CCOs as a vehicle to help manage care and resources for non-Medicaid funds, as evidenced by its recent move of substance use residential dollars to the CCOs. If this trend continues the role of the CCOs will grow, leaving an even smaller role for the County. If the County is no longer part of Health Share, its ability to influence important issues that impact Multnomah County residents with mental health and addictions challenges will diminish considerably. Such issues include services design and delivery, workforce development, quality of care, access to care, and integration of physical, mental health, and addiction services.

The drawbacks of remaining the RAE include that decisions impacting the County budget and operations are increasingly being made by Health Share, a private entity that is focused solely on Medicaid operations. The

County has a broader perspective in managing the behavioral health system as a whole, and these differing viewpoints can create conflict in priorities and make management of the contract difficult.

In addition, remaining a RAE does present a financial risk to the County, particularly in a changing health care environment. Valid concerns exist with regard to the methodology employed by Health Share to develop the behavioral health risk premium, which did not incorporate the fact that Multnomah County residents have a variety of risk factors that may not be apparent from simply considering diagnosis and medication history alone. The risk factors include homelessness and the migration of people with serious mental illness to Portland for access to health care facilities or other social services. Because individuals with serious mental illness often require more intensive services which may not be readily apparent from a diagnosis code alone, the risk method used to set rates may not adequately incorporate acuity.

Should the County choose to continue its role as a RAE, it will need to make some necessary improvements to its managed care and LMHA operations in order to strengthen its capabilities while minimizing the risks. Addressing the operational and financial accounting issues the County has experienced in managing the RAE will be critical in achieving long-term success with this option. Absent making these changes, the risks of remaining a RAE will grow considerably (e.g. financial risks, political issues with providers, Health Share removing delegation for certain responsibilities such as UM, etc.).

Multnomah County may also want to consider creating a managed care operation distinct from the LMHA but with continued County oversight, possibly a 501-C.3. By doing this, some of the bureaucratic issues faced by the County that can make it difficult to operate a managed care organization (e.g. provider contracting, hiring, purchasing, etc.) would be alleviated.

Option 2: Propose to become a single RAE for the region

In this scenario, the County would propose to Health Share that they consolidate their behavioral health RAE's into one organization. There are different options for how this single regional RAE could operate. Multnomah County could develop an agreement with the other counties and Health Share to manage the behavioral health services for the Medicaid population living in the tri-County area. Alternatively, the three counties could establish a quasi public entity that would serve as the behavioral health RAE for the region.

There are many benefits for Health Share to consider operating a single behavioral health RAE for the region, and as the largest county, Multnomah County would have the most capacity to take on this role. Benefits include distribution of risk over a larger pool of individuals; and consolidation of administrative operations, such as UM, QM and reporting, thereby creating administrative efficiencies and reducing administrative burden for Health Share and the providers.

However, the County would still incur the risks of remaining a RAE: decisions impacting the County budget and operations are increasingly being made by Health Share, a private entity, and the financial risks while reduced, remain. Additionally, a single RAE may not be politically feasible, given the position of the other counties. Forming a quasi public entity would take time to develop and establish but this type of structure might be more politically viable. If this option were proposed, the County would need to make the same investments in improving their managed care operations as required under option 1.

Option 3: Serve as the RAE for specialized behavioral health services only

In this scenario, the County would continue to serve as a RAE but only for a limited number of specialized services for adults with serious and persistent mental illness and youth with serious emotional disturbance as well as for the crisis services continuum (mobile crisis and outreach, urgent walk-in clinic, crisis call center,

etc.). The capitation payment and risk for standard outpatient and inpatient mental health services would be shifted to the physical health RAEs. One of the major benefits of this approach would be that the County's financial risk would be considerably lowered given that the inpatient benefit would be included in the capitation of the physical health RAEs. However, it would be critical for the County to conduct an actuarial analysis to determine that there is adequate funding for the specialty services given risk would be assumed for a smaller population.

Access to inpatient care, particularly for individuals using substances has been a point of contention between the County and Health Share and including the inpatient benefit in the physical health plan capitation would eliminate this issue while promoting integrated care for people with COD since the substance use detox and outpatient benefit is already within the capitation of the physical health RAEs. By remaining as a RAE for a sub-set of Medicaid services, the County could continue to promote integration of the specialized behavioral health services with the funding and services it has available through the state and county general funds it receives in its role as the LMHA. It would also allow the County to maintain its expertise in serving adults and youth with serious behavioral health challenges.

One of the drawbacks of this option is that the political pressure on the County related to rates, and utilization management will not be eliminated for specialty programming. The option also has the potential drawback of further bi-furcating the Medicaid mental health system, creating a more fragmented system. This option shifts some dollars from the County, leading to a loss of some County jobs. An additional risk here is the potential for cost-shifting on the part of the physical health RAEs, with potential increases in utilization of the crisis continuum. If this option is selected, the County should conduct a thorough analysis of potential unintended consequences to the County and its crisis continuum of care that could result from giving up gatekeeper functions for psychiatric inpatient care.

Option 4: Propose to become an Administrative Services Organization

In this scenario, the County would propose to Health Share that they become an Administrative Services Organization (ASO) managing the behavioral health benefit without accepting the financial risk. The County would continue to contract with a network of providers, ensure the adequacy of the network and ensure that access standards could be met. The County may still provide medical necessity reviews and authorization for services; but they would do so following the guidelines of Health Share. The County would also continue to provide care coordination for high utilizing members. However, the County would not be operating on a capitation, and would not be at risk for the medical services.

This option has some benefits, especially in reducing the financial risk, while continuing to have the County operate a comprehensive mental health and addictions system, and to receive revenues for the operations of the program.

The potential cons of this change include that the County would still be a vendor to Health Share, with the same differing perspectives, but the County would have little authority over critical policies and decisions impacting UM. While this type of change would eliminate financial risk, it would also eliminate the potential financial benefits of effectively managing a capitated contract. It is also unclear if this option is viable given the current health care financing environment in Oregon.

Option 5: Terminate contract and become a provider of certain Medicaid mental health services and continue to serve in the role as the LMHA

In this scenario, the County terminates its current contract with Health Share, and re-contracts with whatever entity becomes the behavioral health RAE to be a provider of certain Medicaid reimbursable services. The

County is currently the direct provider of only a handful of Medicaid reimbursable services, primarily those serving youth such as the County's school-based mental health services.

This option would lower the County's financial risk, and would allow the County to continue to generate some Medicaid revenue for services.

However, the County would still be accountable to a private entity for the services it delivers, and there would be a substantial loss of Medicaid funds that help support administration currently, resulting in a loss of County jobs. As discussed above, by no longer serving as a RAE, the County would lose considerable influence in the new system. The likelihood that the County will be subject to cost-shifting from Medicaid also increases if it were no longer serving as the RAE.

Prior to making this decision the County must identify the actual costs associated with administration of the Medicaid Managed care program and the LMHA in order to make an informed decision about the impact of the loss of legitimate Medicaid revenues on the LMHA. It will be important to determine the staffing and infrastructure necessary to operate the LMHA as a stand-alone entity that will still be required to interface with the CCOs. Upon identification of the cost to operate going forward and the funds available absent Medicaid administrative support, the County can then determine how much, if any, additional funding it may need to allocate to MHASD to continue operating only as the LMHA. While it may be financially less risky, there will be increased fragmentation.

TABLE 3: ALTERNATIVE ARRANGEMENTS AND FUTURE OPTIONS

Option	Pros	Cons
➢ **Continue as a RAE as part of Health Share**	➢ Being a part of Oregon's health system transformation and potentially achieving the "Triple Aim": ✓ Improving the health of individuals with mental health and addictions in Multnomah County ✓ Increasing the quality, accessibility, and reliability of their care ✓ Lowering or containing costs	➢ Decisions impacting County budget/operations increasingly being made by a private entity
	➢ Maintains accountability for the mental health and addictions service system at the County level	➢ Financial risk at County level in a changing financial environment
	➢ Greater integration of Medicaid and non-Medicaid mental health services	➢ Differing perspectives on approach to management of care results in tension on how to effectively operate the managed care organization
	➢ Maintains the County's ability to operate a comprehensive mental health and addictions service delivery system	➢ Requires additional resources to assure both the RAE and LMHA are operating effectively
➢ **Propose to become a single RAE for the region**	➢ Distributes risk over a large pool of individuals	➢ Political feasibility question with other counties
	➢ Creates administrative efficiencies by consolidating certain activities (i.e. UM, QM, reporting, etc.)	➢ Decisions impacting County budget/operations increasingly being made by a private entity
	➢ Reduces administrative burden on providers	➢ Financial risk at County level in a changing financial environment
➢ **Become the RAE for specialized behavioral health services only**	➢ Potential opportunity for better integration of behavioral health and physical health	➢ Political pressure on the County related to rates, UM, etc. will not be eliminated if issues regard specialty programming.
	➢ The same entity is managing inpatient for mental health and substance abuse services, reducing conflicts regarding who pays for which member for dual diagnosis.	➢ Creates a more fragmented system
	➢ Maintains the County's expertise on	➢ Shift of some dollars from County operations to a

Option	Pros	Cons
	specialized mental health programming.	private contractor – loss of County jobs
		➢ Increases the likelihood that the County will be subject to cost-shifting from Medicaid
➢ **Become an ASO**	➢ County no longer at risk for Medicaid services	➢ County would lose the financial benefit from effectively managing the managed care program
	➢ Would allow the County to receive revenues to support operations	➢ County would be a vendor to Health Share and would have little control or authority over criteria or direction impacting UM decisions
	➢ Would allow the County to continue to operate a comprehensive mental health and addictions system	
➢ **Terminate contract with Health Share but continue to provide certain Medicaid services and operate as the LMHA**	➢ Lowers the County's financial risk	➢ County would become accountable to a private entity for the services it delivers
	➢ Allows the County to continue to generate some Medicaid revenue for services	➢ Loss of Medicaid funds that help support administration currently -- loss of County jobs
		➢ County loses considerable influence in new system
		➢ Increases the likelihood that the County will be subject to cost-shifting from Medicaid
		➢ Lose opportunity to coordinate behavioral health with other County services

Conclusion

Health care reform, a changing fiscal environment, and the County's new relationship as a subcontractor to a CCO have presented the County with a wealth of potential opportunities to improve the health and well-being of people with mental health and addiction issues. In its dual role as the LMHA and the behavioral health RAE, the County has the unique opportunity to reduce and/or eliminate fragmentation within the behavioral health system to create a fluid and seamless system of care. Opportunities include: improving integration of care for people with co-occurring mental health and substance use challenges, developing alternatives to hospital emergency departments for people in behavioral health crisis, and increasing access to permanent supportive housing to address the pervasive homelessness among people with mental health and substance use disorders.

While healthcare transformation in Oregon presents important opportunities for the County it is not without risks. Should the County choose to continue its role as a RAE, it will need to make some necessary improvements to its managed care and LMHA operations to strengthen its capabilities while minimizing the risks. Addressing the operational and financial accounting issues the County has experienced in managing the RAE will be critical in achieving long-term success.