Mental Health and Addiction Services: Managing Risk in a Changing Environment

April 2014

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Date: April 24, 2014

To: Chair Madrigal, Commissioners McKeel, Shiprack, Smith, and Wendt; Sheriff Staton; District Attorney Underhill; Director Myers; Mental Health Director Hidalgo

From: Steve March, Multnomah County Auditor
Mark Ulanowicz, Principal Management Auditor
Nicole Dewees, Senior Management Auditor

Re: Mental Health and Addiction Services: Managing Risk in a Changing Environment

Healthcare transformation brings with it both great opportunities and great challenges. For years there have been efforts to more closely align the business of mental health service provision with the business of healthcare. The development of comprehensive care organizations (CCOs) is the most significant healthcare transformation to date.

Multnomah County has operated a mental health insurance plan for some time. However, it was operated in an environment as part of an integrated mental health system that included community health services, including crisis response and commitment monitoring. While this integration was done with efficiency in mind, it blurred the separation between the insurance plan functions and other parts of the system. In the new environment, with a new CCO inserted between the state and the County's insurance operations, it is critical that the County be able to clearly differentiate costs associated with Medicaid covered expenses and the costs for other services that the County has determined to be valuable aspects of a comprehensive mental health system.

Working with the Department of County Human Services (DCHS) and the Mental Health and Addiction Services (MHAS) division, we analyzed spending for the most recent complete fiscal year (FY 2013) to determine what costs would be most appropriately charged as part of the Medicaid insurance plan and what costs would be outside of the plan as we transition to the new healthcare model. These determinations have become even more critical as the County loses direct control over important financial risk management tools in the new environment.

DCHS and MHAS have taken steps to assess the new environment and the risks associated with it. As they move to appropriately assign revenues and expenditures and other mental health system components they will be better prepared to work with the Board of County Commissioners around managing the fund balance and financial risks of the Behavioral Health Fund.

We appreciate the cooperation and assistance of DCHS and MHAS in the audit.

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Executive Summary

Mental Health and Addictions Services Division (Division) operates a mental health insurance plan that covers approximately 90,000 Oregon Health Plan (OHP) members in Multnomah County. The Division faces the financial risks associated with running an insurance plan. If the premiums collected by the plan are not greater than the claims and expenses paid, the County must make up the difference out of reserves or other funds.

The Division has been running the insurance plan as a part of an integrated mental health system that includes community mental health services, such as crisis response and commitment monitoring. The integration blurred the separation between the insurance plan and the other system components and decreased the focus on clearly defining which activities and costs should be included in the insurance plan. Without clearly defined activities and appropriate financial information, the County loses its ability to readily determine how well the insurance plan is performing or to make the most informed decisions about managing costs and financial risks, something that has become even more important with the transformation and expansion of OHP.

We found that the insurance plan financial statements have not accurately reflected plan operations, making it difficult to know the extent to which plan premium revenue has covered plan costs. The financial statements did not accurately reflect the insurance plan's operations because the Division included some non-insurance program expenses in the statements and left some insurance plan expenses out.

We also found that the Division did not always categorize insurance plan administrative costs appropriately. In the insurance industry, administrative costs are a key indicator of efficiency because lower administrative costs allow for more money to be spent on care. In the insurance plan financial statements, some administrative costs that were not categorized as such, which gave a false impression about total administrative

costs. We reorganized the financial statements to better reflect insurance definitions of administrative costs and compared our numbers with industry benchmarks. Although comparisons should be viewed cautiously because of differences between the County's insurance plan and benchmark plans, we found that the County's administrative costs were higher than benchmark costs, but they were within the minimum standards set in the Affordable Care Act.

Properly managing the costs and financial risks associated with the mental health insurance plan has become more important with the transformation and expansion of OHP. With the transformation, the Division has lost control over some of its most important financial risk management tools: the ability to set limits on how much is paid for each type of insurance claim and which types of medical claims will be covered. The Division will also likely see additional changes in the number and acuity level of its insurance plan members. It is important that the Division be able to manage costs and risks, because it directly impacts its ability to provide mental health care services to insurance plan clients.

Background

Division operates a Medicaid mental health insurance plan that covers approximately 90,000 insurance plan members in Multnomah County. In exchange for a fixed premium payment from the OHP, the County is responsible for guaranteeing that medically necessary mental health services are available for insurance plan members. By operating an insurance plan, the County faces financial risk. If the premiums are not sufficient to cover the cost of necessary care, then the County is responsible for making up the difference. The County manages the provision, quality, and the cost of mental health care services for its plan members using a contracted network of community providers and hospitals.

The primary financial risk of the mental health insurance plan: if premiums do no cover the cost of care, the County has to make up the difference

The Behavioral Health Fund was created to track the insurance plan's financial activities

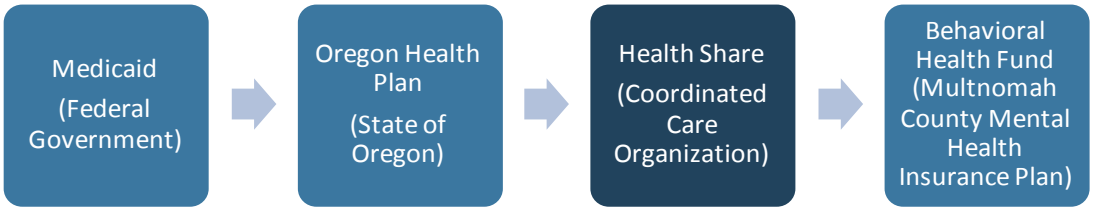
Detailed and accurate financial information is critical to managing any insurance operation. The fund accounting framework the County uses allows the Division to separate the insurance plan's financial activity from other County operations into what is known as an enterprise fund. Enterprise funds are used to account for programs

or operations that are similar to private businesses. The Behavioral Health Fund is the enterprise fund that the Division uses to account for insurance plan operations. The County should be able to use the accounting system and structure to routinely produce the financial information and statements it needs to manage the operations and financial risk of the insurance plan.

Prior to September 1, 2012, the County's mental health insurance plan premiums came directly from the OHP, which received its funding from Medicaid (see Exhibit A). Beginning on September 1, 2012, OHP designated several entities, called coordinated care organizations (CCO), to manage different regions within the state. Multnomah County is now part of the Health Share CCO. Other members of Health Share include Clackamas County, Washington County, and hospitals, medical insurance plans, and community providers located in the tri-county area. Multnomah County's mental health insurance plan now receives its insurance premiums from Health Share (see Exhibit B).

Exhibit A: Flow chart of insurance premium dollars
Prior to September 1, 2012

Exhibit B: Flow chart of insurance premium dollars
Beginning September 1, 2012



Source: Auditor's Office

The mental health insurance premiums vary from year to year. Exhibit C shows insurance plan annual revenue and the average monthly plan enrollment from fiscal year (FY) 2009 to 2013. Premium revenue per client fluctuates each year depending on the characteristics of the clients, but the decline since 2012 is partially due to Health Share receiving 2% of premium revenues to pay its administrative costs and to build its reserves.

Exhibit C: Mental Health Division's Insurance Plan Enrollment and Revenue

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Average Monthly Enrollment	70,786	77,397	85,502	94,231	92,666
Annual Premium Revenue (millions)	$39.02	$42.93	$46.11	$44.54	$42.86
Average Revenue per Client	$551.28	$554.69	$539.29	$472.71	$462.50

Source: Mental Health Division and Multnomah County financial system

The other components of the Division's mental health system serve all County residents regardless of insurance status and include:

- The crisis system, which includes the crisis call center, a walk-in clinic, and Project Respond – a mobile crisis response program.
- The facilitation and coordination of residential and intensive treatment services for severely mentally ill adults and children.
- Commitment services, which include investigation, monitoring, and facilitation for individuals placed on emergency holds in hospitals.
- Direct mental health services for children and young adults.

Introduction to Findings

Rather than running the mental health insurance plan as a stand-alone operation, Multnomah County has been running it as a component of the integrated mental health care system. As a part of the overall system, the lines separating the insurance plan from the other system components have blurred. This integrated system occurred, in part, because the funding for the various system components came primarily from two sources (the State of Oregon – OHP and mental health grants – and the Multnomah County general fund) that each had a strong interest in maintaining the entire system.

This arrangement was possible because mental health system components share many of the same clients and service agencies/providers. The arrangement offered some benefits, such as:

- Allowing the county to mitigate the fallout from fluctuations in funding for the different mental health system components and
- Making it easier to invest in services, programs, and technology that cross system components.

The downside to this sort of arrangement is that there has been less emphasis on appropriately defining which service activities and business functions (and associated costs) should be included in the insurance plan. Without clearly defined activities and appropriate financial information, the County loses its ability to readily determine how well the insurance plan is performing or to make the most informed decisions about managing costs and financial risks.

Finding 1: Behavioral Health Fund financial statements are not an accurate reflection of the insurance plan's ability to cover its costs

Because the Division has not appropriately defined which business operations are included in the insurance plan, it has not assigned the appropriate costs to the Behavioral Health Fund. There were programs and functions that were funded out of the Behavioral Health Fund that were not related to the insurance plan and there were insurance plan functions that were paid for outside the Behavioral Health Fund. As a result, the Behavioral Health Fund financial statements have not been a true reflection of insurance plan operations, making it difficult to know the extent to which the insurance plan is covering its costs.

In order to estimate insurance plan costs, we segmented the Division's mental health system into programs. We then used financial and workload data as well as interviews with supervisors and staff to quantify how much these programs supported insurance plan operations. Exhibit D shows some of the programs that support the insurance plan operations. Also shown is our estimate of the percent of program salaries and other resources dedicated to insurance functions.

The items highlighted in blue are programs that receive fairly significant funding from the Behavioral Health Fund (insurance premiums), but perform fewer insurance plan functions. For example, there is a group of employees that work in the Quality Management work unit. They support many different parts of the Division, including the insurance plan. About 20-39% of the Quality Management work unit's salaries and other expenses are used to support insurance plan operations. However, 40-59% of the total expenses are paid for by the Behavioral Health Fund. In contrast, Utilization Review (the review of medical claims for the insurance plan) is only partially funded by insurance premiums. In both the green and blue sections of the chart, the expenses of the insurance plan are not accurately reflected in the Behavioral Health Fund financial statements.

Exhibit D: FY 2013 Insurance Plan Support Compared to Insurance Plan Funding

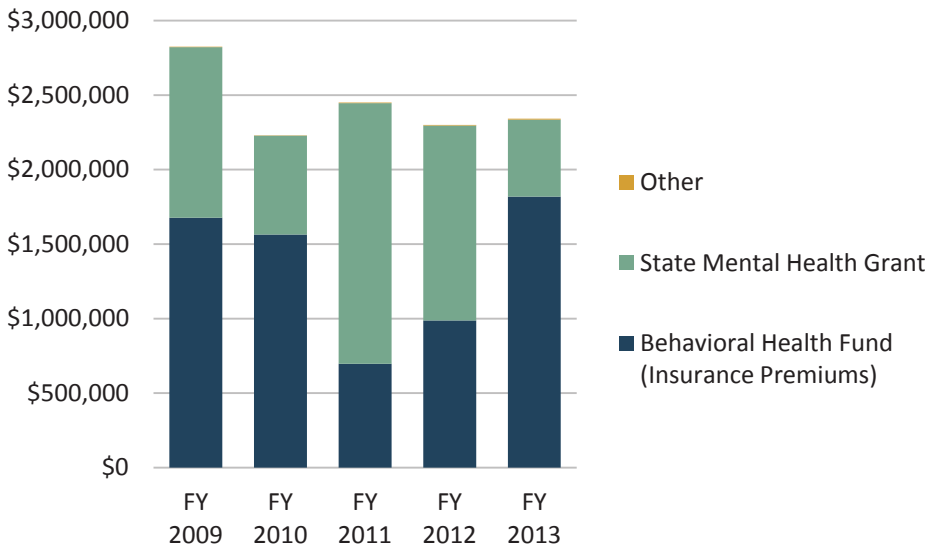
Program	Percent of program salaries and other resources dedicated to insurance functions	Percent of program paid for by insurance premiums	Conclusion
Administration and Accounting	40-59%	60-79%	These expenses may make the insurance plan appear more expensive than it actually is.
Crisis Call Center	40-59%	60-79%	
Quality Management	20-39%	40-59%	
Decision Support	40-59%	40-59%	These expenses may be accurately reflected on the financial statements.
Medical Records	Less than 20%	Less than 20%	
Claims Processing	80% or Greater	80% or Greater	
Utilization Review	80% or Greater	40%-59%	This may make the insurance plan appear to be less expensive than it actually is.

Source: Auditor's Office

The Behavioral Health Fund fills the financial gaps of other programs, making it difficult to know how much the insurance plan costs

In FY 13, about 79% of the money that paid for the crisis call center came from the insurance plan through the Behavioral Health Fund. However, the amount the plan pays does not mirror the amount of work the call center does for the plan. Each year, the crisis call center provided a relatively consistent set of insurance plan functions, such as afterhours utilization review, care coordination, member services, and crisis counseling to insurance plan members, while the amount paid by the insurance plan varied significantly. Exhibit E shows the fluctuations in the funding sources for the crisis call center expenses over the last five fiscal years.

Exhibit E Crisis Call Center Expenses by Funding Source



Source: Multnomah County financial system

The amount paid by insurance plan premiums appears to be a reflection of the need for funding to keep the call center operating. For example, the state cut its funding for the crisis system in FY 2013 and the County used money from the Behavioral Health Fund to make up the difference. Moreover, the crisis call center (and the larger crisis system) is organizationally part of the Community Mental Health Program, which is separate from management of the insurance plan. Crisis counseling and coordination services are available to all Multnomah County residents, not only mental health insurance plan members – the majority of crisis line calls come from either individuals who are not insurance plan members or do not identify themselves as plan members.

Finally, some costs from the call center and other programs may not meet accounting requirements to be included in the Behavioral Health Fund, which is classified as an enterprise fund. According the Governmental Accounting Standards Board, enterprise funds are for activities that are paid for by fees. In the case of the Behavioral Health Fund, the fees are the premiums paid by Health Share so that the County can run a mental health insurance plan. Since not all of the services provided by these programs support the

insurance plan, it would be appropriate for their finances to be managed in a separate fund. The costs of any services provided to the insurance plan could then be charged to the Behavioral Health Fund and paid for using interfund transfers.

Finding 2: The Division does not correctly classify administrative costs, making it difficult to measure and manage efficiency levels

It is important that the County know if its insurance plan is being managed in an efficient manner. In the insurance industry, administrative costs are a key indicator of efficiency because lower administrative costs allow for more money to be spent on care. However, the way the County accounts for some of its administrative costs makes them difficult to measure and manage. In the current financial statements, some insurance plan administrative costs are not classified as such. For example, member services and utilization review would be considered administrative costs by industry standards, but are not classified as such in the Division's financial statements.

Without proper accounting for costs, the County does not have a good understanding of its administrative costs or know which functions are performing efficiently. Two of the most common indicators of administrative efficiency are the administrative cost ratio (total administrative costs divided by total premium revenue) and the medical loss ratio (the amount spent on clinical services and quality improvement divided by total premium revenue). Because the Division did not properly classify all the administrative costs, we could not measure insurance plan administrative costs using existing financial reports. To better understand the insurance plan's administrative costs we created estimates based on available financial and workload data as well as interviews with staff.

Administrative Cost Ratio

The County's mental health insurance plan may have higher administrative costs than industry benchmarks

According to our analysis, insurance plan administrative costs were higher than industry benchmarks we identified. However, this comparison should be viewed cautiously for a variety of reasons, including:

- The available literature of administrative cost benchmarks is for medical insurance plans rather than mental health care insurance plans.

- The way the County charges administrative over head (a charge to pay for central administrative functions such as human resources and finance) may contribute to the insurance plan's higher administrative costs. The county charges a flat percentage of revenue for central overhead that does not account of economies of scale, which is not likely to be consistent with benchmark insurance plans.
- Benchmark insurance plans include a variety of functions in their administrative cost calculations that the County does not perform (or pay for) such as broker commissions, enrollment, and marketing.

Medical Loss Ratio

The County's medical loss ratio meets the Affordable Care Act standards

The Affordable Care Act sets standards for medical loss ratios for health insurance plans. Individual and small group market insurance plans, which include Medicaid plans like the Division's insurance plan, must have a medical loss ratio of 80 percent or higher. Plans that do not meet this standard must provide rebates to plan members. Based on our cost model, the Division's insurance plan meets the 80 percent standard.

One significant difference between the Affordable Care Act standard and the administrative cost benchmarks discussed above is in how the two standards treat care coordination expenditures. Care coordination expenditures (which are significant with the Division's insurance plan) are considered Quality Improvement expenses under the Affordable Care act rather than administrative expenses. The medical insurance plan benchmark studies we reviewed counted these expenditures as administrative expenses.

Conclusion: Existing issues may be exacerbated by changes to the entire healthcare system

Properly managing the costs and financial risks associated with the mental health insurance plan has become more important with the creation of CCOs and the expansion of Medicaid. So far, the Division has seen a reduction in premium revenue and a decrease in risk management flexibility with the Medicaid transformation. The Division will likely see additional changes in the number and acuity level of its insurance plan membership. Managing these costs and risks directly impacts the Division's ability to provide mental health care services to insurance plan clients.

The Division has lost direct control over important financial risk management tools

With the creation of the Health Share CCO, the Division is losing considerable flexibility in its ability to control financial risk associated with the insurance plan. In the past, the Division was able to control some of its financial risk because it had discretion in setting limits on how much it paid for each type of insurance claim and which types of medical claims would be covered. Health Share is working to create a standardized fee schedule (the amount paid for each type of claim) and utilization review standards (determines which services are covered) in the metro area (Washington, Clackamas, and Multnomah). Having the same fee schedule and utilization review standards is an improvement for providers that work with the three insurance plans. However, it also reduces the Division's ability to manage its premium dollars. This governance structure may mean that the Division could be required to pay more for claims and may have to authorize payments for services it did not previously cover.

Potential increase in more expensive clients, with no additional funding

Responsibility for clients with more acute mental illness is being transitioned from the State to the mental health insurance plan, which substantially increases the financial risk facing mental health insurance operations. For example, the State transferred financial responsibility for the mental health services provided to individuals under the supervision of the Psychiatric Security Review Board to the mental health insurance plan. According to the Division, the 40 individuals in this group consume about $1 million in services in a year. And, while the state transferred the responsibility for care and the financial risk to the mental health insurance plan, it did not provide any additional funding. In addition, the state may transfer responsibility for residential services to the mental health insurance plan.

While the County may receive additional funding, this may also increase the County's risk.

The expansion of Medicaid associated with the Affordable Care Act will bring more members to the mental health insurance plan. The extent to which these new members will increase the financial risk to the insurance plan will depend on the acuity of these new members. One group of higher acuity clients that are expected to become mental health insurance members is the group of indigent adults who have been receiving services via the Multnomah Treatment Fund. Many of these individuals are homeless and severely mentally ill, but were not previously eligible for the mental health insurance plan.

The inability to know the true cost of the insurance plan, coupled with decreased control over risk management and an increase in more costly clients may have a significant impact on the financial condition of the mental health insurance plan. If premiums are not well managed, the Division will have to dip into its financial reserves. To further compound matters, Multnomah County will also be responsible for more clients, with the expansion of Medicaid.

Recommendations

In order to be able to accurately measure the insurance plan's costs and manage its financial risk, we recommend that:

- Only revenues and expenses directly related to the insurance plan should be included in the Behavioral Health Fund.
- The Division should develop a methodology by which other mental health system components can charge the insurance plan for services to its members or the plan and that methodology should be consistently applied.
- The Board of County Commissioners, working with the Division, should develop an appropriate plan for managing the fund balance for the Behavioral Health Fund.

In order to be able to monitor efficiency we recommend that:

- The Division should develop definitions to categorize administrative costs that are similar to industry standards.

In addition, we recommend that the County formally evaluate the risk and viability of running an insurance plan in an environment where the CCO covers multiple counties and is composed of providers who may have competing views of the system of care and risk sharing.

Objectives, Scope and Methodology

The objective of this audit was to determine the cost of operating the Division's insurance plan. As such, the scope of the review was limited to those mental health programs and business functions that either received funding from insurance premiums through the Behavioral Health Fund or that directly supported insurance plan operations.

In completing this review, we analyzed data beginning in FY 2009 and continuing through FY 2013. We analyzed program budgets, the County's consolidated annual financial reports, Division's financial reports, and financial data from the County's enterprise accounting system. To develop our estimate of insurance plan costs, we interviewed supervisors and staff as well as used workload

data, where available, to determine the extent to which the various programs and business functions supported the insurance plan.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings, and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions.

Response

April 2, 2014

Steve March, Multnomah County Auditor
501 SE Hawthorne, Room 601
Portland, OR 97214

Re: Mental Health and Addictions Services Audit

Dear Auditor March,

Thank you for the in-depth analysis of costs associated with operating a Medicaid insurance plan. We welcome your findings and recommendations on measuring the insurance plan's costs, monitoring efficiency, and underscoring the importance of risk management as opportunities to improve our processes. The report is especially timely given the changing health care system at both the state and federal levels. Your recommendations will assist us in developing strategies to ensure that operating a Medicaid plan continues to be a benefit to our community and Multnomah County given the changing landscape in the health care system.

To fund the best community system of care and infrastructure, the county has braided separate funding sources as allowed under the regulatory requirements of each fund. This approach funded a more integrated system of care for both uninsured and Medicaid-insured residents. It also resulted in equitable access to quality services, and a larger safety net of services for the most vulnerable residents. We benefited through singular procurements and contracts that included both General Fund and Medicaid-funded services. This braiding also created challenges in assigning allocations to programs and functions.

We agree that during the period reviewed in the audit there were programs and functions that were funded out of the Behavioral Health Fund (BHF) not related to the insurance plan, and that there were insurance plan functions that were paid for outside the BHF. We will explore methods to consistently apply pertinent charges to avoid such blending of revenues and expenses. The department will work with the Board of County Commissioners to develop a plan for managing the Behavioral Health Fund balance.

We also agree that administrative costs should be classified in a way that is similar to other behavioral health Medicaid plans insuring similar populations, and will research benchmark behavioral health plans and standards to determine how best to do this.

As a Local Mental Health Authority (LMHA) we are responsible for developing, funding, and overseeing a mental health and addictions system of care accessible to all residents of our community. As your report makes clear, it is critical to manage the costs and financial risks associated with health care transformation and the expansion of the Oregon Health Plan. Several associated changes will potentially increase risk for the insurance plan. One worth noting is the 20% increase in Multnomah County's Medicaid membership that occurred during the first quarter of 2014. Given the changing landscape, it is vital that the county has authority to make decisions about how to fund the system of care, make operational decisions, and maintain an adequate fund balance to shield the county from financial risk. Our organization has consistently ensured that the county is protected from the downside financial risk of operating the largest mental health insurance plan in the state through a risk reserve. With our Health Share of Oregon (HSO) Coordinated Care Organization (CCO) partners, we have agreed to a 120-day operating expense risk reserve. However, under the new system as a subcontractor of HSO, our decision-making authority is now limited.

To better evaluate the current landscape in which we are operating and what level of risk we can anticipate in the future, Department of County Human Services Mental Health and Addiction Services Division has hired consultants experienced and skilled in this type of analysis. They will assess the risks and impacts of our CCO contract on the county and evaluate how the changes the state is making may affect our LMHA funding and authority.

Again, we appreciate your effort and recommendations for improving our efficiency and cost management.

Sincerely,

Susan Myers,
Director, Department of County Human Services

cc: Marissa Madrigal, Chair, Multnomah County Board of County Commissioners
Emerald Walker, Chief of Staff, Chair's Office
David Hidalgo, Mental Health Director, Department of County Human Services
Rob Kodiriy, Finance Manager, Department of County Human Services