ISSUE REVIEW

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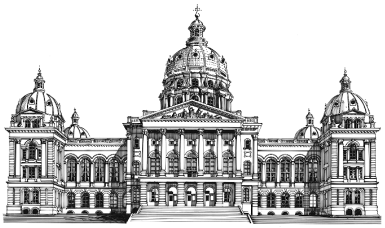


State Capitol
Des Moines, IA 50319
October 18, 1995

Update on Managed Mental Health Care

ISSUE

The State has contracted with Medco Behavioral Care Corporation to provide managed mental health services to all Medical Assistance clients. Medco assumed responsibility for providing services on March 1, 1995. Since that date, providers and client advocates have expressed concern about a variety of issues, including:

- The timeliness of claims processing.
- The criteria used to evaluate the need for admissions to in-patient facilities and the availability of out-patient alternative services to clients around the State.
- The development of additional appropriate treatment alternatives.
- The adequacy of the oversight and contract compliance monitoring exercised by the DHS.

This paper will provide information about these issues and Medco's efforts to address the problems. It will also provide information concerning policy issues raised by the Managed Mental Health Care experience.

AFFECTED AGENCIES

Department of Human Services

Judicial Department

CODE AUTHORITY

Chapter 1186, Section 3.6, 1994 Iowa Acts

Chapter 225C, Code of Iowa

BACKGROUND

In 1994 the Department of Human Services sought proposals from companies interested in providing Managed Mental Health Care services to Medical Assistance clients. The DHS received eight proposals and, after an evaluation by a seven-person team, awarded the

contract to Value Behavior Health, Inc. However, this action was overturned after one of the other bidders, Medco, successfully sued in District Court alleging that Value should have been disqualified because of a conflict of interest and because the evaluation process was flawed. The contract was then awarded to Medco. The original target date for implementation was September 1, 1994, but actual implementation was delayed until March 1, 1995, due to the litigation. The contract with Medco extends until February 28, 1997; the DHS may elect to renew the contract for an additional year after that date.

The contract requires Medco to provide "a full range of mental health care services" through participating providers. The contract requires Medco to document how it continually integrates consumer choice regarding services and supports at all levels of the program; and to provide services that primarily focus on supports to assist persons in living and working in the community, and in fully participating in the life of the community.

The contract states that "it is the full expectation" of the DHS "that the Contractor shall provide services beyond the current scope of services". The contract permits Medco "to develop a full array of services and to use imagination and flexibility in designing a treatment plan which is unique to each individual recipient".

Claims for medical services, including drugs and lab work, continue to be covered by the Medical Assistance Program, regardless of whether these services involve treatment for mental illness.

There are approximately 176,000 people eligible for Managed Mental Health Care services in Iowa; however, in any given month an average of 26,000 receive mental health services. The Iowa program is the single largest state-managed mental health care program in the country.

The contract provides that the State's Medical Assistance Program will pay Medco a specified amount each month. This amount varies depending on the eligibility group. If the actual claims cost less than this monthly compensation amount, Medco retains the difference up to 19.2% of the compensation amount. Any additional savings is divided between Medco and the State, with Medco receiving 20.0% and the State receiving 80.0%. Expenses for mental health services that exceed the rate paid to Medco are entirely borne by Medco.

A list of the various eligibility groups, the amount paid to Medco, and the amount at which Medco starts to share savings with the State, are shown in the following table.

Comparison of Monthly Compensation Rate and Expected Claims Rate Under Managed Mental Health Care

Category	Monthly Compensation Rate	Expected Claims Rate

FIP Less than 19 Years of Age	$ 13.80	$ 11.14
FIP 19 Years of Age and Older	11.14	9.00
SSI less than 19 Years of Age	88.30	71.31
SSI 19 Years of Age and Older	63.72	51.45
Medicare/Medicaid Dually Eligible	13.03	10.52

FIP = Family Investment Program
SSI = Supplemental Security Income

The calculation of savings is based on a 12-month period. The State will not receive any cost savings until after the end of the first contract year, which in the first year is February 28, 1996. The calculation of any amount due the State is subject to independent audit and verification.

For the second year of the contract, the rates paid by the Department for each covered group will increase by the amount of the Consumer Price Index for Urban Consumers - U.S. City Average. The inflation rate for the second year of the contract will be determined after the conclusion of the calendar year.

CURRENT SITUATION

Implementation of Managed Mental Health Care has been marred by problems. Providers have waited weeks, and in some cases months for payments. The criteria used to authorize treatment was based on the assumption that there were appropriate alternatives to in-patient services around the State. Providers were confused about which services were appropriately reimbursed by Medco and which were to be reimbursed by the Medical Assistance claims agent, Unisys.

A Medco spokesman acknowledged that there were difficulties in a recent quarterly report to the Council of Human Services. However, Medco believes it has turned the corner and is on the road to providing quality services and better access than before the implementation of managed care.

Charles Palmer, the Director of the DHS, recently told the Council on Human Services that in recent months the DHS had focused on three concerns:

- The need to pay back claims by October 1, 1995.
- A “floor of safety” for children with mental illness. No child should be denied authorization for admission into an in-patient program without appropriate alternative services being available.
- Service availability should be increased by January 1, 1996. Medco should create a larger system that increases access to services.

Mr. Palmer stated that DHS believes Medco has tried in good faith to meet these concerns and has also met with providers to address issues raised by the various provider groups.

Specific Issues

Timely Claims Processing -- According to a DHS spokesman, Medco opted to perform payment processing at their St. Louis, Missouri, facility rather than contract with another firm. The contract specifies that Medco is required to pay only for covered services that have received prior authorization. The contract requires that 80.0% of the claims that have received prior authorization be processed and either approved or disapproved within 30 days of receipt. The contract additionally requires that 90.0% of claims be paid within 60 days of receipt, and 100.0% within 90

days of receipt. These are the same timeframes as required by the federal Health Care Financing Administration. The contract does not specific a penalty for not meeting the processing timeframes.

Regardless of whether the contractual obligations were in fact met, it is clear that the high standards for claims processing that providers had been accustomed to with the Medical Assistance fiscal agent, Unisys, were not achieved by Medco. In an effort to address the impact of the delays in payment upon hospitals, all hospitals were paid 71.0% of their outstanding claims in mid-July. Reconciliation will be made at a later date for all outstanding payments.

Several reasons have been identified as causing the delays in paying providers.

- During the first months of implementation (approximately March through July), Medco did not have adequate payment processing staff and was not prepared for the volume of claims that was submitted. Medco has 15 claims processing staff, but temporarily hired five additional staff for a two-week period to process a backlog of denied claims.

- Providers misunderstood the benefit plan and sent claims to Medco that should have been sent to Unisys. Claims for drugs, lab work, and medical expenses connected with psychiatric treatment were particularly subject to confusion. Additional information has been sent to providers, and five training sessions have been held around the State.

- New claims codes were used and providers did not receive adequate training. Medco has now simplified the codes, reducing the list from six to three pages. The codes started with those used by Medical Assistance but were expanded to collect encounter data, as required under the contract to meet Health Care Financing Administration requirements. The claims review software has recently been revised to be more flexible and forgiving of miscoding, and Medco has distributed information to providers to decrease errors.

- Claims processing was paper-based, compared to the electronic claims processing many providers used with Unisys. Medco has started a pilot project and plans to provide limited electronic functionality to high-volume providers by January 1, 1996. However, this will not be at the level of service provided by Unisys, i.e. it will not immediately advise a provider if their claim matches with the authorization for services. Medco has stated that their company is not as familiar with Medical Assistance Program requirements as is Unisys, and that their computer system is geared more to clinical prior authorization than to servicing claims.

  It should be noted that the contract for Managed Mental Health Care does not require electronic claims processing. The DHS did require electronic claims processing in the Managed Substance Abuse services contract.

- There were problems with clients who recently became eligible for services. These individuals did not appear on the computer tape provided by the DHS to Medco, delaying Medco's ability to authorize or pay claims for services. Medco did pay the claims when the individual appeared on the computer tape. The DHS and Medco have since agreed that services will be provided through the old fee-for-service mental health program until an individual appears on the computer tape. This is the same approach used for Health Maintenance Organizations (HMO) that cover Medical Assistance clients.

Criteria for Authorization for Inpatient Facilities and Availability Of Outpatient Services -- The criteria that was used until July 1995 was comparatively restrictive of authorizations for in-patient treatment services: such services were authorized only while such treatment was considered medically necessary. After receiving complaints about children being discharged from inpatient treatment without an appropriate, safe, and available community-based treatment alternative, Medco changed its criteria on July 18, 1995.

The new criteria provides that inpatient treatment services will be authorized if a safe and appropriate alternative level of care is not available or if an appropriate 24-hour "safe" environment is needed and not available. Under this new criteria Medco has authorized a higher level of care beyond that required by medical necessity for 83 children between August 4 and October 10, 1995. The average length of stay in acute care under this provision has been 15.7 days. Medco is working with the DHS to finalize new guidelines for subacute care. These are expected to be ready for implementation by November 1, 1995.

Providers and consumer advocate groups have expressed concerns about the availability of services because of some providers' reluctance to sign a contract with Medco. Some providers were originally reluctant to sign due to a dispute over liability language. The language has now been changed to meet the objections. There were also concerns about the payment structure: Medco was paying only for those specific services that had been authorized. For example, a psychiatrist who received authorization to see a patient for a 15 minute medication check would not receive reimbursement for a 30 minute psychiatric visit regardless of the patient's needs. The claims review software now allows payment for the unexpected but medically necessary visit. Medco has also changed its practice on frequency of review: authorization is now made for a patient to see a provider for six initial outpatient sessions, compared to the original practice of authorizing three sessions.

Developing Appropriate Alternatives To Inpatient Facilities -- Medco has embarked upon an effort to expand the availability of "alternative" services. Known as "Phase II", the Medco plan states eight objectives:

- Complete the modification of utilization management guidelines to reflect the special needs of Iowa's Medical Assistance recipients.
- Create definitions for all new services and interventions and describe their relationship to other medical and human services.
- Focus initial implementation activities on clients in greatest need of alternative services.
- Collaborate with providers of traditional services to reconfigure their system of care.
- Solicit proposals for development of alternative services from all mental health providers and other organizations.
- Enhance access to mental health services for persons residing in rural areas.
- Develop capacity for technical assistance to providers of alternative services.
- Determine the Feasibility of Establishing Alternative Reimbursement Methodologies which Complement New Approaches to Service Delivery.

Medco staff have indicated that their goal is to "focus on individualized case management and to redirect consumers to more appropriate levels of care, more clinically effective levels of care, and more cost-effective levels of care."

Oversight And Contract Compliance Monitoring Exercised By DHS -- Each month the DHS receives three loose-leaf binders full of monthly statistics from Medco. The DHS also has access to encounter-level data provided by Medco, and DHS staff report that Medco staff have been very helpful and cooperative. A team of DHS staff meets weekly with Medco to review this data; however, the DHS does not have any staff dedicated to data research and analysis. In addition, the Iowa Foundation for Medical Care performs medical audits and special focus care reviews, and the Drug Utilization Review Commission performs analysis of the use of psychotropic drugs.

The DHS is negotiating a contract with a consortium of universities in the State for a major evaluation of Managed Mental Health Care. This project will assess the changes in the quality of life, compared to baseline data that was collected before the managed care program was started. The evaluation will also measure consumer access to services, the quality of care provided to consumers, and the cost-effectiveness of the managed care program. The evaluation is scheduled to complete data collection by September 1996 with analysis and a report to follow.

ALTERNATIVES

There are a number of policy issues raised by the implementation of Managed Mental Health Care. The General Assembly may wish to consider these in order to provide legislative intent to the DHS for use in developing future contracts for managed care.

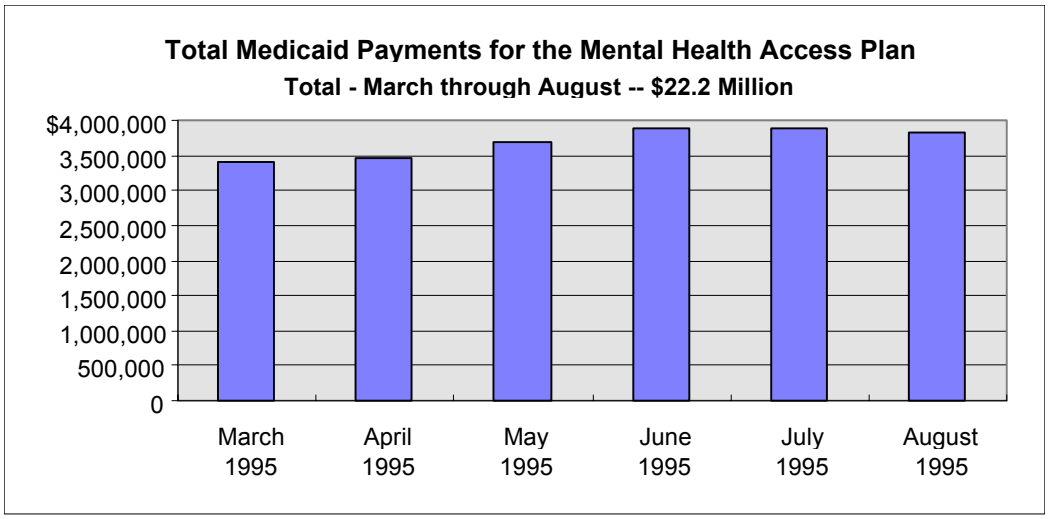
System Integration -- To qualify for additional federal funding the DHS has implemented an additional level of prior authorization for child welfare services called Clinical Assessment and Consultation Teams. These teams are responsible for authorizing the type and extent of rehabilitative counseling and treatment services for children. With the implementation of managed care, an additional and separate system of prior authorization has been created. Many children are involved in both the Child Welfare and Mental Health Systems, and for these children the implementation of Managed Mental Health Services results in their involvement with two separate bureaucracies.

Goals for Inpatient Services -- Several providers interviewed for this paper talked positively of the shift in treatment model caused by implementation of Managed Mental Health Care. There is a greater acceptance of occasional use of inpatient treatment, instead of keeping patients/clients in a facility until they are stabilized to such an extent they will not soon return. Returning a patient/client to the community with outpatient support is seen as part of the treatment, not as the goal of inpatient services.

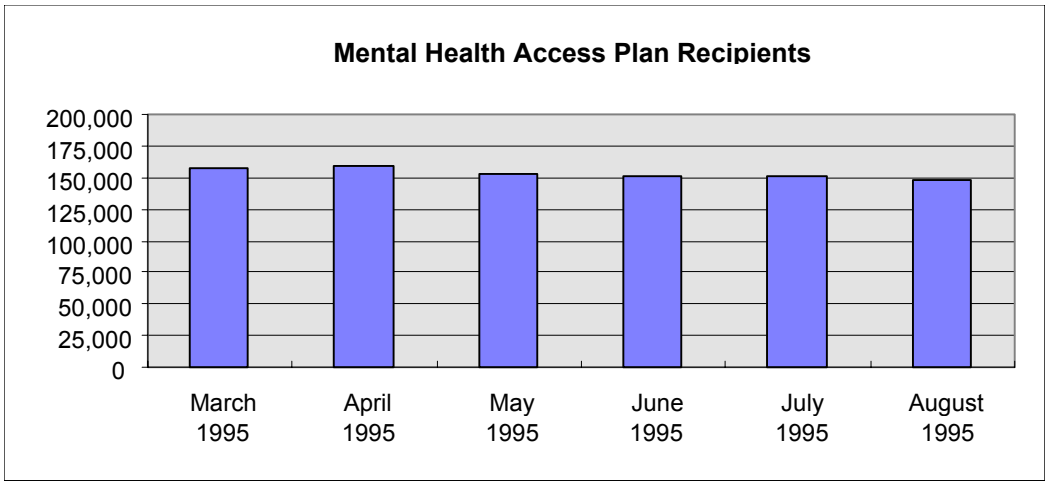
BUDGET IMPACT

According to DHS statistical reports, payments to Medco have averaged $3.7 million per month for the first six months of the contract. Total payments for the first six months of the contract (including all funding sources) were $22.2 million. Although expenditures were not budgeted by month, the annual budget projected monthly expenditures of $4.0 million.

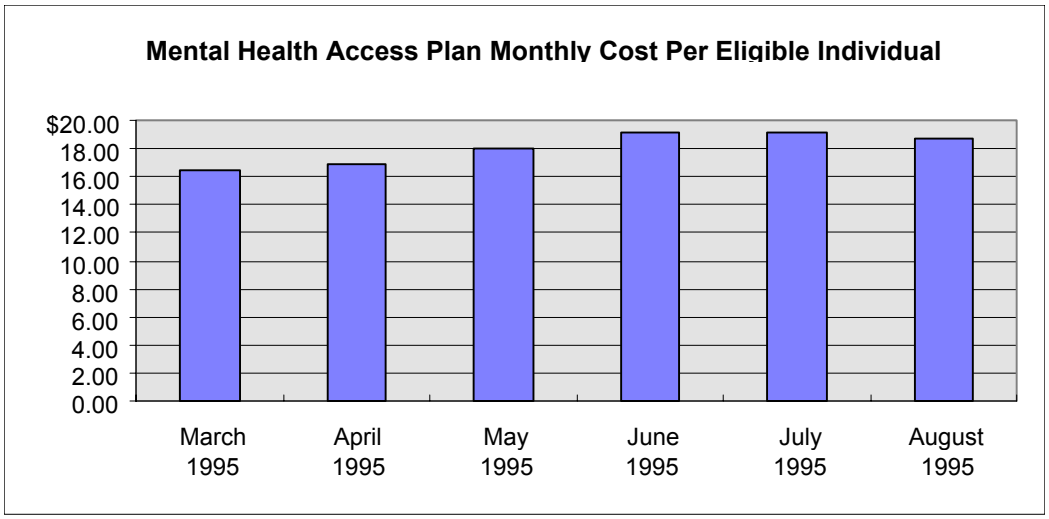
The following chart shows the amount paid each month for Managed Mental Health Care services.



The number of monthly recipients peaked in the second month (April) of the contract at 159,213 and has fallen by a small amount for the last four months. The average number of recipients the first six months was 153,523. The total number of monthly recipients has fallen by 6.3% from March through August. Whether this is due to problems with the data (accurate reporting in the early months) or due to actual decreases in utilization is unclear. However, the number of recipients has leveled off in the last three months with only small changes (one to two percent). Monthly variation in the number of recipients in the Medical Assistance Program is normal. The following chart shows the number of recipients each month.



The number of recipients has fallen slightly from the inception of the Program. The cost per eligible individual has increased $2.31 (14.0%) from March through August. This is due to a change in the mix of eligible individuals. The following chart shows the cost per eligible recipient for each month.



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