August 2, 2016

Patrick O'Donnell, Clerk of the Legislature
State Capitol, Room 2018
P.O. Box 94604
Lincoln, NE 68509-4604

RE: Cost Study/Rates Project Status Report

Dear Mr. O'Donnell,

In accordance with Legislative Bill 956 (2016) Cost Study/Rates Project Progress Report, please find attached a copy of the Division of Behavioral Health Cost Model Status Update dated July 31, 2016.

I am pleased to report steady progress in the cost model development and analysis work.

Sincerely,

Sheri Dawson

Sheri Dawson, Director
Division of Behavioral Health
Department of Health and Human Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH
FY 2017-2018 COST MODEL STUDY PROJECT
Report to the Legislature
July 30, 2016

The Department of Health and Human Services' Division of Behavioral Health submits the following Cost Study/Rates Project progress report to the Legislature, as required by LB 956 (2016). This report shows steady progress in the cost model development and analysis work.

PHASE ONE FINDINGS AND RECOMMENDATIONS FOR IMPLEMENTATION PRIOR TO JULY 1, 2017

Finding 1: DBH rates for Halfway House and Medication Management at 70% and 30% respectively, below Medicaid and Magellan current rates for comparable service expectations.

Recommendations:

1. DBH will implement a Halfway House rate of $115.00 per unit effective Quarter 4 FY 16 (April/May/June 2016). COMPLETED
2. DBH will implement a Medication Management rate of $69.02 per 15 minute unit effective Quarter 4 FY 16 (April/May/June 2016). COMPLETED

Medication Management:

FY17 budgeted units: 38,290
Costs based on old rate ($42.74): $1,636,531
Costs based on new rate ($70.57): $2,702,120
1 unit = 15 minutes

Halfway House:

FY17 budgeted units: 33,435
Costs based on old rate ($67.45): $1,429,019
Costs based on new rate ($117.59): $2,359,492 (This rate reflects FY16 cost model adjustment plus 2.25%)
1 unit = 1 day.

Finding 2: A portion of DBH-funded consumers need assistance to access medication, including state funds or through assistance programs available through pharmaceutical companies. While DBH does not pay for a substantial amount of ongoing medications, it is necessary to develop a standard mechanism to guide funding and practice.

Recommendations:

3. By July 1, 2016, a service definition/description for Medication Support/Education/Case Management will be developed. Such definition will provide for consumer education and assistance to access medication assistance programs when appropriate and outline parameters/criteria for purchasing medications across service types.
4. By December 31, 2016, a cost model for this service definition will be completed.

Initial draft developed and in review process.

PHASE TWO FINDINGS AND RECOMMENDATIONS FOR JULY 1, 2017

Finding 3: Criteria will need to be established and placed in contracts to sustain base level of capacity equal to capacity utilized in FY16 for services receiving increased rates.

Finding 4: Implementation of rate increases will require careful examination and analysis of utilization of all services during Regional Budget Planning processes and recommendations applied as determined.

Finding 5: DBH centralized data system implemented in FY 16 will afford additional data and greater accuracy of utilization data for FY 17.

The Division's centralized data system (CDS) went Go-Live May 16, 2016. Currently there are 1125 active users. Mid-year FY17 (January 2017) utilization data will be accessed and compared to pre-CDS data.

Finding 6: Implementation of Medicaid and Long-Term Care Heritage Health vendors in FY17-18 with focus on integration with Behavioral Health necessitates outreach with vendors as to comparable costs and rates across services; review of potential variability in payment methods and encouraging full utilization of cost models across services and systems.

Division, Region and provider staff are participating in meetings with Medicaid and the three new Heritage Health vendors regarding administrative practices, coding, service definitions and utilization guidelines. Comparable costs and rates across services will be addressed.

Recommendation:

5. Subject to FY17 mid-year review of utilization and projections, review the feasibility of implementing DBH service rates for Short Term Residential, Community Support Mental Health and Substance Use, Day Rehabilitation, and Psychiatric Residential Rehabilitation services.

   Midyear review will include, but is not limited to, a review of trended utilization, projected annualized costs, impact on capacity to specific services and overall network service capacity.

PHASE THREE FINDINGS AND RECOMMENDATIONS FOR MID-YEAR FY 2017-2018

Finding 7: Cost Model work to date on Outpatient services is in process and additional data is needed. Full impact of impact of outpatient rate is unknown without analysis of group utilization data. A cost model for group services is needed prior to finalizing recommendations on rates.

Recommendation:

6. Group cost model work will be completed in Phase III of Cost Model Study Project (FY 17).
7. Implementation of statewide rates for Outpatient services (I/F/G) and Assessment are deferred to Phase Three.
8. Phase III cost model work continues with potential analysis of Acute and SubAcute inpatient psychiatric services, including EPC hold, and Professional Partner Services.

Revised cost information and rates for outpatient group have been received and cost analysis is underway. Initial conversation occurred with consultant and Regional Administrators as to initiating Phase III efforts and establishing final services for review.

One cannot underestimate the impact of external factors to the work including projected revenues in general funds, congruency in services and rates with other third party payers, value based contracting and the results of the statewide needs assessment as to needs and gaps in the service delivery system.

As the system continues to move forward with cost model work, it is important to re-emphasize that a redesign of system rate adjustments, in the absence of completed cost model work, is premature. Feasibility, including analysis of fiscal and utilization data sufficient to confidently project the impact to the overall statewide system, is prudent. Failure to do so could contribute to instability in an already fragile public system.

We extend our thanks to those providers and regional staff who have, and will, participate in the cost model project work. It is time-consuming and the effort is greatly appreciated. We share a commitment to serving individuals in the public behavioral health system.