

Milwaukee County Department of Health and Human Services Behavioral Health Division

*Study of Funding Alternatives to Support Mental Health and Substance
Abuse Services and Programming: Support to Fulfill Section 51.42(8) of
Act 203*

Review of Report:

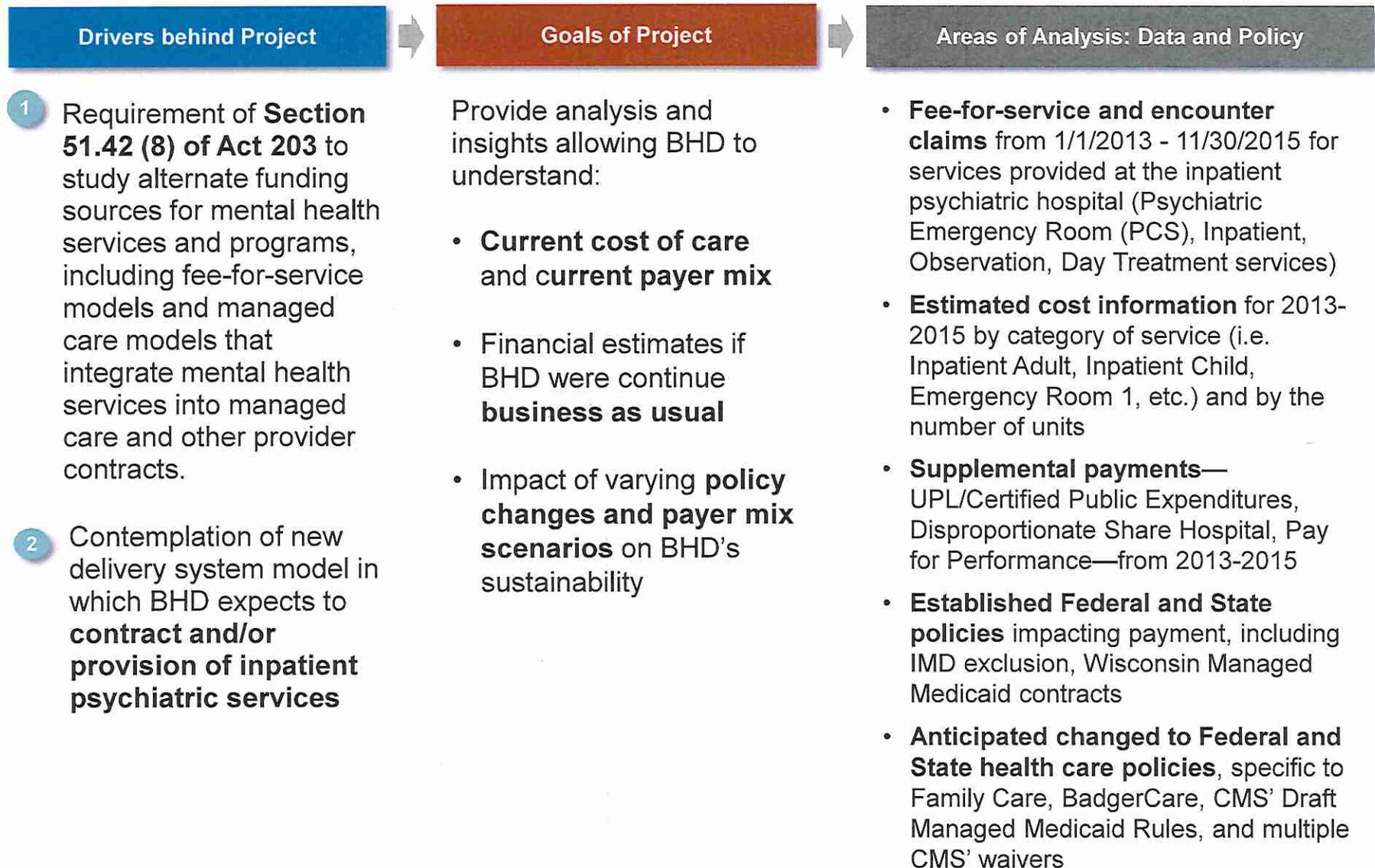
Milwaukee County Mental Health Board Finance Committee

March 31, 2016

For Discussion

- Project Goals and Scope, Approach
- Baseline Analysis of Financials and Payer Mix
- Report Findings – Elements 1-4
- Questions

Act 203 and Need to Understand Impact of Delivery System Transformation Drove Type of Analysis and Findings

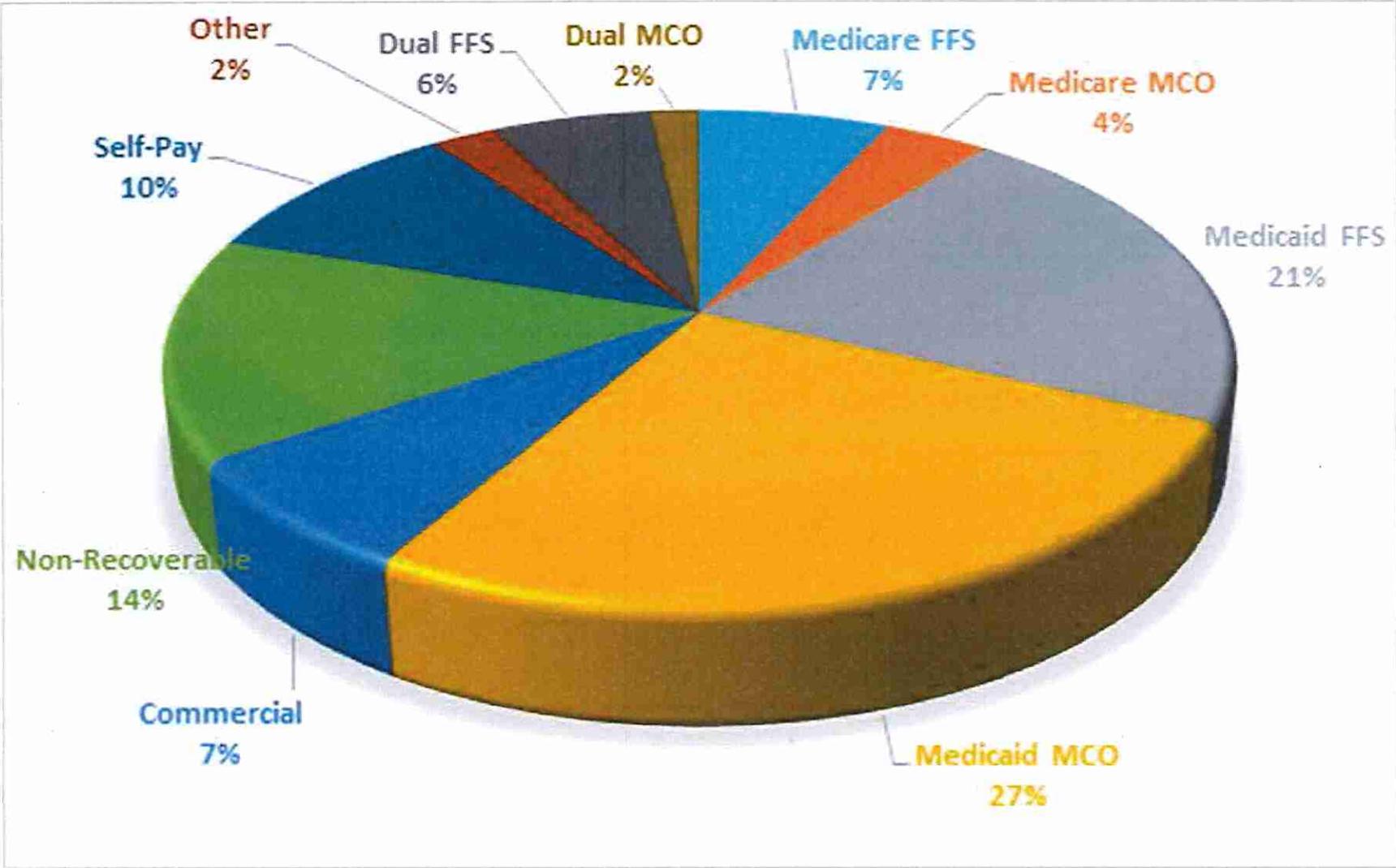


Baseline Financial Analysis

Current Financial Snapshot with Adjusted 2015 Data

Services Summary	2013		2014		2015 Adjusted	
	Dollars	% of Total	Dollars	% of Total	Dollars	% of Total
Gross Billed	\$47,985,185	100%	\$49,895,177	100%	\$52,122,784	100%
<i>Inpatient</i>	\$35,738,190	74%	\$37,147,445	74%	\$40,047,963	77%
<i>Psychiatric Emergency Room (PCS)</i>	\$7,322,089	15%	\$6,881,784	14%	\$6,899,908	13%
<i>Observation</i>	\$3,449,976	7%	\$4,089,057	8%	\$3,519,177	7%
<i>Day Treatment</i>	\$1,474,930	3%	\$1,776,891	4%	\$1,655,736	3%
Net Revenue	\$17,313,803	100%	\$20,486,539	100%	\$24,014,720	100%
<i>Inpatient</i>	\$13,545,976	78%	\$17,070,241	83%	\$20,017,320	83%
<i>Psychiatric Emergency Room (PCS)</i>	\$2,924,712	17%	\$2,302,993	11%	\$2,625,570	11%
<i>Observation</i>	\$859,303	5%	\$949,183	5%	\$1,021,521	4%
<i>Day Treatment</i>	-\$16,188	0%	\$164,123	1%	\$350,309	1%
Cost	\$47,705,178	100%	\$52,737,986	100%	\$54,312,895	100%
<i>Inpatient</i>	\$35,830,037	75%	\$39,007,773	74%	\$42,777,896	79%
<i>Psychiatric Emergency Room (PCS)</i>	\$7,140,228	15%	\$7,861,725	15%	\$6,842,244	13%
<i>Observation</i>	\$3,259,983	7%	\$4,091,597	8%	\$3,074,305	6%
<i>Day Treatment</i>	\$1,474,930	3%	\$1,776,891	3%	\$1,618,450	3%
Supplemental Payments	\$877,222	100%	\$2,014,466	100%	\$2,610,137	100%
<i>UPL/CPE</i>	\$0	0%	\$319,000	16%	\$957,000	37%
<i>P4P</i>	\$0	0%	\$0	0%	\$81,085	3%
<i>DSH</i>	\$0	0%	\$1,169,655	58%	\$1,103,421	42%
<i>WIMCR Day Treatment</i>	\$473,604	54%	\$149,305	7%	\$237,923	9%
<i>Medicare Bad Debt</i>	\$56,128	6%	\$51,677	3%	\$64,690	2%
<i>GME</i>	\$213,001	24%	\$219,890	11%	\$76,586	3%
<i>Inpatient Cost Report</i>	\$134,489	15%	\$104,939	5%	\$89,432	3%
Gross Payment	(\$29,514,153)		(\$30,236,980)		(\$27,688,038)	
Gross Margin	-162%		-134%		-104%	

2014 Distribution of Consumers Receiving Services by Financial Class/Payer (2014)



Findings

Key Findings Demonstrate Need to Create More Sustainable Business Model

Element 1: Analysis of Cost to Provide Care

Element 2: Analysis of Payer Models

Element 3: Report on Alternative Funding Sources

Element 4: Review Revenue Recognition Policy

- Net Revenue as a percent of cost is increasing.
- The historical cost from 2013-2015 is trending at a higher rate than gross billed
- Net revenue as a percentage of gross billed is increasing.
- Profitability by Financial Class/Payer varies significantly.
- The level of charity care is historically reducing net revenue by over 40%.
- Commercial business has been the most profitable.
- Inpatient, Observations and Day Treatment utilization has been stable while the utilization of the other services has decreased.

Key Findings Demonstrate Need to Create More Sustainable Business Model

Element 1: Analysis of Cost to Provide Care

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- Modeling of: Shift in business from Medicaid FFS to Medicaid managed care, increase in Commercial Non-MCO and Commercial MCO business, decrease in Unit Costs for all services, total coverage of IMD excluded members, and shift of Non-Recoverable and Self-Pay Financial Classes/Payers to other Financial Classes/Payers
- BHD estimated a loss of approximately \$3,000,000 in potential revenue due to IMD excluded members in 2015; reimbursement of 100% of these costs could increase BHD margin up to 21 percentage points each year.
- Some of the costs (e.g. facility rent) may be higher than the market standard; a 5% reduction in cost each year would improve the gross margin by 30 percentage points by 2018.
- With the cost beginning to exceed most payer gross billed amounts in 2015, there may be opportunity to increase fee schedules or contracted rates under a managed care program.

Key Findings Demonstrate Need to Create More Sustainable Business Model

Element 1: Analysis of Cost to Provide Care

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Element 4: Review Revenue Recognition Policy

- Opportunities exist to:
 - Mitigate IMD exclusion impact, reducing non-recoverables and self-pay
 - Leverage broader coverage of Behavioral Health Services within Managed Care contracts
 - Negotiate rates with MCOs better aligning payment with cost of care
 - Maximize UPL and DSH payments through IGT levers

Lessening Impact of IMD Exclusion, Potential Increases in MCO Revenue, Supplemental Payments and Will Improve Revenue, Gross Margin

Calendar Year	Final Revenue (in millions)	Gross Margin
2014 Actual	\$22.50	-134.1%
Adjusted 2015	\$26.62	-104.0%
Scenario	2018 ¹ Revenue Impact (in millions)	Increase to 2018 ² Gross Margin
1. 25% per year reduction of Non-Recoverable and Self-Pay Moves 75% of Non-Recoverable and Self-Pay revenue and cost to all the other financial classes by 2018	\$5.62	35.4%
2. Increase Medicaid MCO revenue Renegotiate rates with Medicaid MCO's from 63% to 85% of cost	\$2.91	20.1%
3. \$1M state share increase in Supplemental Payments Increase state share of supplemental payments by \$1 million (\$2.41M all funds)	\$2.41	16.9%
4. Shift \$1M of IMD excluded claims to being covered Shifts \$1M of IMD claims from being excluded to being included in revenue	\$1.00	7.4%
5. 25% per year Shift in Medicaid FFS to MCO Shifts 75% of Medicaid FFS claims to Medicaid Managed Care by 2018	\$0.62	4.3%
6. 10% per year increase in commercial business Increases commercial by 10% each year from 2016 to 2018, 30% by 2018.	\$0.59	2.6%

¹ For purposes of this report, 2018 Revenue and Gross Margin are based on 2015 adjusted amounts without trend. Therefore, the 2018 estimates are only modified for the scenarios analyzed.

Opportunities to Enhance Funding Range from State and Federal Payment Policy Changes to Contracting Negotiations



Managed Care Policy

Mitigating IMD exclusion impact, reducing non-recoverables and self-pay

- Medicaid SSI FFS beneficiaries, age 21 and over and younger than 65, receiving inpatient psychiatric services NOT CURRENTLY PAID FOR could be (voluntarily or mandatorily) enrolled in an SSI MCO
- 14 days of inpatient care (short-term stays) for Medicaid beneficiaries enrolled in MCOs, age 21 and over and younger than 65, that is NOT CURRENTLY PAID FOR could be reimbursed if CMS approves changes to the managed care rule

Broder coverage of Behavioral Health Services within Managed Care contracts

- Integration of BH services as a covered benefit under managed care for Family Care members
- Use of Section 1115 waiver authority by DHS to test payment and delivery system innovations specific aimed at reducing impact of SUD and potentially cover services such as short-term acute treatment, intensive outpatient programs, residential treatment service, screening and intervention services, integration with primary care, medication assisted treatment and recovery supports services

Opportunities to Enhance Funding Range from State and Federal Payment Policy Changes to Contracting Negotiations (continued)

Managed Care Contracting

Negotiating rates with MCOs better aligning payment with cost of care

- In 2015, BHD was paid 63% of its cost to provide care (adjusted 2015, ratio of net revenue to cost); there may be opportunities to increase fee schedules or contracted rates under and Medicaid managed care program. Dependencies such as further analysis of BHD cost structure and comparison to the Milwaukee market, Medicaid payment policies, availability of State and/or local matching funds, BHD/County resources to negotiate managed care rates, etc. would need to be addressed.

Supplemental Payments

Maximizing UPL and DSH payments through IGT levers

- Due to the gap between allocated amount of UPL and the actual supplemental payments for the private acute care hospital peer group, acute care hospitals (potentially contracted to operate inpatient psychiatric beds in a unit) could in theory use the room under the acute UPL to justify additional UPL payments.
- There may also be a gap between DSH limit, total current DSH payments statewide, and the DSH payment to BHD.
- Through IGT, BHD may be able to increase the federal payments for these programs, similar to payment methodologies previously utilized to support the former Milwaukee County General Assistance Medical Program (GAMP). *IGTs require statutory authority, as well as State Medicaid and CMS approval*

Key Findings Demonstrate Need to Create More Sustainable Business Model

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- BHD's approach to its claims lag policy, revenue recognition, contractual allowances, other adjustments and write-offs appears reasonable

Questions

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