Department of Human Services / Addiction and Mental Health Division (AMH)
January 26, 2007

2007 ITS Rate Setting Frequently Asked Questions

Why was there a new rate setting period?

On October 1, 2005, the implementation of the Children's System Change Initiative (CSCI) moved reimbursement of children's Intensive Treatment Services (ITS) into Managed Care. Certain assumptions were made to develop the capitation rates including the enrollment distribution of children served at higher levels in managed care versus those not enrolled and the expected utilization of ITS services for children and adolescents enrolled in Mental Health Organizations (MHOs).

After implementation, DHS examined the data and discovered that the actual enrollment in MHOs and claims experience of the MHOs differed significantly from the assumptions used to develop the ITS rate adjustments. More children than expected received ITS through fee-for-service (FFS) rather than managed care. In addition, MHOs were able to change the ITS service utilization pattern more quickly than anticipated.

How are the rates determined?

The Actuarial Services Unit (ASU) works with its Contractor to analyze the data and determine the cost of providing services. The rates are based on the encounter data submitted to DHS by the MHOs through the Medicaid Management Information System (MMIS), supplemental encounter data submitted by the MHOs, and FFS claims data. From this data, children who qualified for ITS services and in fact received ITS services during the analysis period were identified. Services fell into three categories:

- Psychiatric Residential Treatment
- Psychiatric Day Treatment; and
- Community Based Services.

Each child was identified as using one or more of these services for each month of their ITS eligibility. Once all eligible children were identified, the costs associated with treating the children were determined, and the average monthly cost per user was calculated. The relative prevalence of ITS-eligible children and their respective treatment types among each of the MHOs were then calculated, and ITS cost factors relative to the statewide average were developed. These relative utilization factors reflect the historical experience

with adjustments for changes in AMH policy affecting the enrollment of these children in MHOs. Separate ITS adjustment factors are calculated for each of the four relevant
eligibility categories:

- PLM, TANF, and CHIP Children Aged 1 – 5;
- PLM, TANF, and CHIP Children Aged 6 – 18;
- ABAD without Medicare; and
- SCF Children.

These factors are multiplied by the total intensive mental health services per member per month for each eligibility category to develop the plan- and region-specific ITS rate adjustments.

How was the dataset compiled?

Data from October 1, 2005 though June 30, 2006 was analyzed. Ultimately the data used was service claim data with dates of service from April 1, 2006 through June 30, 2006 for a defined set of members was used in calculating rates because this was the time period with the most complete data. The Members included were those that the MHO determined to be eligible for the Intensive Service Array (ISA), those that utilized ITS services, and ITS client lists compiled by the MHOs and AMH. Community-based Intensive services were included in the analysis for children determined eligible for the ISA. Some duplication existed and those Members were only included once.

What happened to the glide path?

The glide path was implemented to facilitate a gradual movement to Statewide Rates. The decision was made by AMH and ASU to use Plan Specific Rates rather than the established glide path. This is because variations in utilization among the MHOs did not support the glide path and Plan Specific rates provided incentives that were supported by the principles of CSCI implementation.

The decision to utilize Plan Specific Rates was made for 2007 only and the feasibility of continuing this approach will be discussed with our partners in various forums.

What were the results?

The following table displays the change in capitation rates for the MHO as a whole and in ITS Rates specifically. Some MHOs operate in more than one area. The

label of Region I and Region II are used only to differentiate various geographic areas within the MHO's service area and neither Region I or II refer to any particular area.

MHO	Change in Weighted Average Capitation Rates from January 2006 to January 2007* for all Rate Groups		Change in Weighted Average from January 2006 to January 2007* for ITS Services specifically**	
	Region I	Region II	Region I	Region II
ABHA	-15.4%	-2.5%	-41%	-14%
Clackamas Co.	4.1%	-3.0%	11%	-6%
FamilyCare	-5.8%		-39%	
GOBHI	-4.5%		-10%	
JBH	-2.7%	-4.7%	-10%	-15%
LaneCare	13.1%		20%	
MVBCN	3.1%	-7.5%	-6%	-70%
Verity	4.4%		-10%	
Washington Co.	2.8%		10%	
Overall System	1.4%		-7%	

*based on June 2006 Enrollment
** ITS services included in four (4) Rate Groups: Children 01-05, Children 06-18, SCF Children and Assistance to the Blind and Disabled without Medicare

How can I find out the impact on the services?
AMH has not changed the services provided through the CSCI. The adjustment in rates is to bring the MHO reimbursement in alignment with the cost of services being provided.

You can contact the respective MHO for questions specific to them; or Jay Yedziniak, OHP Coordinator for AMH for questions concerning the ITS Rate Setting process (503-947-5522 or joseph.a.yedziniak@state.or.us); or Ralph Summers, Medicaid Policy Manager (503-945-9827 or Ralph.h.summers@state.or.us); or Bill Bouska, Child & Adolescent Mental Health Services Manager for questions concerning the CSCI (503-945-9717 or bill.bouska@state.or.us).