The CMH MEDICAID Funding Story
Past, Present, and Future

Judith Taylor, PhD
CMH Chief Historian, Analyst, and Archivist

MACMHB Conference: Spring 2015
Agenda

• Medicaid 101
• Michigan CMH Medicaid evolution
• Specialty Services and Supports Managed Care FY99 shift
• Medicaid Rate Setting : Past, Present, Future
• Medicaid Expansion – Healthy Michigan
• Status of PIHP Medicaid Specialty services/supports carve out: now, current issues, future
• PART ONE: Basic Medicaid 101
Wikipedia Definition

• Medicaid in the United States is a social health care program for families and individuals with low income and limited resources. The Health Insurance Association of America describes Medicaid as a "government insurance program for persons of all ages whose income and resources are insufficient to pay for health care." (America's Health Insurance Plans (HIAA), pg. 232). Medicaid is the largest source of funding for medical and health-related services for people with low income in the United States. It is a means-tested program that is jointly funded by the state and federal governments and managed by the states, with each state currently having broad leeway to determine who is eligible for its implementation of the program. States are not required to participate in the program, although all currently do. Medicaid recipients must be U.S. citizens or legal permanent residents, and may include low-income adults, their children, and people with certain disabilities. Poverty alone does not necessarily qualify someone for Medicaid.
Medicaid 101

• 1960’s – significant federal changes:
  – Medicare
  – Medicaid: created under Social Security Act in 1965
  – CMH Act
  – Civil Rights/Voters Rights

• Medicaid created as a health insurance for persons with low income
Medicaid 101

• Established as a Federal-State shared program
• State option to participate in Medicaid
• State financing share based on set of economic indicators – adjusted every year
• Federal share – FMAP. Varies by state. Michigan hovering in mid 60%
• Mandated eligibles: Michigan has been pretty aggressive in adding optional eligibles
• Mandated coverage: Michigan has taken great advantage of optional coverages
Medicaid 101: Eligible Groups

- Persons qualify for Medicaid through various program types – each of which have a different mandated financial/income level (FPL), plus there are optional groups of persons and optional income levels
  - Children up to age 18/TANF: mandated 138% FPL, optional to 150% FPL (note CHIP can cover children up to 300% FPL).
  - Parents of children/Temporary Aid to Needy Families/TANF: FPL about 45% (protected income level)
  - Caretaker relatives: FPL about 45%
  - Young Adults (ages 19-20): optional coverage; FPL about 45%
  - Aged (over 64) – about 70% FPL; optional to 100%
  - Disabled (SSI and non-SSI) – about 70% FPL; optional to 100%
  - Blind (SSI and non-SSI) – about 70% FPL; optional to 100%
  - Refugees

Note: Medicaid can be used provide various assistance supports: eg to cover Medicare premiums for low income persons, but not make them eligible for Medicaid coverage; emergency services coverage
Medicaid Coverage

• Mandated coverage is a basic health insurance packet: Inpatient, physician
• State creates a State Plan and a Medicaid Manual
• Any willing provider
• EPSDT (early periodic screening diagnosis treatment) for children under age 21
• Optional coverages under various sections of the federal laws for Medicaid that can be used to add services to State Plan
  – Under 21 inpatient
  – Pharmacy
  – Clinic Services
  – Rehabilitation option
Medicaid Waivers

• Medicaid allows states to apply for waivers. These basically fall into one of the following as used by Michigan to pursue maximizing FFP, create more efficient options to FFS (ie managed care); decrease use of institutions; provide a more flexible array of services
Medicaid waiver options

• 1915B: waives some of basic Medicaid rules – primarily used to do managed care – ie limit any willing provider, not to FFS
• 1915 (a)(1)(A) used to provide alternative services at MCO/CMHSP/PIHP level
• 1915c: targeted to persons who would have been in an institution; provides for broader array of services and may waive financial limits
  – Home and community based waiver : Children with DD
  – Home and community based waiver: I/DD in stead of using State DD Centers
  – SEDW – instead of using Hawthorn
  – MiChoice – instead of using nursing homes

• 1915 B3: Provide alternative services to State Plan
• 1115 : Research/demonstration waivers (eg ABW and now Healthy Michigan)
Medicaid Waivers and Federal Options Continued

- 1915-i: Variation on 1915-c. converts state plan services to home and community based without institution requirement. Currently used in Michigan for autism benefit
- 1915(j) Independence Plus Waiver
- 1915(k) Community First Choice Waiver

- MiChild (1997) under auspices of federal CHIP program
- Special Health Care Children
- Family Support Subsidy – originally all GF in early 1980s (thanks Debbie Stabenow), now moved under TANF

- ABW created in 2004 to make use of unspent CHIP funding – eventually feds banned that use of CHIP funding
- etc
• PART TWO: Michigan CMH Medicaid History
Michigan CMH Medicaid History 1965 to 1998

• Until 1982 there was very little Medicaid funding supporting the CMH system and persons served. Benefit was basically limited to inpatient and physician. Rest was all State General Funds (GF)

• Most of the Medicaid funding was in hospitals and state facilities – and even there for persons will mental illness (ages 21-64) it was limited by the IMD rule; was more generous for DD facilities

• CHANGE FACTORS:
  – Community Placement efforts to decrease use of state facilities
  – State Economy and thus State GF took a hit in 1980
CMH Medicaid History Continued

• DMH pursues alternative to DD Centers under the ICF-MR coverage. Alternative Intermediate small group community based facilities developed (AIS)
• DMH pursues a C-waiver to provide enhanced services to families with a child with DD living at home (DD Child Waiver). Later under Katy-Beckett waives financial limit – treats the child as family of one
• 1982 DMH pursues a Mental Health Clinic Services Waiver.
• Establishes CMHSP as Medicaid Provider Type 21. Criteria to be PT21 basically limits it to CMHSPs
• Begins the journey of covering a wide array of CMH services by Medicaid. Plus accompanying Medicaid rules and documentation
• Fee for service with fee screens; CMH only receives the federal share, they use their GF to cover state match (then about 45%)
• Initially Services basically limited to clinic services (ie therapy)
• A couple of years later shifted away from a waiver to a State Plan coverage – and began to add optional services
CMH Medicaid History Continued

- Case management added in 1987 – used for both MH and DD (per month rate)
- Covering “habilitation” services was a challenge
- Added personal care, ACT, Home-based, Psycho-social Rehab (Clubhouse)
- Added Crisis Residential and Crisis Stabilization teams in conjunction with CMHSPs taking over Community Hospital authorization in 1996
CMH Medicaid History Continued

• State had a 2-3 year grant/demonstration project for Community Living Supports Arrangements (CSLA- DD) – begins to introduce community living supports and supported employment into the mix

• Mid-late 1980s, DMH (Ben Censoni) pursues a Home and Community Based Service C-waiver (also known as Habilitation Supports Waiver) as alternative to persons with DD being served in state DD Centers (at that time there were about 5 plus several DMH residential programs). Recognizes “Habilitation” needs of persons with DD. Adds CLS in both licensed and non-licensed settings; adds supports coordination. Adds a lot more documentation. Cost effectiveness compared to cost of a day in DD Centers
CMH Medicaid History Continued

• 1990s DHS/Medicaid starts to use HMOs to do managed care for TANF eligibles
• 1995 – DHS/Medicaid asks that CMH assume gatekeeper functions for psychiatric inpatient in full-service community hospitals (not free-standing psychiatric hospitals as they meet IMD definition)
• 1996 Department of Community Health created – brings DPH, DMH and Medicaid under one department
• Governor Engler asks DCH Director Jim Haveman to create managed care initiatives for a) basic health care, b) aging, c) children, d) mental health/SUD, e) developmental disabilities
• **Goal – to reduce risks to state for escalating costs of Medicaid**
• 1996 Mental Health Code changes : enacts Person-Centered philosophy and practice; creates CMH option to become an Authority
CMHSP/PIHP Medicaid Waiver History

• FY99 – Medicaid managed care initiated with 49 CMHSPs; 15 CMHSPs designated for SUD. Incorporated PT21, PT65/69, PT68/73, PT 41/75, PT31

• Used a 1915B (managed care) with 1915 a-1-A (alternative services) and 1915C combination waiver

• One of a kind waiver in the country

• Covers all three populations: MH, DD and SUD

• Addressed spend-down and retro-eligibility challenges by doing Medicaid managed care in conjunction with GF

• Single contract covering Medicaid and GF

• PURPOSE: Provide prepayments that allow for flexible spending consistent with PCP principles (1996 code change); eliminate FFS behavior and limitations; No cost savings; Provide cost/rate increases each year
Waiver History continued

• FY01: DMB removed payments for spend-downs – loss of $30m;
• FY01 DMB removed payments for retros (24 month tail) and built about 5% into rates – layered on to rates for current eligibles
• FY02 – use of $26m local match to draw down $37m FFP. CMHSPs/PIHPs(Prepaid Inpatient Health Plans) had had no rate increase since FY99. Made PIHP Managed care Medicaid exempt from local match requirements.
Waiver History continued

- Waiver renewal process for Fy01 and Fy03 – CMS requires Michigan to procure PIHPs. Original plan developed in 2001 met with great resistance from advocates and CMH system and legislators. Hammerstrom-Johnson step in and with DCH develop an alternative that is accepted by CMS
- Solution includes requiring an application process and independent RFP review/selection process
- Solution also includes reducing the number of PIHPs down from 46; linked to minimum volume of eligibles (20,000) and risk
- 2002 – 44 CMHSPs work out who they want to partner with; 2 CMHSPs get partnered up with a PIHP after AFP process
- 2002: AFP used to reduce to 18 regions; FY03 split into 2 contracts (PIHP and CMHSP)
- PIHP language embedded in Michigan’s Social Welfare Act (not in Mental Health Code)
Waiver History Continued: Impact of BBA in 2004

• FY04: Impact of BBA (managed care rates and program integrity) and negotiations with CMS on how to incorporate our B/C combo.
  - Separate out C-waiver
  - Add 1915B3 as basis for services other than State Plan
  - Use FY98 FFS actual as rates base with only BBA allowed adjustments to trend to FY04
  - EQRO
  - Encounter data reporting, MUNC
  - Rate rebasing at least every three years using data that is no older than 3 years; includes rate increases
Sidebar: Hospital IMD 2004 Resolution

• Under State FFS Medicaid – these facilities are not a covered Medicaid benefit. Seen as 100% state responsibility
• Up to 1997 Medicaid HMOs used these facilities; since 10/1/98 Medicaid CMHSPs/PIHPs had used these facilities
• CMS determined that PIHP use of freestanding psychiatric hospitals (aka IMD, aka PT68) could not be a B3 service
• CMS determined that as a managed care entity PIHPs could use Medicaid funding for these facilities “in lieu” of using a full service community hospitals as long as:
  * Data and costs were separately reported (PT68)
  * DCH is keeper of IMD list
  * Per diems were on average less than PT73 (savings construct)
  * FY98 IMD use NOT in rate base used for PIHP Fy04 rates, but if above met, then costs could be included in future rate setting
• FY04 PIHP reports included a report on per diems
Waiver History continued

• ABW added in FY04 – not as a Medicaid program (used SCHIP $$); replaced state only funded program; CMH at $40m (GF removed – used for match for ABW $13m, match for FY04 Medicaid rate increase $11m, rest used for match for ABW-health care

• Quality Assessment Assurance Program (QAAP) tax assessment at 6% added in FY05 – creates additional local funds for the state budget. Used to finance a number of health care initiatives as well as help other parts of state budget; plus PIHP rate increase for FY06

• FY08: Added targeted children funds (approx $13m)
• FY09: Added targeted DCW funds; QAAP shifts to Use Tax
• FY10: ABW becomes Medicaid (1115 waiver) under 18 PIHPs
Waiver History continued

• Waiver renewal every 2 years: FY06, FY08, FY10 missed the submission date; added ARR and new rate methodology, FY12 – extended to FOUR years due to cost effectiveness problem

• B/B3 growth issue been around since 2004. It is not a rule – it is in cost effectiveness instructions. Michigan is doing the “right” thing for consumers by providing more B3 services, BUT that does not convince OMB

• Hospital Reimbursement Adjustment (HRA) added FY10, increased FY11 ($45m)

• Mt Pleasant placement incentive added FY09 – impacted 16 PIHPs (approx $10m)

• FY12 Use tax (6%) replaced by claims tax (and then added back in again in 2014)
Waiver History continued

• DCH expresses concerns about number of regions – 18 contracts is too many
• 2013 AFP used as a way to address CMS concerns about lack of procurement of PIHPs
• Reduce to 10 PIHP regions effective January 2014
• 2014 Healthy Michigan (under 1115 authority) replaces/expands ABW, April 2014
Waiver History continued: Integration

• 2012 – Dual eligible (MME) project planning originally statewide – CMS wanted pilots – 4 selected – RFP for Health Plans (ICOs) – implemented in 2 regions in March 2015, other two in May 2015

• MME project originally designed to fully integrate PIHP into Health Plans; stakeholders expressed concerns; model shifted to a well coordinated plan between Health Plans and PIHPs with the Bridge; then shifted back to Health Plan (ICO) as primary. Changes the nature of PIHPs

• Behavioral Health Homes – 3 pilots in 2014

• Michigan still has B/B3 cost effectiveness problem
• PART THREE: Medicaid Funding and Rates
Medicaid Rates - Past

- FY99 rates – separate for MH, DD, SA
- Based on FFS (historical) spend
- Used FY96 FFS with adjustments to FY99 – many changes in that time period – DCH completed all residential transfers, IGT, AIS home conversions, big expansion of C-waiver, decreased use of state facilities, CMH gatekeeper to MSA hospital services (underfunded in approp transfer)
Medicaid rates – Past Initial FY99

• RATE STRUCTURE: Since the Medicaid base was significantly skewed to DD (approx 2/3 of funding) and given that development of DD services and consumers/need was very unevenly distributed across CMHPs (eg based on where DMH developed community placements over the previous 2-3 decades), it was decided to use a rate structure that was separate for DD, MH and SUD.
• Within MH and SUD it was also important to separate by DABs vs TANF
• DD FY99 base at $800m, 1/3 was AIS, 25% C-waiver; used P/E eligibles only – approx 250,000, geog factor range 0.43 (Montcalm) to 3.26 (Sanilac)
• MH FY99 base at $370m, 1/3 was hospitals, $320m DABs, used TANF (750k) and DABs (includes Q, 375k), TANF range 0.60 (Woodlands) to 2.67 (Gogebic), DABs range 0.46 (Montcalm) to 1.78 (Great Lakes), after 10% movement to average
• SA FY99 base at $24m, 2/3 DABs used 30% movement to average
Rates FY99 to FY03

- No rate increases appropriated until FY04, except DCW in FY99
- FY01 retro-eligible payments eliminated – costs for retros layered on top of rates for current month eligibles
- DD facility exit/entries adjustments to geographic factors
- FY02 and FY03 re-allocation Medicaid $60m drawdown and GF swaps
- FY03 EO 1.1% rate reduction
- Eligibles trend relatively flat to 2003
- Large 307 transfer $28m from Detroit-Wayne to Oakland and Macomb in 2002
- PIHPs reduced to 18 for FY03: DCH kept the previous CMHSP level rate structure through December 2003
Medicaid Rates – Past: BBA 2004 changes

Based on FY98 FFS actual, with several adjusts; impact on PIHPs using FY98 vs past rate used estimated FY98: 30% lost, 30% gained, about 40% stayed same – started the 6 year roller-coaster. Not implemented until January – payments not until March-April

Applied 5% managed care savings MH and 9% SA – to get to appropriation amounts (all other Medicaid rows later adjusted for eligibility trend)

FY04 impact compared to FY03 rates: plus 13% to minus 7%

• Split out C-waiver and used an enrolled model – much discussion with CMS re attrition-replacement since current funding base was ‘c-waiver free’. 7900 as cap on slots, PIHP assignments – based on history. Used 4 cell age/gender (under/over 40). Geographic factor range 0.76 (Lifeways) to 1.32 (Muskegon)

• NOTE: B-waiver use by high cost persons with DD vs C-waiver distribution and severity levels has oodles of history and created distortion between B and C.
Rate Structure since 2004

- Statewide rates – derived from the complete data set:
- C-waiver – pulls out all C-waiver (HK) data, applies age/gender (later replaced by age/living arrangement, replaced by living arrangement only)

- TANF MH/DD and DABS MH/DD – State Plan (SP) and B3
- TANF SA and DABs SA – SP and B3
- For each of TANF and DABs – 12 cell age/gender

- Geographic factors – compares each PIHP in each of the 5 payment domains to state average
Medicaid Rates – Past: BBA 2004 changes

- DABs and TANF rates: 12 cell age/gender
- Rates split by SP and B3: MH DABs 65% SP
- **Mix of MH and DD (ie non-C use) in DABs**
- FY04 DABS MH/DD range: 0.81 (Wayne) to 1.69 (Oakland)
- DABs factor influenced by split of DD between C and non-C funding. C-waiver allocations have an uneven history across PIHP regions
- TANF MH/DD range 0.37 (Genesee) to 2.71 (Thumb)
- SUD range DABs 0.61 (NorthCentral) 1.27 (Macomb); TANF 0.92 (Pathways) to 1.18 (Kalamazoo)
Medicaid Rates – Past

- FY05 – Mid-waiver – rates just trended: 2% appropriated rate increase, QAAP added late in year
- FY06 – Rebasing – used one year data (FY04) and FY04 “allowed amounts”. Since rate changes in 2004 did not really happen until late in year, spending base did not reflect FY04 rates. Created swing +19% to -17%!! (C-waiver and GF swaps to help smooth)
- FY07 - Mid-Waiver : 2% appropriated rate increase; DCW rate revisions later in year
Medicaid Rates – Past

• FY08 rebasing using FY05 and FY06 encounters and MUNCs (for service costs). Note actuary does not use PIHP admin info only uses service costs in MUNC – cost/unit and to reconcile to for total spend in sub-categories. Appropriated 2.5% rate increase. **Swings +7% to -8%**

• Adds living arrangement to C-waiver – drops gender and only use over/under 18

• Adds $13.2m for children; added to MH/DD DABs only

• Managed care adjustment for “excessive” use of H2015. Reduced $9m from 2 PIHPs

• SUD rates – data not useable, trended to approp

• FY09: Mid-waiver, rate increase 2.9%, Use tax, Mt P
Medicaid Rates – Past

Roller coaster: FY04 (based on FY98 FFS) thru FY09 (based on FY05 and 06 encounters & MUNC costs):

- DABs MH/DD high from 1.68 to 1.87; low from 0.77 to 0.71
- TANF MH/DD high from 2.61 to 1.67; low from 0.37 to 0.53 (different PIHP)
- C-waiver high from 1.32 to 1.27 (different); low from 0.67 to 0.55
Medicaid Rates - Present

Ever since FY99 there has been discussion about Medicaid rates and “equity”. In FY99 MH and SA rates had adjustments to state average (undone in FY04).

- Was the FY98 base really representative of “need”?
- Was “historical spend” the best metric of need? What other factors were available with reliable data?
- The FY99 rate methodology was never intended to be always the same – was supposed to have increasing factors added into the actuarial work.
- There have been multiple Medicaid rate setting (and GF formula) work groups over the past 15 years. Each time there was a rebasing – there was a workgroup. There was the 462 work group (2007) that fell apart as a DCH/CMH partnership – but was followed by MACMHB workgroup efforts.

In 2009, Mike Head, DCH MH/DD Director, decided something different needed to be done and not solely rely on historical spend.
Medicaid Rates - Present

State actuary (Milliman) told to come up with other rate setting factors.

• Medicaid’s data base is very limited on eligibles characteristics. SSI/D (ie P/Es) we don’t even have their qualifying disability. Dual Eligibles had been looked at before. We now know how significant this is in overall Medicaid. Duals use of PIHP Medicaid – 50% of funding, 30% eligibles

• CMH data set is much richer in data elements on need/characteristics – but has completeness/validity problems

• Co-morbidity Model Factors for MH/DD:
  • Age/gender - already accounted for under BBA
  • Program Code (7)
  • Dual eligibility (2) (not used in TANF)
  • Waiver C use of B/B3 (2) (not used in TANF)
  • DD (2)
  • SMI (2)
Medicaid Rates - Present

• The co-morbidity factors creates a 112 cell matrix used by the actuary to create a MH/DD DABs composite to normalize each PIHP’s costs to statewide eligibility distribution. That is, what the PIHP DABs per eligible cost would be with the statewide enrollment distribution. This is used to create a PIHP DABs geographic factor
Medicaid Rates – Co-Morbidity Model: FY10

- The MH/DD DAS and TANF co-morbidity model and the historical model were first applied to FY10 rates. The blend was 2/3 historical, 1/3 co-morbidity model. However there was a max gain (15%)/min loss(0%) corridor across all the funding categories (ie including C-waiver which did not have changes in methodology).

- **FY10 Impact 0% to plus12.3%**

- The FY10 rates were not implemented until May 2010 – by then there was an appropriation problem with $40m overspend for the last 2 months. Made for some very bizarre rates for 5 months! And thus encounter/cost base to be used for FY12 rates
Medicaid Rates – Present: FY11

FY11 – Mid-waiver, but DCH rebased again.

- Developed new c-waiver model – using PIHP size (i.e. how many c-slots) and living arrangement (Buhlmann-Straub credibility formula) Shrank variance a lot from 0.54 to 1.27, to 0.88 to 1.09
- MH/DD DABs and TANF used 50-50 blend
- Applied corridors plus/minus 5%.
- **Impact plus 4.4% to minus 4.8%**
- SUD – used SUD data, applied modified co-morbidity model; impact **plus 12% to minus 8%**

Eligibility trend created major approps problems $118m overspend. Approps was increased, but PIHPs still had a $20m half year impact (went to low rate range numbers)
Medicaid Rates – Present: FY12&FY13

• FY12: Appropriated rate increase was just for claims tax. Waiver renewal; rebased using same methodology; added EPSDT (part of B/B3 solution) – created much more complicated age/gender factors. Used 50-50 blend, with PIHP adjusts to mitigate impact.

• Impact: **Minus 4.2% to plus 3.1%.** Trended SA

• FY13: Mid-waiver, rate increased 1.2%, did not rebase – trended
Medicaid Rates – Present FY14

• FY14: Waiver extended due to cost effectiveness problem – still not resolved. Appropriated increase 1.25%. Rebased using FY11 and Fy12 data (a period of major change in eligible trend, plus FY11 had major funding/rate changing issues so significant under-spending). Overall rate reduction of about 2% (because spending level was down compared to funding/approps in base years). SUD loss of 7%.
• Applied same methodologies, with no gain/loss corridor limits. Loss 9% to gain 2%
• Consolidated into 10 PIHPs as of January 2014
• DCH implemented a performance with-hold of 0.2%
• April and July rates adjusted for tax changes
Medicaid Rates FY15

• Appropriated rate increase 1.25%
• Applied same methodology with one change re DD factor – split into four levels: None, mild, moderate, severe
• Used 50-50 historical to co-morbidity
• Overall base up 3%
• Impact minus 0.8% to plus 7.1% (MH/DD), and C-waiver minus 5% to plus 6.7%; SUD minus 6% to plus 25%
Medicaid Eligibility Trends and Implications

• DABs eligibility PAYMENT base in FY99 was 375k; as of April 2014 at 495k; as of March 2015 at 492k. Increases in 2003 and another jump up starting in 2008; now basically flattening.

• DABs eligibility trend differs a lot across the 18 PIHPs – UP lowest trend, Macomb highest (runs twice state average)

• FY10-FY12 rate rebasing – losses by 3 or 4 PIHPs more than offset by eligibility trend; gains were amplified.
Medicaid Eligibility Trends and Implications

• “Unspent” revenues (ie savings, contributions to ISFs and lapse to DCH): FY10 $87m (4%), FY11 $119m (6%), FY12 $32m (2%) with 3 PIHPs overspent. FY14 likely will be a very different picture – ISFs being used up, and savings dropping a lot.

• FY14-15 DABs trend flattening, may be small woodwork effect with Healthy Michigan apps (only seen negative impact from Marketplace apps).
• BUT lost a large number of DABs Age 19-25 Program Q young adults – shifted to HMP
• TANF trending down – lost 20% from July 2014 to March 2015

• Demand characteristics will increase – aging of the CMH population
• PIHPs appropriated rate increase half of that for MHPs
• 1-2% rate increases, with flat DABs eligibility, insufficient to meet needs
Medicaid Rates : FY16 and Beyond

• Medicaid rate setting work group – did some initial work on ideas for rate factors; plus they wanted to see this as a longer term project, not just one-time for FY15 or FY16 rates
• DCH submitted Section 504 (appropriation boilerplate) report in 2014 and 2015 summarizing work group discussions, but with no recommendation
• DCH and CMH system involved in intensive effort in latter part of FY15 to review/revise reporting instructions to get more consistency in how codes used and priced
• New PIHP regions also working within their regions on improving consistency
Medicaid Rates : FY16 and Beyond

• FY16 rates would use FY13 data and MUNCs from 18 PIHPs, and FY14 data and MUNCs (9-months new regions, 12 months from stand-alones)
Medicaid rates: Future

- Work Group Discussions:
  1. DCH has not evaluated impact of current co-morbidity model as it has said back 2010 it would
  2. DCH has concerns about “unspent” revenues and what should be an OK risk reserve/fiscal solvency requirement
  3. How will MME project impact? Original proposal had PIHPs with brand new rate structure. Cannot apply that to 4 pilots without wreaking havoc on residual Medicaid funding
  4. Boundary between DABs and C-waiver – skews the data, ie high factor DABs are PIHPs with high % more costly persons with DD (former AIS)
  5. Milliman has done a number of data analyses – cost break down by population and by B/C; average cost/case by expense bands. While including both B and C did have a smoothing effect, there is still a lot of variance.
  6. Milliman has yet to run the co-morbidity model using both B and C encounters/costs to see how overall PIHP range/standing would be impacted
7. Really need severity/assessment data for all populations. Milliman has not used CAFAS or ASAM data to explore severity for SED and SUD. DCH intent to add a MIA statewide assessment tool for Fy15. SIS in slow roll-out. Will not have any good assessment data for several years.

8. Looked at variables being used by PIHPs for allocation – eg DWMHA/MCPNs using Wisconsin Milliman factors, SE Michigan (ditto), Access – SES/Hudson materials

9. Other variables discussed:
   • Cost of labor/living/specialties
   • Geographic/economy of scale – eg transportation
   • Diagnosis
   • Health conditions
   • Social security data on disability
   • SES (looked at ACCESS materials)
   • Data from QI file
   • More on residential
   • Dual eligibles
Medicaid future rates

Best Guesses:

• Add something for cost of labor (DCH did a survey – but most of PIHP cost is at “aide” level not clinical practitioners) into the co-morbidity model
• DCH and the actuary do not like the PIHP cost/unit variance – neither do most of us. See FY08 cost metrics study and recommendations.
• For MHPs they use statewide rates to establish the MHP rates – but that is more defined, is an enrollment model (not covered lives) and has a well established chronicity adjuster.
• DCH/actuary could use a statewide cost/unit for many of the codes – it is residential per diems that are most challenging
• In the absence of any good new factors, DCH will continue to shift the % blend between historical and co-morbidity
• Change rate structure to separate out dual–eligibles
• Be more like health plans
Rates – additional issues

• Eligibility trend flattening, but PIHP demand trend will continue to increase (aging of CMH population) – can capitation be adjusted?
• Rate increase at 1% is not sufficient within flat eligibles
• Minimum wage impact – can that be addressed? In the past state used Direct Care Wage pass through adjusts
• Population based rate structure? With separate rates for dual-eligible care/caid?
• Rates in a 1115 structure could be very different
• PART FOUR: Medicaid Expansion also known as Healthy Michigan Program (HMP)
Healthy Michigan Program

• Medicaid expansion under ACA
• 100% federally funded for first 3 years: 2014-2016; after that up to 10% state match
• Target: Low income adults who do not qualify for regular Medicaid (ages 19-64), up to 138% FPL
• Cannot have Medicare – but could have other insurance
• Replaced ABW which was for very low income adults who did not live with a child
• Two thirds of persons expected to have incomes below 100% FPL
• Picks up a large number of Medicaid-only spend down persons – but very few of CMH spend-downs most of whom also have Medicare
Healthy Michigan

• Michigan added “responsible health behaviors” characteristics to program – impacts premium, deductible, co-pays. **REQUIRES A WAIVER – NEEDS TO BE RENEWED FOR 2016**

• Michigan estimate 470,000 adults might be eligible and would take 2-3 years to ramp up. Enrollment has far exceeded expectations.

• Reached 400,000 within 6 months; Reached 600,000 in first year

• Budgeted at over $3b additional funding for health care

• Expected to provide relief to hospitals (emergency rooms) for “free care”
Healthy Michigan: PIHPs

- Expected to have higher prevalence of SUD
- DCH was able to get CMS approval for all the B3 services and an enhanced SUD benefit.
- Psychiatric hospitalization in a free-standing psych hospital (IMD) is NOT a covered benefit
- Mild- moderate MH needs to be served by Medicaid Health Plans
- Estimated 10,000 former ABW and 35,000 former CMH GF persons would be enrolled
- CMH GF reduced by 59% (FY15) – assumes almost 2/3 of CMH GF spending was on persons who would qualify for HMP
Healthy Michigan Rates 2014-2015

• Governor had originally proposed $436m for the MH/SUD Healthy Michigan Benefit for FY15. Assumed close to full enrollment. This gives a pmpm at $85. House/Senate fiscal staff indicated they thought this was adequate.

• Fy14 -- ABW was $15 for SUD and $53 for MH/DD = $68

• Medicaid averages $286 for DABs pmpm, and $87 for DABs and TANF

• DCH decision to operate like Medicaid rather than ABW, mild/moderate MH needs to be served by MHPs. Results in funding at $255m (net of taxes) in FY15. At average 425k enrolled, gives $40 pmpm
Healthy Michigan Rates 2014

- Initial draft rates were $30 (MH) and $5 (SUD) with $5 for adverse selection/ramp up. Ie at the $40 pmpm level suggested by Fy15 Executive Budget. A PIHP work-group informed DCH that many of the actuary’s assumptions were incorrect: Not like TANF, no SUD benefit in MHPs, SUD not strong in Medicaid base, CDPS does not apply well to PIHP services, etc
- For 2014 however there is a huge ramp-up problem with significant adverse selection ie most needy, including CMH consumers signing up first
- Rates were implemented at close to former ABW levels ($53 MH and $17 SUD)
- DCH also provided for retro-enrollment payments to occur in Fy14 to offset the loss of GF and the adverse selection in these first 6 months
- Enrollment reached 400,000 by end of September – much higher than actuarial assumptions. Impacts penetration rate assumptions
- Most PIHPs land up with large HMP surplus at end of Fy14
- NOT clear how those surpluses can be managed in Fy15 and beyond
Healthy Michigan Rates 2014

• HM Rates
  – Adjusted for adverse enrollment during ramp-up
  – Based on TANF patterns reported by PIHPs
  – Will bring in persons on commercial insurance – will have lower prevalence
  – Added 10% for additional SUD benefits
  – 6.75% admin load
  – 1% claims tax

• Cert letter indicates separate risk corridor for HM
Healthy Michigan in FY15

• Enrollment still trending up at 10k per week – same trend line as in FY14. Not sure where they are all coming from
• PIHP HMP rates were reduced by 30% for FY15, assumed average per month of 445k eligibles payments
• Initially DCH wanted to let PIHPs co-mingle risk with Medicaid. CMS has not allowed that – ie HMP funding cannot be used for Medicaid; can go the other way
• Risk arrangement is still not clear
• The initial FY15 30% rate reduction was a challenge, but the offsetting enrollment trend is likely resulting in unspent HMP, which may have to be returned to feds
• Likely will see FY16 rates reduced, though enrollment/use trend is very unstable.
• SUD use started very slow (since Block Grant still available) – is now picking up in FY15
HMP Impact on Medicaid

- There has been an erosion of Medicaid enrollment with persons shifting to HMP
- DABs – primarily young adults (former foster care). This creates significant funding loss to POHPs ($250 pmpm vs $37)
- TANF has decreased by 20%, with some of those adults shifting to HMP. Here the HMP rate is better than TANF rate
HMP – rest of FY15 and into FY16

• ROLLER COASTER
• Will the enrollment trend flatten?
• What is the lag between persons getting insurance and recognition that they have mental health and SUD need?
• How much will rates reduce?
• How much savings will the hospital system garner?
• GOOD NEWS 600,000 adults now have insurance. Michigan uninsured adults at about 4%, down from 10%
• Over $3 billion added to Michigan’s health care economy
• Every dollar spent on health care has a major economic ripple
• What will happen after Fy16 when states can opt out of Medicaid expansion?
• PART FIVE: The Future for Michigan’s Specialty Services and Supports
PIHP Environmental Scan: Immediate Issues

- PIHP specialty Waiver status – not clear
- Continuing issue with B/B3 cost effectiveness
- Note – expanding C-waiver as an option – 3000 person not in C currently. Would shift $150m out of B3. Creates a more level playing field between B/B3-DABs and C-waiver
- FY15 is 4th year of a 2-year waiver cycle
- DCH exploring waiver options – eg 1115 mega-waiver that combines existing B/B3 and C
- Medicaid Health Plan RFP – to be issued soon for 2016. Will anchor on Prosperity regions. Unknown re other changes in scope
PIHP Environmental Scan: FY16 and Beyond

• Integration – one stop shopping/ one MCO
• Integration/coordination – health care needs of CMH consumers
• Can the specialty carve-out be sustained?
• Dual eligibles – Medicare/Medicaid: CMS demonstration sites. Michigan – Blended funding at ICO; Bridge; PIHP as subsidiary
• Carve-in construct
PIHP environmental scan - continued

• DCH 10 prosperity regions – don’t match PIHP regions
• PIHP regional structure (in the beginning n=49, went to 18, went to 10) – added layer vs more consistency
• PIHPs hybrid – county, Authority, 204b regional entity
• Public Governance – local accountability benefits vs privatization
• Shared Risk vs Full Risk – advantages and disadvantages
PIHP environmental scan - continued

• Home and community based rules – implications for living arrangements and day-time activities
• Wages for CMH consumers
• Autism expansion – who, what and how funded
• Funding trend will not match demand trend – aging of CMH population
What to watch out for Fy16 and Beyond

• Reduce number of waivers in 2016
• Regional alignment and MHP regions
• Flat eligibles, increased demand
• Changes to affordable care act (HMP impact)
• Better health care for CMH consumers
• Pursuit of values of community inclusiveness
• Peers and recovery models of practice
• Choice and self-directed services/supports
Advocacy

• Nothing about us, without us
• Need to hear the voices of those impacted
• Benefits of a carve out – can/how they be factored into an fully integrated health care system
• CMHSPs serve over 250,000 persons per year, including spending GF on over 100,000 persons in Fy13 – not all of them obtained insurance or the right insurance for their needs. They deserve a functioning Community CMHSP safety net – or else they will land up in the prisons/jails and homeless.
THANKS

Many persons have been instrumental in the evolution of Medicaid within the CMHSP system:

- Ben Censoni
- Jim Sims
- Pat Barrie
- Bill Harrison
- Bev Hammerstrom
- Susan Lawther
- Judith Taylor
- Jim Haveman
- Bill Allen
- Marilyn Hill
- Rich Visingardi
- Jeff Patton
- Shirley Johnson
- Judy Webb
- Steve Fitton
- Tom Watkins