

State Notes

TOPICS OF LEGISLATIVE INTEREST

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Proposed Integration of Michigan Medicaid Behavioral and Physical Health Services **By Steve Angelotti, Associate Director**

Introduction

In fiscal year (FY) 1998-99, the State shifted to a managed care model for Medicaid behavioral health services. Those services have been provided by Pre-paid Inpatient Health Plans (PIHPs), which are groupings of local Community Mental Health boards (CMHs).

The State also moved, over several years before FY 1998-99, to a managed care model for Medicaid physical health care, generally delivered by Medicaid health maintenance organizations (HMOs).

Michigan's approach, in which Medicaid behavioral health services are delivered separately from Medicaid physical health services, is known as a "carve-out"; i.e., the Medicaid behavioral health services are "carved out" from the rest of Medicaid services. Many states have moved to a more unified model, in which managed care entities handle both physical health and behavioral health.

Governor Snyder's FY 2016-17 Department of Health and Human Services (DHHS) recommended budget included new boilerplate language, Section 298. This new section would mandate that funding and services currently provided to and by PIHPs be transferred to the Medicaid HMOs by the end of FY 2016-17. The language includes provisions that would require stakeholder development of what has been called the "integration plan" and require reports on the implementation of the integration plan. It also would require the Medicaid HMOs to contract with existing CMHs to provide specialty services and supports.

The Governor's Section 298, if implemented as written, would shift over \$2.3 billion in full-year funding from the PIHPs (which would effectively no longer exist) to the Medicaid HMOs. Because the implementation likely would not take place until late in FY 2016-17, the full shift of funding would not occur until the FY 2017-18 budget.

The proposal has met with considerable controversy, with strong opposition from many Medicaid behavioral health providers and recipients. The Snyder Administration began to back away from the language as written and formed a large workgroup, involving all major actors, to discuss approaches to integration.

Both the House and Senate Appropriations Subcommittees on the DHHS budget chose not to include Section 298 as written by the Governor in their respective FY 2016-17 budget proposals. Instead they included language supporting the efforts of the workgroup.

The issue of integrating care is still salient due to the workgroup. This article will provide a background on how the State reached this point and explore some of the side issues involved, such as the concept of "privatization", the concerns about Medicaid HMOs' lack of experience with the affected populations, and what may happen over the next few months.

Background – Reasons for the Move to Managed Care

The vast majority of Medicaid clients receive their services via a managed care model. Over the years, the delivery of most health care services has shifted from a fee-for-service model to managed care.

Under fee-for-service, a person obtains health care services, such as a doctor visit, a hospital stay, or a prescription, and the provider bills the person's insurance company (or bills the person himself or herself if the person is uninsured). The insurer reimburses the provider the insurer's going rate for the given service (for instance, \$50 for a routine physician office visit, \$3,000 for a cardiac catheterization, or \$20 to fill an amoxicillin prescription).

In the case of fee-for-service Medicaid, this meant that the State's Medicaid program played the role of fee-for-service insurer. Therefore, after a Medicaid patient visited a doctor, the doctor would bill Medicaid, and the Medicaid program, assuming the billing was determined to be legitimate, would reimburse the doctor at the Medicaid payment rate for the given service.

The fee-for-service model theoretically puts cost risks on the insurer (such as Medicaid) and effectively puts all responsibility to control costs on the insurer as well. Insurers reimburse any legitimate provider for a legitimate claim, so there is limited leverage in negotiating payment rates with providers.

Over time, a new model known as managed care began to emerge. Entities called health maintenance organizations became prominent in the health insurance field. There are three key aspects to managed care that affect delivery of and payment for services as described below.

First, the HMO assumes most of the financial risk. In other words, the employer or program contracting with an HMO pays the HMO "capitation" payments for each employee, employee dependent, or recipient served. The capitation payment is determined based on the projected costs for a person. (For instance, there may be a specific capitation payment for a man between ages 18 and 25 and a different one for a woman between ages 55 and 64, based on actuarially determined average health care cost estimates; total payments are based on the number of people enrolled and their age/gender demographics.) The HMO receives money for the people it covers; then, the HMO handles reimbursement of health care costs and effectively assumes the risk of costs (within negotiated limits). Since HMOs have a strong incentive to limit costs, it is believed that they work to root out inappropriate services as well as fraud. They also face financial risk in case some people incur higher-than-expected costs.

Second, HMOs create provider networks. By creating networks of individual providers (i.e., doctors) and institutional providers (hospitals), HMOs are able to reduce costs. Costs are reduced because an HMO can negotiate with the providers seeking to be part of its network. The key is that the network does not include every provider in a given area. If a provider is an oncologist, for example, and a person knows that the provider is "in network" with a major HMO, while others are not "in network", the provider is likely to get more patients from that HMO insurer than under a fee-for-service model. Having more patients means that average fixed costs for the provider are reduced, so overall reimbursement to that provider may be lower without the provider being any worse off. This leads to cost restraint.

Third, HMOs, due to their rational self-interest in restraining costs, tend to be more aggressive in finding methods to reduce costs. These methods include utilization review, an emphasis on preventive care, and incentives to ensure that individuals use the most effective care.

Michigan and Medicaid Managed Care

Michigan's Medicaid program covers all health care costs but it has long been split into two realms: physical health and behavioral health (behavioral health being a catchall term to describe mental health and substance abuse services).

For decades, the Medicaid physical health services were provided mostly via a fee-for-service model through mostly private providers (whether individual providers or institutional providers). There was a relatively small HMO line item in the budget for those who voluntarily opted to be in a Medicaid HMO, but managed care represented perhaps 3% of total Medicaid spending.

The Medicaid behavioral health services were provided on a fee-for-service basis through the local county-run Community Mental Health boards. A CMH, just like a doctor or a hospital, would provide a Medicaid-covered service to a Medicaid client and bill the State for reimbursement. Community Mental Health boards also would contract with doctors and hospitals to provide mental health services and reimburse them, so they did act somewhat like an insurer.

In the late 1990s, the State sought and received a Federal waiver and began to move toward mandatory physical health managed care for most Medicaid clients. The State sought bids from private HMOs and other private managed care entities. (Some hospitals set up "clinic plans" that were HMOs by another name.) The State began to enroll the majority of Medicaid clients into managed care for their physical health needs. This meant that the State was contracting with private, often for-profit, HMOs to provide Medicaid services.

Only a few populations were exempt from mandatory Medicaid managed care for physical health - those exempt were generally clients who had other insurance (such as people who were dually eligible for Medicare and Medicaid, that is, low-income mostly elderly people). Also exempt (until recently) were pregnant women. People who had enrolled in Medicaid but had not yet chosen or been assigned to an HMO also were covered on a fee-for-service basis until enrolling in an HMO.

This process had a number of fits and starts, but eventually things began running smoothly and most would agree that the Medicaid physical health managed care program in Michigan has been a success, with restrained cost growth, fairly high levels of client satisfaction, and relatively few controversies. The fact that these HMOs are private and many are for-profit has not been controversial, at least not for well over a decade.

In 1998, the State also moved to shift behavioral health services to a managed care model. In this case, there was no attempt to bid out the services to private HMOs. The behavioral health services were "carved out" from regular Medicaid and contracted to a separate group of providers.

The State directed that groupings of multiple CMHs boards and some large individual CMHs, called Pre-Paid Inpatient Health Plans, serve as the managed care entities for Medicaid behavioral health. The groupings of CMHs were deemed necessary by the Federal government because some CMH boards covered such small populations that their fixed costs would be rather high. At first there were 18 PIHPs (compared to the current 46 CMH boards); at present there are 10 PIHPs.

It should be noted that much of the PIHP spending is not for "typical" health care services. Probably 40% is for services for the developmentally disabled, in particular group homes and day services. These are not services that are typically provided by "regular" health insurers such as HMOs, even ones that cover mental health, because the developmentally disabled population for regular health insurers is very small. Similarly, the PIHPs spend a lot of money on services for the severely mentally ill, another population that is not very prevalent in regular health insurance, as the severely mentally ill tend to have little or no income and usually are on Medicaid.

Another unusual feature of the intersection of Medicaid physical and behavioral health in Michigan relates to psychiatric visits. The first 20 visits to a psychiatrist are paid by a client's physical health Medicaid HMO. Only after that point does the PIHP pick up the cost.

In 2002, the Engler Administration had to re-bid the Medicaid managed care behavioral health services. At the Federal level, the Bush Administration argued that private behavioral health managed care providers, that is, behavioral health HMOs, had to be allowed to bid to provide services. There was strong opposition from the PIHPs and many in the mental health community. Eventually, the Engler Administration negotiated a revised waiver with the Bush Administration that allowed the current PIHPs the "right of first refusal". In other words, the PIHPs would get contracts unless they chose not to participate or unless they were judged unqualified to provide services. To this point, no PIHP has refused the contract and none has been judged unqualified, so Medicaid behavioral health managed care services have continued to be provided by quasi-public PIHPs.

The Present Situation

The public behavioral health system in the State is composed of Medicaid and non-Medicaid services. The PIHPs handle Medicaid services. The CMHs handle non-Medicaid services, which include services to populations not eligible for traditional or expansion Medicaid and services that are not covered by Medicaid (jail diversion and 24-hour wrap-around services, among others). About 96% of the behavioral health budget is Medicaid, with only 4% or about \$117.0 million allocated for non-Medicaid services.

There has been talk over the years, even since the Engler-era rebid, of allowing private entities to bid to provide Medicaid behavioral health services. There have been other entities, in particular the Medicaid HMOs, that have sought to broaden the spectrum of services provided by those HMOs to include behavioral health. Other states have implemented this approach; California did so in 2014, for instance, effectively ending the "carving out" of Medicaid behavioral health services and unifying Medicaid managed care services under one umbrella.

Section 298

Boilerplate Section 298, in the Governor's proposed FY 2016-17 Department of Health and Human Services budget, would direct that the behavioral health carve-out be ended and that the HMOs assume responsibility for all Medicaid managed care services. Section 298 would require the DHHS to transfer responsibility and financing for Medicaid behavioral health services from the PIHPs to the Medicaid HMOs before the end of FY 2016-17. There were some protections built into the language, in particular a requirement that the Medicaid HMOs still contract with the CMHs for specialty services (such as services to the developmentally disabled). The language also would set up a workgroup of interested parties to iron out details.

Left out of the language is any provision for legislative oversight subsequent to implementation of Section 298. The way the language is written, the Administration could transfer authority and funding from the PIHPs to the HMOs at any point in FY 2016-17. Due to past Attorney General Opinions on separation of powers, all the Legislature would be able to do is change the language to require subsequent legislative approval during FY 2016-17 via a supplemental bill, which could be vetoed.

Discussion

The pro and con arguments are both about outcomes (the long-term outlook for services) and process (the approach being suggested by the Administration). There are also concerns about "privatization" and issues concerning the practicality of the proposed approach.

Outcomes

Effectively speaking, the Administration's proposal would eliminate the role of the PIHPs before the end of FY 2016-17. Their funding and responsibilities would be transferred to the Medicaid HMOs. This would be a rapid changeover, with no pilot programs to work out any kinks and no ability for the Legislature to slow down the process once it started.

The obvious concern is whether recipients would be better off under this new approach. How would continuity in services and, in particular, continuity in service providers and even medications be protected? How would the most unique and costly behavioral health populations, the developmentally disabled and severely mentally ill, be served under the proposed setup? While there is discussion of workgroups and protections in Section 298 (and required contracting with CMHs for specialty services), the transfer of funding and responsibility would have to occur whether or not the workgroup addressed protections to all parties' satisfaction.

On the other hand, there are concerns that the current system does not coordinate care: that people facing both behavioral health and physical health issues have to go through two different doors to receive services. The issue becomes more confusing because some behavioral health services are covered by Medicaid HMOs (the first 20 psychiatric visits per year) or fee-for-service Medicaid (since many behavioral health medications are reimbursed on a fee-for-service basis). Thus, coordination of care, which is one of the strengths of the physical health managed care approach, is more difficult to achieve for Michigan Medicaid clients receiving behavioral health care. Transferring responsibility to one managed care entity could help increase coordination of care.

Process

As indicated above, the proposed process is basically a carte blanche approach. The Administration would decide when the conditions had been satisfied; the Administration also would have to transfer funding and responsibility before the end of FY 2016-17 whether or not all concerns had been addressed. There would be no process for piloting the proposed approach to work out any potential pitfalls. There would be no ability for the Legislature to weigh in if there were problems, other than through boilerplate in a supplemental bill repealing Section 298. Therefore, the approach would require a lot of trust in both the Administration's good intentions and in its ability to implement the proposal.

The Use of the Term "Privatization"

The term "privatization" is generally used to describe a process in which public entities provide services through contracts with -- or reimbursement to -- private sector providers. For instance, trash collection may fairly be described as "privatized" if a city contracts with a private firm to provide the service.

Opponents of Section 298 state that the proposal would lead to the "privatization" of Medicaid behavioral health services, due to the transfer of such services from quasi-public entities like PIHPs to the private Medicaid HMOs. Opponents also note that some of these private HMOs are for-profit HMOs; thus, their argument is that Section 298 would "privatize" government-funded services by transferring them to entities, some of which are for-profit.

This discussion is a matter of semantics, however, because *Medicaid already is a heavily privatized program*. Even in the fee-for-service era, Medicaid was effectively a largely privatized program. The State does not employ doctors to provide Medicaid services; instead, it reimburses mostly private doctors who see Medicaid patients. The State has not built State hospitals to provide physical health care to Medicaid patients; instead, it reimburses mostly private hospitals to provide such care. This was true under fee-for-service and it continues to be true under managed care. Furthermore, many CMHs and PIHPs themselves contract out services to private entities, so they engage in "privatization" themselves.

Other Practical Issues

The issue of experience is ambiguous. On one hand, physical health HMOs, with either limited behavioral health experience or no experience with large numbers of severely disabled individuals, may or may not be capable of handling a large influx of developmentally disabled and severely mentally ill patients. On the other, the PIHPs may or may not be able to provide optimal care to populations with behavioral and physical health challenges.

Proponents and opponents also have brought up administrative costs, with opponents claiming that PIHP administrative costs are lower on a percentage basis than those of Medicaid HMOs, and proponents stating that any higher administrative costs are due to better oversight of expenditures and services. In reality, there is no solid rational way to compare Medicaid HMO physical health administrative costs to Medicaid PIHP behavioral health administrative costs; the two entities are covering a different array of services through different models for populations with differing needs. (While both physical health and behavioral health managed care entities cover the same Medicaid population, the behavioral health services are more strongly focused on specific disabled individuals.)

Conclusion

This discussion has provided an overview of the Section 298 controversy. In considering the proposal, it is important to start from first principles, especially regarding the evolution from fee-for-service medicine to managed care. That helps frame the discussion on the physical health and behavioral health sides of the equation.

The Administration is proposing a major change in how Medicaid behavioral health services are financed and delivered. The Legislature thus far has responded by rejecting the Administration's

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original proposal. The Administration has now moved to slow down the process and establish a workgroup that has been discussing approaches to possible integration of services.

Both the House and Senate DHHS Appropriations Subcommittees have included language in the budget bills supporting the workgroup but have explicitly rejected the key component of Section 298, the carte blanche authority for the Department to transfer responsibility and funding from the PIHPs to the HMOs before the end of FY 2016-17.

It is likely that the final FY 2016-17 DHHS budget will include language similar to the Subcommittees' language, with support for the workgroup but no authority for the transfer of responsibility and funding for behavioral health services.

Assuming the major actors (PIHPs, HMOs, behavioral health client advocates, the Administration, and the Legislature) reach some sort of agreement on an approach to integration, it is possible for such a proposal to be outlined in the Governor's FY 2017-18 budget in February 2017. This would allow for the precise details of the proposal to be examined and debated by the Legislature in the FY 2017-18 budget process. That approach would preserve the Legislature's role in accepting or modifying any integration proposal.