Macomb County Community Mental Health – Introduction

Macomb County Community Mental Health is a “stand-alone” Pre-paid Inpatient Health Plan (PIHP) under contract with the Michigan Department of Community Health (MDCH), serving Macomb County children and adults who present with mental illness (MI), developmental disabilities (DD), and substance use disorders (SUD). Approximately eighty-five percent (85%) of the Macomb PIHP financial support comes from Medicaid funding for the delivery of federal behavioral health services entitlements. Macomb PIHP provides MI, DD and SUD treatment and prevention services to approximately 30,000 consumers a year. This Position Paper discusses the State’s prior rebasing actions and current rebasing effort and indicates concerns with the latter’s potential damaging effects on consumers of Macomb PIHP Region 9 and the other Metro Region PIHPs.

Capitation Funding Overview:

The State of Michigan provides Medicaid funding to the Prepaid Inpatient Health Plans (PIHPs), including Macomb County Community Mental Health (Macomb PIHP Region 9), through a capitated, managed care system. This system design to support the financial funding was implemented in Fiscal Year (FY) 1999 as a mechanism to provide sufficient covered lives to manage risk, as well as to provide for some economies of scale in administrative and managed care functions. The State uses an actuarial firm, “Milliman”, to develop capitation rates, which are used to determine the amount of funding that is paid to the PIHPs.

Capitation rates are developed on a per member per month (PMPM) basis and vary by benefit “type” and program code. The benefit types include mental health, substance abuse, “b 3” and “c” waiver services. The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized under Section 1915(c) of the Social Security Act. The program enables a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver’s target population. Waiver services (“b 3” and “c”) complement and/or supplement the services that are available to participants through the Medicaid State plan; i.e., Inpatient Services, Crisis Services and what is known as the “Public Safety Net”, and other federal, state and local public programs that support consumers and families within the community.
The Center for Medicare & Medicaid Services (CMS) recognizes program code types that include 1) Aged, Blind, and Disabled (DAB), and 2) Temporary Assistance to Needy Families (TANF). Funding is based on the number of eligible individuals in each of these defined populations. A State geographic factor is applied to the capitation rates to take into account the differentials in costs depending on the geographic region of the County in which consumers receive services. These rates must be actuarially designed and approved each year by CMS. The State may propose to continue the previous year’s rates with adjustments for changes in the economy; however, minimally, every other year the State must rebase its rates.

**History of Rate Setting:**

As indicated above, the rate setting process was introduced with the advent of Managed Care in FY 1999.

At the time, rates were based on each PIHP’s historical spending patterns and regional differences. This allowed for continuation of funding levels, whereby all PIHPs generally received the same amount of allocated funds that they had received in the prior fiscal year; i.e., historical funding based on previous spending patterns. This funding formulary process continued until FY 2009 when the Department of Community Health decided that rates should no longer be based primarily on historical spending. Co-morbidity factors were introduced in an attempt to move from funding the PIHPs primarily on the basis of historical spending, to recognizing a revised funding strategy based on consideration of other variables which the State believed affected costs for each PIHP. These factors included population age/gender, services program codes and other variables. In FY 2010, a capitation model was developed that modified the funding formula process based primarily on historical spending, to a funding model that was based two-thirds on historical spending, and one-third on co-morbidity factors. In FY 2011, the State again modified the funding formula to a 50-50 distribution based on historical spending and co-morbidity. Currently, the State’s actuary is using co-morbidity factors to determine each PIHP’s capitation rates. These co-morbidity factors currently include population age/gender, program codes, dual-eligibility, prevalence of persons with Developmental Disabilities and/or Mental Illness, and the number of consumers with c waive eligibility. The final adjustment made to each PIHP’s capitation rates is the application of a geographic factor. This factor looks at the PIHP’s per member per month distribution and how that distribution compares to the Statewide average. The actuarial rates are then multiplied by this factor to determine the final capitation rates that each PIHP will receive.
Rebasing Plan – Fall of 2014:

It is anticipated and strongly expected that the Department of Community Health will again rebase PIHP rates in the fall of 2014. The State formed a workgroup earlier this year for which the focus is to identify additional morbidity factors that can be used by the State’s actuary to once again rebase PIHP rates. Numerous additional variables have been introduced and considered by the workgroup; however, final co-morbidity factors have not yet been relayed to the PIHP Behavioral Health System at this time. Macomb PIHP’s grave concern is that, in the State’s zeal to arrive at and set rebasing of rates based on a State average, the State will not give sufficient attention and weight to the regional variables that were previously acknowledged when differential regional funding was initially set with greater allocated funding levels particularly for the Macomb PIHP and the other Metro Region PIHPs. These variables consider the reality that the average level of consumer disability varies from region to region with a higher level in Macomb and the Metro Region than is present across the State and a greater need for more intensive services to be provided to these consumers. The per unit and per case costs of services also differs from region to region, with higher costs in the Metro Region due to required factors such as greater service needs per consumer, higher lease/real estate costs, higher cost of living/salaries of professional staff, etc. necessitating higher geographic funding adjustments. Inadequate consideration and attention to necessary geographic factor adjustments for the Macomb PIHP and the other Metro Region PIHPs will result in serious shortfalls in funds for the Metro Region as a whole.

Impact on MCCMH PIHP Region 9 and other Metro-Region PIHPs:

The actual dollar impact of this impending re-designed rebasing of capitation rates on Macomb PIHP Region 9 is unknown. Macomb PIHP has surmised that the intended effect of the State’s re-designed rebasing effort is to move PIHP capitation rates closer to the State average. In so doing, the State will likely remove additional significant Medicaid revenue from the Macomb PIHP and the Metro-Region PIHPs and transfer the funding into other PIHP regions across the State. The impact of such funding transfers is expected to reduce the Medicaid funding that the Macomb PIHP has had available to provide needed services to its densely populated County and decrease available funding to provide services for Macomb’s consumers. Macomb PIHP has already realized the negative impacts of the funding cuts made by the State on the General Fund population that came into effect on 04/01/14.
However, unlike the General Fund population, Medicaid beneficiaries, pursuant to the PIHP contract with the State, are to be assured the provision of the full array of federal health care entitlements as covered services within the Medicaid benefit package. Services cannot be eliminated or significantly delayed due to State funding cuts.

Macomb, as a Metro Region PIHP, must issue strong objections to this re-designed rebasing process and anticipated impending loss of funding to the PIHP along with a strong warning that any significant added Medicaid funding reductions as a result of capitation rates rebasing will seriously compromise the PIHP’s capability, per its contract requirements with MDCH, to maintain a substantial provider network to meet the behavioral health care needs and provide adequate care for its consumers. Continued Medicaid funding reductions will damage the PIHP’s and the provider network’s ability to retain a strong, competent direct care giver and professional workforce. Ultimately, reduced services and diminished quality of care with resultant loss of quality outcomes would be realized across Macomb County with deleterious effects on vulnerable/dependent consumers.

Conclusion:

Macomb PIHP Region 9 is not opposed to the necessary rebasing of capitation rates pursuant to CMS requirements. However, as previously stated, if there is significant decrease in funding for the Medicaid program based on the anticipated impending State rebasing of capitation rates with ultimate transfer of funds from Macomb PIHP and the Metro Region PIHPs to other PIHP Regions in the State in the attempt to arrive at a State average, it will critically undermine and seriously jeopardize the capability of Macomb PIHP Region 9 to provide the quality of needed behavioral health services for the consumers of the County. Macomb PIHP Region 9 implores the State to adequately consider and take into account the unique geographical factors of these densely populated areas, and the high intensity service needs (as determined to be medically necessary) of the consumers who reside within them, before taking precipitous actions that will be injurious to Medicaid consumers.

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