White Paper:

Potential Impact of the Final Rules for Medicaid Managed Care on the Washington Public Mental Health System

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This is a work in progress; we welcome your comments and additions. Please e-mail either of us (Dale@mcpphc.com, Barbara@mcpphc.com) with your thoughts.

The Medicaid Managed Care "Rule Book" has changed, bringing threats to the Washington State mental health system.

I. Why this White Paper?

In the last decade the Washington State mental health system has been operating under a set of "working assumptions" related to the State's Integrated Mental Health Services Medicaid 1915 (b) managed care waiver, including:

- Cost savings from the Medicaid managed care plan can be used to provide additional mental health services to state residents.
- Under managed care, added flexibility is available to help clients "get what they need", even if it doesn't fit into a defined service code.
- Recording and tracking every unit of service under managed care is not as important as focusing on service delivery.
- There is a fair amount of latitude in serving indigent, Non-Medicaid individuals, as long as the needs of the Medicaid population are being met.

In June of 2002, with the publication of the federal Final Rules for Medicaid Managed Care, a new "Rule Book" was created that turns these "working assumptions" on their heads and brings new and important challenges to the Washington mental health system. Specific threats include:

- Elimination of the ability to count any and all Non-Medicaid services in the calculation of future Medicaid payments from the Federal Government.
- Implementation of a Medicaid capitation rate setting process that is based primarily on the counting of historical services; if it wasn't recorded, it "didn't happen".
- Rules for the Regional Support Networks (RSNs) that include the same level of administrative and quality management standards as commercial health plans serving the medical care needs of the Medicaid population.
- Significant increases in the oversight of Medicaid managed care programs by the Federal Government's Center for Medicare and Medicaid Services.

The potential impact of these changes began to come to light during the 2003 Washington mental health actuarial study that was recently completed by Milliman USA. This white paper is an attempt to build on those efforts and provide background information, detail of the important changes, potential impact on the system, and suggestions for change.

II. Important Background

A brief history of how we got here.

Many, but not all mental health system stakeholders have a long history with the Washington state public mental health system. This section has been written as a quick refresher for long-timers and background for stakeholders who are newer to the system.

1. Title XIX of the Social Security Act

Medicaid is a joint Federal and State program developed in the mid-1960s.

In 1965 Congress established the Medicaid program as a joint Federal and State program to finance medical care to low income individuals. This program was established in Title 19 of the Social Security Act.

Under the Medicaid program, each State establishes its own eligibility standards, benefit packages, payment rates and administrative systems, and the Federal Government provides matching funds that vary from fifty cents on the dollar (18 states) to 77.08% (Mississippi).(1)

When the Medicaid program began, payments for healthcare services were made on a fee-for-service basis from the State Medicaid Authority to organizations and clinicians credentialed as Medicaid providers. Prior to 1982, 99% of all Medicaid enrollees received coverage through a fee for service program. A few exceptions included Washington State, which began a capitation contract with Group Health Cooperative in 1970, and Kaiser Permanente, which began serving Medicaid enrollees in three states through capitated contracts in 1972.(2)

Enrollment in Medicaid has climbed nationally from four million in 1966, shortly after the program began, to forty-seven million in 2002. Spending for the same period has grown from $400 million to $257 billion, an increase of 64,150% in thirty-six years! This has created an enormous burden on State and Federal budgets and has been labeled "The Perfect Storm".(3) This rapid growth has been due primarily to:

- Increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and economic recession
- Expanded benefits and greater use of services
- Increase in elderly and disabled persons requiring higher cost care
- Technological advancements, including new psychiatric medications
- Increase in payment rates to providers of health care services, when compared to general inflation (4)

Another change has been the extent to which state mental health programs have grown their reliance on Medicaid as a funding source, using increasingly larger proportions of their state general funds as

Medicaid match.

2. Medicaid Managed Care

Managed care has been used in the Medicaid program for over 20 years.

By the early 1980s it became clear that combining a fee-for-service mechanism with a Federal entitlement program (Medicaid) was a recipe for uncontrolled costs. At the same time managed care was becoming the vehicle for controlling costs in the commercial insurance marketplace.

This led to the expansion of Medicaid contracts with Managed Care Organizations (MCOs), where care was paid for on a fixed per member per month capitation basis and a variety of care and cost management strategies were used.

By 2002 more than 58% of Medicaid beneficiaries were enrolled in managed care arrangements [(5)] and there have been numerous studies that have supported the claims of improved access and quality and reduced costs.

3. Medicaid Managed Care Waivers

To facilitate the move to managed care the Federal Government in 1982 established a "waiver" process where states could become exempt from certain Medicaid regulations such as freedom of choice of provider. This was necessary for MCOs to operate their programs and contain costs.

Under these waivers States generally received Federal matching funds up to 100% of what has been previously paid in the fee-for-service system, plus adjustments for inflation, labeled the "Upper Payment Limit". States were then responsible for managing costs within a relatively fixed budget. If savings were realized, the State and the MCOs would be able to retain those funds, as long as the parties operated "within the rules" of the Medicaid waiver.

Two types of waivers were made available to States, 1115 Waiver Demonstration and Research Projects, and 1915(b) Freedom of Choice Waivers. As of 2002, 41 states and the District of Columbia have one or both types of waivers in effect. [(6)] About half of these states have behavioral health waivers.

4. Washington State's Medicaid 1915 (b) Waiver

Washington State moved the mental health program to Medicaid managed care in July 1993 with the implementation of an Integrated Mental Health Services Medicaid 1915 (b) waiver.

Section 1915(b) of the Social Security Act permits states to waive

Washington State implemented managed care in the Medicaid mental health system in 1993.

statewideness, comparability of services, and freedom of choice as a way of providing more flexibility to state Medicaid programs.

States obtain such a waiver by submitting an application to the Center for Medicare and Medicaid Services (CMS). Approved waivers are valid for 2 year periods, and can be renewed on an ongoing basis, if the State applies.

There are four 1915(b) Freedom of Choice Waivers:

(b)(1) mandates Medicaid Enrollment into managed care

(b)(2) utilizes a "central broker"

(b)(3) uses cost savings to provide additional services

(b)(4) limits number of providers for services

A 1915(b) waiver program cannot negatively impact beneficiary access, quality of care of services, and must be cost effective (cannot cost more than what the Medicaid program would have cost without the waiver).[7]

The current Washington waiver utilized Sections (1) and (4) of Section 1915(b) to mandate Medicaid enrollment in managed mental health care plans – the Regional Support Networks – and limit the number of providers for service.

5. MCOs and PHPs – Two Sets of Rules

For the first 20 years of the Medicaid managed care programs Prepaid Health Plans were exempt from many administrative and quality rules.

During this period of waiver submissions there were two flavors of managed care organizations. Those that provided full health care coverage including inpatient and outpatient services were called Medicaid Health Maintenance Organizations (HMOs), more recently relabeled Managed Care Organizations (MCOs). These comprehensive health plans were often associated with commercial insurance carriers such as Premera Blue Cross and Group Health Cooperative, or Medicaid focused carriers such as Molina. These carriers obtained accreditation from the National Committee for Quality Assurance (NCQA). The NCQA standards set a high bar for MCOs a decade ago, but now have become expected business practice.

Organizations that provided a more limited array of services, such as behavioral health or dental care, were classified as Prepaid Health Plans (PHPs). The Regional Support Networks in Washington, the Oregon Mental Health Organizations (MHOs) and the California County Mental Health Departments are all examples of PHPs.

Because of the more limited nature of PHPs the Federal Government chose to exempt those entities from many of the administrative and quality requirements in the Medicaid managed care regulations. This, in part, led to a substantial growth in PHP enrollment throughout the

country, especially in behavioral health, where many states have created behavioral health PHPs that have operated alongside Medicaid MCOs providing the medical care. In Washington State, the RSN PHPs were specifically exempted from meeting the insurance carrier requirements of the Insurance Commissioner.

Exemption resulted in a great deal of variation among PHPs in relation to how they implemented key managed care strategies in the areas of quality improvement, access to care, utilization management, credentialing, member rights and responsibilities, preventive health, and coordination of care.

6. The Balanced Budget Act of 1997

The Balanced Budget Act of 1997 was designed to save money in the Medicare and Medicaid programs and give additional flexibility to States.

The Balanced Budget Act of 1997 (BBA) was a bi-partisan effort to cut federal spending and balance the federal budget through a substantial rewrite of the Medicaid and Medicare program rules, with the goal of saving $130 billion over a five year period. Within the Medicaid program, the BBA was designed to cut $17.2 billion in federal spending and increase flexibility to the states, especially in their ability to implement and run Medicaid managed care programs.

The 537 page House/Senate BBA bill required significant rule-making and it wasn't until January 19, 2001 that the Clinton Administration issued the final regulations – President Clinton's last day in office. The following day the Bush Administration delayed the effective date of these regulations. In August 2001 CMS issued a new proposed rule and further delayed the implementation of the regulations. Finally, on June 14, 2002, five years after the BBA was passed, CMS issued the Final Rules for Medicaid Managed Care Programs. [(8)]

The BBA rules represent the first comprehensive revision to Federal statutes governing Medicaid managed care in over a decade and contain numerous and significant changes to the Medicaid system. Key changes relevant to this white paper include:

- Implementation of Medicaid Managed Care without a Waiver: Section 4701 of the BBA permits states to require Medicaid beneficiaries to enroll with a Managed Care Organization as a state plan option without a freedom of choice waiver. This rule was implemented in 1998, prior to the Final Rule, through the issuance of a State Medicaid Director letter. To date twelve states have taken advantage of this option, including four where this is their first foray into managed care (Maine, Mississippi, Nevada, and North Dakota). The 20 State Medicaid Director letters that were issued between the passing of the BBA and the issuance of the Final Rules were the only definitive guidance made available during this five-year period.

- Removal of Exemptions from Administrative Rules for many Prepaid Health Plans: The Final Rules significantly change the landscape for many PHPs, including the Washington State Regional Support Networks (RSNs), the Oregon Mental Health Organizations (MHOs), and the California County Mental Health Departments. This is discussed in detail in Section III of this White Paper.
- Repeal of the Upper Payment Limit and Implementation of Actuarially Sound Payment Rates: The Final Rules also make significant changes in how states calculate managed care payment rates and the corresponding Federal match. This is also covered in detail in Section III below.

7. Tensions between CMS and the States

Medicaid Block Grants and Federal implementation of the Balanced Budget Act are creating tensions with States.

There are two sets of tensions between CMS and the States that are relevant to this White Paper – the current push to Medicaid Block Grants, and CMS Regional Office implementation of the Final Rules.

Laura Hermer from the University of Houston's Health Law Policy Institute published an article in April 2003 entitled, *Medicaid Block Grants: The Bush Administration Plays Hardball with Cash-Strapped States*.(9) The article describes how the current administration is attempting to provide financial incentives to States to block grant Medicaid funding and thus fix the Federal obligation to the program and remove the entitlement nature of Medicaid. This would shift the risk of covering an aging population to the States and Hermer suggests that, "Bush's proposal for Medicaid offers states short-term relief at enormous – and unreasonable - future cost." As of this writing, debate continues on the subject and Governors appear disinclined to accept the proposal.

As the CMS Regional Offices have worked with States to implement the Balanced Budget Act Final Rules significant tensions have arisen, especially in Washington State, which is in the process of renewing a number of its managed care waivers.

A press release being issued by the Washington Department of Social and Health Services describes several reversals, delays and rejections of Medicaid State Plans and waiver renewals.(10) Local newspaper articles have described how CMS has threatened to cut off between $2.4 and $3 billion in Federal Medicaid funds (11) and DSHS has confirmed that these funds may be at risk. In an attempt to resolve the problems, DSHS has asked the Washington State congressional delegation to intervene.

At this writing it is not clear how much of the difficulty is due to Washington having fallen out of compliance with the new BBA Final Rules, inappropriate and overly rigid CMS Region X interpretations, or a planned effort on the part of the current administration to "encourage"

States to move into Medicaid Block Grants, which will bring decreased regulation, but increased financial risk to the States.

It is important to note that the concerns expressed by DSHS in the press release are in addition to the risks identified in this White Paper, but need to be factored into the overall analysis and resulting action steps.

III. Digging into the Final Rules

To gain a true understanding of the opportunities and threats facing the Washington State public mental health system it is important to dig beneath the surface and analyze the BBA Final Rules and their implications for the system. This section takes a targeted approach to this task by reviewing a handful of the Final Rules.

1. PIHPs and PAHPs replace PHPs

Terms have changed: RSNs have now become PIHPs.

The Final Rules create two forms of prepaid health plans – Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). As the names suggest, PIHPs manage inpatient and outpatient care; PAHPs do not. Both have risk contracts with the State that do not cover comprehensive medical services to enrollees.

PAHPs, like their predecessor PHPs, are exempt from many requirements of the Final Rules. PIHPs, on the other hand, have been essentially placed on par with the comprehensive MCOs and must comply with a substantial number of rules from which they had previously been exempt.

Because the Medicaid mental health plans in Oregon, Washington and California all carry inpatient risk they are now considered PIHPs and are now required to look and act like true health plans and comply with detailed regulations related to:

- Enrollee Rights and Protections (Section 438, Subpart C)
- Quality Assessment and Performance Improvement Standards (Section 438, Subpart D)
- Grievance System (Section 438, Subpart F)
- Certification and Program Integrity (Section 438, Subpart H)

While these items have similar headings found in current contracts between the State of Washington and the Regional Support Networks, there is a much higher level of Federal specificity related to the regulations and the protocol for monitoring compliance.

2. State Mental Health Division Obligations

The Centers for Medicare and Medicaid Services now plays a larger role in managing and monitoring RSN contracts and performance.

Contracting with Regional Support Networks

The Final Rules specify that the CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts. A lengthy "CMS Checklist for Managed Care Contract Approval" must be used to determine whether the contracts comply with the Balanced Budget Act regulations.

A review of a recent Checklist identified 230 items that must either be in the contract with the PIHP (RSN) or in an accompanying document that is legally binding on the RSN.

The Washington Mental Health Division has been meeting with CMS on this issue since September 2002 and as of late August 2003, CMS has not approved the 2003 – 2005 RSN contracts, which had a July 2003 start date. What this means for RSNs and provider organizations is that the Federal share of the Medicaid dollars has not been obligated. (10)

Monitoring Regional Support Network Compliance

In February 2003 CMS issued "Monitoring Medicaid Managed Care Organization (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR parts 400, 430, et al."

Following up on the contract requirements, the protocol is a 254 page document that is required "to be used in independent, external reviews of the quality and timeliness of, and access to, care and service provided to Medicaid beneficiaries"(12) by Regional Support Networks.

Combined, the contract checklist and monitoring protocol provide insight into a much higher level of Mental Health Division and RSN performance expectations than existed in the past. Important items are described in the following sections.

3. What do the Contract Checklist and Monitoring Protocol Tell Us?

The following items highlight three important new contract requirements for Regional Support Networks.

Adequate Provider Capacity

42 CFR 438.206(b)(1): Delivery Network

The contract must require that in establishing and maintaining the network, the entity must consider the following:

New rules require a stricter analysis and documentation of whether an adequate number of providers are available to meet the needs of Medicaid enrollees.

the network, the entity must consider the following:

(a) The anticipated Medicaid enrollment,

(b) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP,

(c) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services,

(d) The numbers of network providers who are not accepting new Medicaid patients,

(e) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

42 CFR 438.207(b) Documentation of adequate capacity and services

The contract must require that the entity submit documentation to the State to demonstrate, in a format specified by the State, that it

(1) Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

While these two items appear straightforward, the only way that the RSNs can demonstrate they are in compliance with the requirements is to develop and complete a population-based study for projecting the service needs of the Medicaid enrollees, comparing those needs against the capacity of the provider network, and taking steps to fill the gaps. While this type of work is done routinely at MCOs and commercial health plans, it is a sophisticated set of activities not now carried out by most Washington State Regional Support Networks (RSNs), the Oregon Mental Health Organizations (MHOs), and the California County Mental Health Departments. Most providers in these systems are also not accustomed to participating in these processes.

New rules increase the quality monitoring and reporting requirements including the use of an External Quality Review Organization for collecting and auditing RSN performance data.

Quality Assessment and Performance Improvement Program

42 CFR 438.240 Quality assessment and performance improvement program

(a) General rules. (1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(2) Submit performance measurement data as described in paragraph (c) of this section.

(3) Have in effect mechanisms to detect both underutilization and overutilization of services.

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Again, this may seem to be an extension of previous contract requirements regarding RSN Quality Plans, but it is the detailed review that changes the level of expectation. The protocols state that the site reviewer must review the Performance Improvement Projects (PIPs) initiated, in progress or completed during the review year, including the design, methods, analysis and results of each PIP using a validation protocol. External Quality Review Organizations (EQROs) may be used to conduct compliance audits of selected performance measures for all contracted MCO/PIHPs. This validation process includes a review of the MCP/PIHP information and reporting systems as well as evaluation of the methodologies for calculating performance measure rates. ERQOs may also be used to review the PIPs described above. MCOs that have NCQA accreditation have worked with these outside vendors as a part of submitting their HEDIS data. This will be a new step for Washington State Regional Support Networks (RSNs), the Oregon Mental Health Organizations (MHOs), and the California County Mental Health Departments.

Each PIHP must adopt at least two clinical practice guidelines in order to comply with the new rules.

Practice Guidelines

<u>Sec. 42 CFR 438.236(b) Practice guidelines</u>

Each contract must require an MCO and when applicable a PIHP or PAHP to adopt practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

(2) Consider the needs of the enrollees;

(3) Are adopted in consultation with contracting health care professionals; and

(4) Are reviewed and updated periodically as appropriate.

The protocol provides important additional detail by stating that each MCO/PIHP "should have adopted at least two practice guidelines in order to comply with this requirement" that are "based on a review of valid and reliable clinical evidence or a consensus of health care professionals in the particular field."[13] This is a significant new requirement that will need to be integrated with the development of Evidence Based Practices and will require substantial effort within each Washington State Regional Support Network (RSN), the Oregon Mental Health Organizations (MHOs), and the California County Mental Health Departments.

While this section contains only three out of the 230 contract items, it helps illustrate the new "expectation" that mental health authorities become sophisticated managed care systems that engage in true population based planning, have rigorous quality improvement standards, utilize evidence based practices, and have processes in place to document and monitor these activities.

4. Medicaid Financing under the BBA

The Final Rules include a very important change in the Federal financing of Medicaid managed care programs - the repeal of the <u>Upper Payment Limit</u> (UPL), replacing it with the requirement for States to set <u>Actuarially Sound Capitation Rates</u>.

Many States have considered the Upper Payment Limit a double edged sword. On the one hand they were "guaranteed" 100% of the inflation-adjusted funding that they had received under the old, fee-for-service systems, even if they were able to achieve cost savings. But States that had either done a good job managing costs in the old system, or had

systematically underfunded the Medicaid programs were "stuck" at the old levels, regardless of the needs of the Medicaid population.

Prior to the release of the Final Rules CMS received comments from 387 entities including States, national and State organizations, health plans, advocacy groups and individuals, many of which focused on the rate-setting provisions.[14] Nearly all commenters expressed strong support for replacing the Upper Payment Limit with an actuarial process. CMS had been working for several years to move away from the UPL and characterized this feedback as a "broad consensus" in support of this change.[15]

From late 2002 to mid-2003 the actuarial firm, Milliman USA, completed such an actuarial study for the Washington State 1915(b) Medicaid mental health waiver. Many details of how such a study is completed were clarified through this process and several stakeholders became concerned that this requirement would have the effect of putting the Washington State mental health system into a "death spiral". Both concerns and opportunities are described below:

Non-Medicaid costs cannot be included in the actuarial ratesetting process.

Concern: Non-Medicaid Costs

In an actuarial study that was completed for the DSHS Mental Health Division in the mid-1990s the State was successful in including Non-Medicaid costs in the study under an indigent-care category, which had the effect of raising the Medicaid rates. Consistent with this approach, the Division promoted the theory that was described in a State Medicaid Director letter issued by CMS in June 1998.

> *" when a capitated payment is made to an MCO or a PHP, the entity is required to meet contractual obligations to serve Medicaid beneficiaries within the money provided, and that except for limits that may be set on allowed profits (in for-profit entities), the MCO or PHP can use its savings as it wishes. In effect, it is no longer "Medicaid money." In fact, should an MCO or PHP voluntarily choose to serve people who are not Medicaid eligible, it is free to do so. However, we believe it is not appropriate for the State Medicaid agency to require in its contracts with an MCO or PHP that savings from capitated payments be used to provide health services to individuals not otherwise eligible for Medicaid."*

Washington State has followed this guidance in contract development with RSNs, but at the same time created a difficult situation by requiring RSNs to serve "priority populations", regardless of their Medicaid status, without providing dedicated funding for the Non-Medicaid individuals in those populations. Further, there has been no definition of what it means to first "meet the needs of the Medicaid population". Among

Washington's RSNs there is considerable variation in the Medicaid penetration rate (the percent of Medicaid enrollees seen by the mental health system). Nationally, in the early 1990s, a consensus white paper suggested that 10% should be the target for managed behavioral healthcare organizations holding statewide contracts.

The Final Rule's Ratesetting Checklist addresses this issue head-on by stating unequivocally that services to Non-Medicaid individuals and Non-Medicaid-approved services to Medicaid enrollees must be removed from the utilization and cost data used in the study. Although the CMS interpretation in the 1998 letter has not changed, only the costs of Medicaid-approved services to Medicaid enrollees can be used in setting upcoming rates. Thus, if RSNs use their "excess funds" to serve Non-Medicaid individuals they are, by definition, reducing the rates they will receive in future contracts; thus the origin of the term "death spiral". (Note: A rough outline of the actuarial study steps listed in the Ratesetting Checklist can be found in Appendix A.)

There is concern about whether all of the SAMHSA evidence based practices will be covered by Medicaid funding.

Concern: State Plan Services Only

The Final Rule's Ratesetting Checklist further states that States must document that the actuarially sound capitation rates can only include services covered in the State Plan.[16] State Plan services are those service codes a State has included in the "benefit package" to Medicaid enrollees and which have been approved by CMS.

During the Milliman USA study there was much discussion about services that were excluded because they were either not in the current State Plan and/or were generally not covered by the Medicaid program. For example, Medicaid does not pay for residential care, vocational rehabilitation, and certain types of inpatient care. As of this writing CMS has not approved the Washington State waiver renewal, partly because of CMS' non-acceptance of service codes that the Mental Health Division considers important to the State Plan.

Related concerns have been raised about whether CMS will cover the Evidence Based Practices (EBPs) that have been developed by a sister agency, the Substance Abuse and Mental Health Services Administration (SAMHSA). At a recent conference of the National Association of State Mental Health Program Directors, Glenn Stanton, Deputy Director, Center for Medicaid and State Operations, CMS, gave a resounding "MAYBE" to the question of whether Medicaid will pay for EBPs. As many State Medicaid Programs move to adopt these practices the concern that Medicaid may not cover portions of the Family Psycho-social Education and Supported Employment EBPs, in particular, create concern.[17]

Concern: Allowable Services will not be Properly Captured and Counted

Under a system that uses actuarial approaches to set RSN capitation rates, if a service has not been properly recorded at the provider agency, accurately transmitted to the RSN, and then submitted and accepted by the Mental Health Division's data system, the service "did not occur".

This is in direct conflict with day to day practices that arise from the current Washington State mental health financing system, which doesn't require the submission of service data as a condition for payment. RSNs are paid on a capitation basis and providers are paid in a variety of non-fee-for-service methods. There is indeed the risk that a substantial number of allowable services will not be accurately recorded by clinicians, or if they are recorded, will not make it into the state data system, resulting in their not being counted as part of the historical utilization in the actuaries' Base Year Data. This will result in capitation rates that are below the actual historical utilization.

The Final Rules create a significant opportunity to fund mental health services based on an assessment of the needs of the Medicaid population.

Opportunity: Actuarially Sound Utilization Adjustments

The Final Rule's Ratesetting Checklist describes the standard actuarial procedure related to adjustments of historical utilization data based on the States' mental health system design.

> *"These adjustments increase or decrease utilization to levels that have not been achieved in the base data, but are realistically attainable CMS program goals. States may pay for the amount, duration and scope of State plan services that States expect to be delivered under a managed care contract. Thus, States may adjust the capitation rate to cover services such as EPSDT or prenatal care at the rate the State wants the service to be delivered to the enrolled population. The RO should check to ensure that the State has a contract clause for using mechanisms such as financial penalties if service delivery targets are not met or incentives for when targets are met."*[18]

Actuaries have accumulated large quantities of data to assist in actuarial projections of medical costs related to the variety of medical specialties for different Medicaid eligibility categories. Use of these data allows health plans and payors to set actuarially sound rates for capitation payments for medical care in Commercial, Medicare and/or Medicaid plans. Unfortunately, these databases and the corresponding computer projection models have not been developed for Medicaid enrollees receiving Medicaid mental health services.

In the past decade there has been substantial progress within the mental health community to develop such models. Anthony Broskowski, PhD.

of Parteo Solutions, and Dale Jarvis, author of this White Paper, among others, have developed Revenue/Expense - Capacity/Demand models for numerous mental health systems throughout the country, based on correlating historical utilization and cost data with new service delivery designs.

Under the Final Rules, Washington State has the opportunity to translate its mental health system design into a financial model that projects the expected utilization and cost for the system. The risk to the system is that this modeling will not occur and services that should be provided to consumers, but are not currently made available, will be lost in a rate setting exercise that is based on historical data only.

Actuaries are looking at the "true cost" of providing mental health services during their ratesetting studies.

Opportunity: Service Costs

The 2002/2003 Milliman USA actuarial study used the current Washington State Medicaid fee schedule to calculate system costs, multiplying the service utilization times the Medicaid rates. Although Milliman made adjustments to these costs as part of calculating a range of actuarially sound capitation rates, the Medicaid rates were used in calculating the bottom of the range. This is in a State that has not used Medicaid fee schedules for almost ten years to pay for mental health services.

The Final Rule's Ratesetting Checklist directs the actuaries to ensure that *"Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the covered Medicaid population."*(17)

Following this guidance, Oregon's Medicaid actuaries, PricewaterhouseCoopers (PWC), recently requested the actual cost of service for each service code from the Oregon Mental Health Organizations as they work to determine the next round of capitation rates. Unfortunately, the Oregon MHOs were only given a week's notice! In nearly all mental health authorities on the West Coast this information has not be been calculated for many years, if ever.

The opportunity for Washington State is to proactively study the true cost of providing service across the state and work with the actuaries to ensure that these figures are built into the 2005 capitation model. The risk is that this work will not occur in a timely fashion and service costs would be understated, causing the capitation rates to be too low.

Other Rate Setting Opportunities

Service Substitutions

In recent discussion with actuaries from William M. Mercer Co., they stated that alternative mental health services – those not in the State Plan - could be used to adjust the capitation rates if and when the State has

been able to demonstrate to CMS that the alternative services are more cost-effective than the State Plan services that would have otherwise been provided. A similar statement was also made this past July by Milliman USA actuaries, with the caveat that the Ratesetting Checklist has been changing frequently and this option could "go away". A review of the June 14, 2002 Federal Register creates further questions about this option. In response to a commenter's question about whether non-State plan services provided as cost-effective alternatives can be factored into the development of the capitation rates, CMS responded with:

> *"…actuaries must adjust the data to reflect FFS State plan services only. States cannot use unilaterally contractually required or "suggested" services not part of the State plan (also known as '1915(b)(3) services') to calculate actuarially sound rates. We are open to suggestions from States and their actuaries, but we will not modify the basic principle that rates be based only on services covered under the State plan."* [19]

Incentive Arrangements

The Ratesetting Checklist allows States to design incentive arrangements for MCOs, PIHPs, or PAHPs that provide up to 5% additional payment to the managed care organizations if they meet the terms of the arrangement.[20]

IV. What Options Are Available and What Are the Potential Impacts on the System?

Stakeholders have three options to consider for responding to the Final Rules.

The challenge for stakeholders of the Washington State public mental health system is to determine the course of action most appropriate for promoting the mission of the Mental Health Division - A Public Mental Health System that Promotes Recovery and Safety.

To-date discussions among stakeholders can be grouped into three categories:

1. State Opts Out of 1915(b) Mental Health Waiver and Returns to Fee-for-Service

Option1: Opt out of managed care and move to a Fee-for-Service System.

One argument that has been put forward suggests that the Final Rules are creating a "double whammy" for the States. The Administrative and Quality rules are massive and a dramatic change of practice for PIHPs including the Regional Support Networks. The move away from the Upper Payment Limit and the inability to include Non-Medicaid activity in the rate setting process is significantly out of sync with how Washington has utilized its resources. If the State were to opt out of managed care the system would no longer be subject to these new rules

and a "death spiral" could be prevented.

As stakeholders consider this option, they must also be clear about the implications of moving away from a managed care system to a fee-for-service system. According to the Medicaid sections of the Social Security Act, a fee-for-service system would require the following:

- All Medicaid enrollees would have the freedom of choice to choose their provider of care. Mental health clients would select their provider, present their Medicaid coupon, and receive medically-necessary care. The providers would submit claims to the Washington Medical Assistance Administration (MAA) and receive payment per the Medicaid Fee schedule. For outpatient providers this would be very similar to how Medicare Part B is billed, as well as how the care for Oregon Health Plan "Open Card" enrollees is paid.
- The Balanced Budget Act's managed care Quality Review and Improvement provisions would not apply to the system, nor would any other provisions or capabilities for managing care. There is little or no ability to manage access or utilization under a fee for service system. Providers would have an uncapped ability to bill MAA. The Federal Government and the State of Washington would each be responsible for contributing their fifty cents on the dollar for all submitted claims.
- The Regional Support Networks' role would change for Medicaid enrollees. Management of Medicaid services would move outside the purview of their responsibilities. It is unlikely that CMS would approve a return to the pre-waiver process of sending MHD general funds to the counties that then contracted for priority population services to providers, who in turn, used those funds as match when billing MAA for services to Medicaid enrollees. It is also very likely that all current State funding would be needed to fund the State Medicaid match, with no funds left for Non-Medicaid services or for RSN administration. Recent analysis has shown that in the current system there is insufficient Non-Medicaid funding to cover even the costs of the regional crisis systems.
- The State would likely be forced to manage cost through three mechanisms:
    - Keeping the Fee Schedule low to discourage provider billings.
    - Limiting the Benefit Package; restricting the type of services that could be provided.
    - Changing the Eligibility Requirements for State-Optional

Medicaid enrollees – those not mandated by the Federal Government – so that those individuals would either have no mental health benefit or a significantly restricted benefit.

2. State and RSNs Work to Minimize the Amount of Change Necessary to Operate under the Final Rules

Option 2: Attempt to minimize the amount of change at the RSN and provider levels and stabilize the system.

The Final Rules are just now being interpreted and implemented across the country. Many provisions look very similar to the current contracts between the State and the Regional Support Networks. There is some degree of interpretation for many of the rules. DSHS, with the issuance of the September 2, 2003 press release described above, is bringing the Congressional delegation into the process to assist with moderating what appears to be a hard-line stand by CMS.

In an effort to maintain the stability of the mental health system and control administrative costs that could skyrocket if overly conservative interpretation of the Final Rules were taken, the Mental Health Division would take a stand to support the existing structure and system design. A careful analysis of each section of the Final Rules would be made and the MHD would work with other colleagues in DSHS, the State Office of the Attorney General, the Legislature and the Congressional delegation to minimize the impact of the Final Rules.

As stakeholders consider this option, the following questions and issues should be addressed.

- Has the PHP exemption from many of the Medicaid managed care administrative rules created a stronger or weaker system in relation to meeting the needs of the public mental health consumers?
- Why does the quality review and improvement bar appear unreasonable for RSNs when it is similar to the NCQA requirements that health plans consider expected business practice?
- Now that ability to include services to Non-Medicaid individuals has been unequivocally removed from the ratesetting equation, is it even possible to continue Washington's public mental health system without addressing the Non-Medicaid issue and implementing significant changes?
- If efforts to challenge CMS were not successful, would it create a situation whereby stakeholders were distracted from necessary change efforts and valuable time lost?

3. State and RSNs Design, Develop and Implement Significant Changes that are in Alignment with the Mission of the Mental Health Division

Option 3: Use the rule changes as an opportunity to make significant improvements in the mental health system.

Under this scenario the State would work with RSNs, providers, consumers and family members, and other stakeholders to use the Final Rules as an opportunity to initiate changes in the system. Greater emphasis would be placed on measurement and accountability at all levels of the system. Changes would be made in the Regional Support Network system such that any and all RSNs would be prepared to obtain NCQA accreditation, should they apply. This might necessitate the reduction in the number of RSNs.

The state would accelerate its work implementing evidence-based practices with special attention to the SAMHSA EBPs. Clinical redesign efforts would be quantified and modeled to identify gaps in the service delivery system, followed by strategies to fill those gaps in cost-effective ways. This design work would become part of the 2005 actuarial model in support of a more accurate projection of utilization and cost.

As stakeholders consider this option, the following questions and issues should be addressed.

- Is the gap between the status quo and the Final Rules too great to bridge within the available time?
- Does the system have the human and fiscal resources and elasticity necessary to create substantial change without causing significant destabilization?
- Can the State, RSNs, providers and consumers and family members find ways to work together in a change process that is inclusive, leverages the strengths of all parties and creates successful results?

V. Conclusion

Stakeholders must decide how the Washington State public mental health system will respond to a major change in Federal regulations.

However one interprets the Final Rules for Medicaid Managed Care, it is clear that the changes are numerous and substantial. One community mental health center director has described the current challenges as the most significant that have faced the Washington public mental health system since 1994 when managed care began to be implemented throughout the State.

Efforts have already begun to address several issues. There have been two major stakeholder meetings to learn about the actuarial study and its implications. Four State-sponsored stakeholder workgroups have been created to prepare for the 2005 actuarial study. The QA/QI Manager for the Mental Health Division has begun a dialog with RSNs and other stakeholders about the Division's new Quality Strategy and the implications for change at the State and RSN level.

At the same time it appears as if the "collective mind" of the Washington public mental health community has not been able to make up its mind. Are the challenges too overwhelming to handle? Are they not really such a big deal? Are we already doing enough? It is critical that stakeholders continue this dialog and reach a set of reasoned conclusions, so that a well-crafted, coordinated and effective plan for change can occur.

Appendix A: Actuarial Study Workplan Steps

The following steps are summarized from the CMS Checklist for Managed Care Contract Approval, Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate Setting, Edit Date: 7/22/03.

Step 1: Identify a Base Year, from which utilization and cost data will be collected. *(Item AA.2.0)*

Step 2: Collect utilization data related to the State Plan from the Base Year. *(Item AA.2.0)*

Step 3: Filter out utilization data for non-Medicaid eligibles, including individuals who are in their spenddown periods, and non-State Plan services provided to Medicaid eligibles. *(Items AA.2.1, 2.3, 2.4)*

Step 4: Address Medicaid/Medicare dual eligibles utilization and cost based on how the State Plan addresses this population. *(Item AA.2.2)*

Step 5: Determine relevant costs for the Medicaid-eligible services. *(Item AA.2.0)*

Step 6: Compile data from steps 1-5 into a set of baseline utilization and cost data.

Step 7: Factor in allowable administrative costs and profit allowances. *(Item AA.3.2)*

Step 8: If Medicaid population has changed adjust the data to reflect the new enrollees. *(Items AA.3.3, 3.4)*

Step 9: Ensure that Disproportionate State Hospital payments are not in the data. *(Item AA.3.5)*

Step 10: Adjust the data for medical cost and utilization trend inflation factors, including price increases. *(Item AA.3.10)*

Step 11: Determine whether there is projected to be any change in utilization and make the adjustments accordingly. States may pay for the amount, duration and scope of State plan services that States expect to be delivered under a managed care contract. *(Item AA.3.11)*

Step 12: Determine whether a change in utilization of "medical procedures" over time should result in an adjustment, due to technological advances. *(Item AA.3.11)*

Step 13: Address any incomplete data issues. *(Item AA.3.14)*

Step 14: Establish Rate Category Groupings that represent per member per month rate cells; e.g. age, gender, region, eligibility categories. *(Item AA.4.0)*

Step 15: Make data smoothing adjustments as needed. *(Item AA.5.0)*

Step 16: Determine the relevant risk adjustment. *(Item AA.5.3)*

Step 17: Develop Stop Loss, Reinsurance or Risk Sharing Arrangement adjustments, as appropriate. *(Items AA.6.0, 6.1, 6.2, 6.3)*

Step 18: Finalize rate ranges for each Rate Category and project expenditures, based on these rates. *(Items AA.1.2, 1.3)*

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NOTES

(1) Federal Register: November 15, 2002 (Volume 67, Number 221), Page 69223-69225

(2) Federal Register June 14, 2002 (Volume 67, Number 115), Page 40989

(3) There's Something About Medicaid, Health Affairs, Volume 22, Number 1, pages 17, 18

(4) Centers for Medicare and Medicaid Services website, http://cms.hhs.gov/publications/overview-medicare-medicaid

(5) Medicaid and Managed Care: A Lasting Relationship?, Health Affairs, Volume 22, Number 1, page 77

(6) Based on a review of state waiver documents found at http://cms.hhs.gov/medicaid/

(7) Centers for Medicare & Medicaid Services, 1915(b) FREEDOM OF CHOICE WAIVERS, http://cms.hhs.gov/medicaid/1915b/default.asp

(8) Preliminary Summary: Medicaid Managed Care Final Regulations, National Health Law Program, November 10, 1997, http://www.healthlaw.org/pubs/BBAtoc.html

(9) Medicaid Block Grants: The Bush Administration Plays Hardball with Cash-Strapped States, Laura Hermer, The University of Houston's Health Law Policy Institute, April 30, 2003

(10) DSHS Press Release, "Medicaid Services in the Balance: The Real Cost of the Federal Government's Increasingly Contentious Actions Towards Washington and Other States", September 2, 2003

(11) Seattle Post-Intelligencer, Thursday July 31, 2003.

(12) Monitoring Medicaid Managed Care Organization (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR parts 400, 430, et al., Page 1

(13) Monitoring Medicaid Managed Care Organization (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR parts 400, 430, et al., Page 148

(14) Federal Register June 14, 2002 (Volume 67, Number 115), Page 40994

(15) Federal Register June 14, 2002 (Volume 67, Number 115), Pages 40996-40997

(16) Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03, Page 16

(17) Using Medicaid to Support MH Services: Info & Dialog, Glenn A. Stanton, CMS, July 14, 2003

(18) Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03, Page 4

(19) Federal Register June 14, 2002 (Volume 67, Number 115), Page 41003

(20) Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03, Pages 17-18