State Notes

TOPICS OF LEGISLATIVE INTEREST

Spring 2012

The Snyder Administration's Proposed Dual Eligibility Waiver
By Steve Angelotti, Associate Director

Introduction

On Monday, March 5, 2012, the Snyder Administration released its proposal for integration of care for those dually eligible for the Medicare and Medicaid programs.

This article provides an overview of the proposal and its potential impact on State revenue.

Background

The Medicare and Medicaid programs were established over 40 years ago to provide health insurance coverage for, respectively, elderly and low-income Americans. There are individuals who are eligible for both the Medicare and Medicaid programs; they are known as dual eligibles. In general, Medicare pays for physician, pharmaceutical, and institutional services other than nursing home services, while, for dual eligibles, Medicaid covers the 20% coinsurance for many Medicare services and pays for most nursing home services.

The vast majority of Medicare recipients are in a fee-for-service system, where the Federal government directly reimburses providers for services to Medicare recipients. (A relatively small number of people are in Medicare Advantage, the Medicare managed care program.) Most Michigan Medicaid recipients are in managed care, where the State pays a Medicaid health maintenance organization (HMO) what is known as a capitation payment and the HMO coordinates and reimburses the services. The advantage of managed care is the ability of the HMO to manage costs and coordinate care for its clients.

The State of Michigan has been very aggressive in putting Medicaid recipients into managed care and has claimed large savings from doing so. However, Michigan residents who are dually eligible for Medicare and Medicaid are generally not in Medicaid managed care. The main reason is that Medicare is the primary payer for services to dual eligibles, so managing the care on the Medicaid end would be the tail wagging the dog. Medicare decides whether the physician bill is paid, Medicaid just pays the 20% share, and there is no care for Medicaid to manage.

The dual eligible proposal would allow the State of Michigan to blend the Medicare and Medicaid funding streams into one stream of money. The State then would use the money to purchase physical health and behavioral health care services from managed care and other similar entities on behalf of the dual eligible population.

The Department of Community Health (DCH) took public comment on the proposal through April 4, 2012, before submitting it to the Federal Centers for Medicare and Medicaid Services (CMS) for approval.

Michigan was one of 15 states to receive a waiver from CMS to develop a plan to integrate care for the roughly 211,000 dual eligibles in the State. Most of the health care costs for these individuals are covered presently by Medicare, in particular for physician, hospital, and pharmaceutical services. Medicaid covers the cost of coinsurance and covers most long-term and behavioral health care costs for this population.

Because these people are covered by two separately run programs, coordination of care is very difficult and, as noted above, managed care is nearly impossible. There are also disincentives at the State level to innovate – for instance, efforts by the State to reduce hospitalization rates among the elderly would lead to limited fiscal benefits to Michigan as the savings would accrue to the fully federally funded Medicare program.

Under the integration proposal, the State would be able to merge the Medicare and Medicaid funding streams and set up integrated care, contracting with managed care and accountable care entities. The belief is that more coordinated care would result in better services and outcomes for clients as well as reduced costs for the State and Federal government.

The majority of the 211,000 dual eligibles in Michigan are low-income elderly people. However, there are many nonelderly who are Medicare recipients, in particular disabled individuals with work histories and many developmentally disabled and mentally ill individuals. In fact, over 40% of dual eligibles are under the age of 65, with developmentally disabled and mentally ill individuals under age 65 comprising 15% of the total dual eligible population. Because the population affected by this waiver extends beyond the low income elderly, designing a program is more complicated than just addressing issues surrounding medical care for the elderly.

Pages 7 through 10 of the report linked above provide some data on costs for dual eligibles. Of most significance is that, in Michigan, the Medicaid and Medicare programs spent a combined total of almost $8.0 billion in 2008 on the dual population, almost $40,000 per dual eligible. This is not a surprise as the dual eligible population is one with significant health care costs and many pre-existing chronic health conditions.

The Administration's proposal would have a major impact on the public behavioral health system, that is, Community Mental Health (CMH) boards and the Pre-Paid Inpatient Health Plans (PIHPs). Due to many developmentally disabled and mentally ill adults being Medicare-eligible, nearly half of CMH and PIHP expenditures are for services to dual eligibles. The CMH and PIHP community expressed strong concern about the integration proposal as it was being developed.

The proposal also would affect long-term care services, as nursing home and intermediate-level services for many dual eligibles would be provided through something resembling a managed care model instead of the current fee-for-service model. There also likely would be an expansion of intermediate-level home and community-based services.

Design of the Proposed New Service Delivery System

The Department's proposal would set up a partial-risk model, with services reimbursed by managed care entities and accountable care organizations (ACOs). These organizations differ from traditional managed care entities because an ACO may resemble a capitated managed care entity or resemble a traditional fee-for-service model, or be a blend of the two. On the physical health side, the Administration is using the term "integrated care organization" or ICO to describe the entities that would receive contracts to provide physical health services to the dual eligible population.

A partial-risk model differs from the usual full-risk model in that the State could end up sharing some of the costs if expenditures exceeded expected levels. Under a full-risk model, the private entity managing the care would absorb all excess costs. The Administration's proposal notes that the State expects to convert from a partial-risk plan to a full-risk plan over time, especially as data become available to allow for better risk adjustments in payment rates. The Federal government appears to prefer the full-risk model and this aspect may be a discussion point in negotiations with CMS.

The Role of PIHPs

The behavioral health services would be provided by the PIHPs (as is the case presently). However, there would be a change in the PIHP model. At present, the 46 CMH boards have banded together into 18 PIHPs. The DCH proposal envisions five or six regional PIHPs as opposed to 18, so this proposal would lead to greater consolidation of PIHPs. This was certain to be a major discussion point during the public comment on the proposal.

Furthermore, under the Federal health reform legislation, individuals under 133% of the Federal poverty level who are not currently Medicaid eligible (generally single nondisabled adults) would become Medicaid-eligible on January 1, 2014. This means that the vast majority of the non-Medicaid services provided by the 46 CMHs would be Medicaid reimbursed. Therefore, the consolidation not only would affect the 18 PIHPs, but would effectively transform the entire CMH system, both Medicaid and non-Medicaid, into a system run through five or six PIHPs.

The intent is for the PIHPs and ICOs to be separate entities. There had been discussion, at various points in the process, about having all services be provided by ICOs, which would have meant transferring 40% of the PIHP budgets (the portion covering services to dual eligibles) to the ICOs. There was strong resistance to this idea from the behavioral health community and the Administration's proposal represents an attempt to avoid that conflict.

It should be noted that just because the State opted not to fold behavioral health services into the ICOs, one should not conclude that this could not happen in the future. The contracts would be for a specified period of time and the State could, in the future, choose to seek fully integrated care and have the ICOs cover all behavioral health services for dual eligibles.

When PIHPs were created a decade ago, the original proposal was to allow any entity, including private firms, to compete to provide behavioral health services to Medicaid clients. The final proposal gave right of first refusal to CMHs, which preserved the public mental health system's lead role in Medicaid behavioral health care. This waiver expires on September 30, 2013, and the State could opt to bid out the PIHP services at that time.

While each person in the integrated care program would be eligible for services from two entities, the ICO for physical health and the PIHP for behavioral health, the intent is for coordination of care between the ICOs and PIHPs. This would be done through a concept called a "care bridge", where the ICOs and PIHPs would contract with each other for coverage of services and both might have some financial responsibility. There would be multidisciplinary teams, including social workers, to work with the clients to ensure full coordination of care.

The intent is to define which services belong with which entity, with the understanding that there would be an overlap in terms both of assessment and meeting needs. Each individual would have a care coordinator on both the physical health and behavioral health sides and the care bridge would address problems that could come up. Furthermore, ICOs and PIHPs would use the same electronic health record platform. Finally, "person-centered" planning would be the basis for decisions for clients by both the ICOs and PIHPs. The Administration, in its proposal, makes it clear that coordination of care, electronic records, and person-centered planning would be key quality measures used to evaluate bidders and, eventually, the entities providing care.

Safeguards

Perhaps the greatest concern during any shift to an expanded managed care model is ensuring continuity of care. This is especially important for the dual eligible population, which includes many individuals with severe pre-existing health conditions. The Administration states that its contracts would include requirements to maintain existing services and providers "until an assessment is completed and care transition arrangements are made through the person-centered planning process". The Administration also states that nursing facilities would continue to receive the same Medicare or Medicaid reimbursement for clients who reside in those facilities.

One of the keys to these safeguards is the person-centered planning process, which would allow the clients to have significant input on the services provided and, in particular, their living arrangements.

Enrollment

Pursuant to Federal requirements, enrollment in the waiver would be voluntary: "Initial enrollment will offer a two-month period to decide whether to opt out or to select an ICO". The default would be enrollment; if a client did nothing, he or she would eventually be assigned to an ICO. A client who opted out would remain in the fee-for-service Medicare and Medicaid programs. Enrollees would have a choice of at least two ICOs in their region, but would be assigned to the single PIHP in their region.

The question arises, why would people who presumably are reasonably satisfied with their current services from Medicare and Medicaid switch to this new coordinated care system? The Medicare managed care program, Medicare Advantage, serves as an example. Medicare Advantage providers attract clients by offering more extensive benefits and lower out-of-pocket costs. In a similar manner, it is expected that the ICOs would try to attract clients by offering greater benefits, such as dental or vision. Joining the waiver also likely would be appealing to some due to care coordination services as well as a greater likelihood of obtaining currently capped home and community-based services.

The Administration's plan is to roll out the program over a full year, starting in July 2013, with staggered starts for the different regions. The belief is that starting the program statewide at one time would lead to a more difficult transition. Furthermore, the State would learn from any problems during the initial start-up and would hope to avoid them when the program started in other regions.

Various populations would be enrolled at different times, too, with the elderly not receiving long-term care services, the mentally ill, and disabled individuals outside of the developmentally disabled community joining during the first three months of the roll-out. In the next calendar quarter long-term care recipients would be enrolled; then, in the final quarter, the developmentally disabled would be enrolled.

Enrollment would be done through an enrollment broker with no ties to the ICOs or PIHPs. This would be similar to what is done now with regular Medicaid and the Medicaid HMOs, as Maximus handles enrollment for Medicaid. The ICOs would not be allowed to do outreach or advertising to attract clients.

Revenue and Savings

The amount of money that the Federal government would provide to reflect what "would" have been spent on Medicare will be subject to discussion between the State and CMS. If the waiver goes into effect in 2014, there is no way to know for certain how much would have been spent on Medicare services to dual eligibles in 2016; the amount will have to be estimated based on actual costs and projected expenditure trends. A similar process was used in developing the Medicare Part D pharmaceutical "clawback". The clawback, a payment by the State to the Federal government, was created when the Medicare program took over responsibility for dual eligible pharmaceuticals. The State has to pay the Federal government an amount equal to the projected State share of costs if dual eligible pharmaceuticals were still covered by Medicaid.

On the savings front, the Governor's recommended FY 2012-13 DCH budget assumed savings of $29.7 million Gross and $10.0 million General Fund/General Purpose due to the dual integration waiver. Given that the waiver would not begin enrolling clients until July 2013, these savings, which would have to be realized for a subset of the population over the last three months of FY 2012-13, are questionable. As the Administration noted in the paper, there would likely be some cost increases due to the expansion of intermediate level care

and supportive services. The Administration does, however, expect some savings from a shift from inpatient services to community services, which would offset and perhaps eventually exceed the cost increases.

Assuming that savings eventually did occur, another concern is how they would be shared between the State and Federal government. The DCH estimates that, by the time the program starts, there will be about $9.0 billion in Medicare and Medicaid spending on the dual eligible population, and the vast majority of that will be Federal dollars (as all Medicare spending is Federal and almost two-thirds of Michigan's Medicaid spending is Federal). Therefore, assuming that the integration of care was successful in saving money, there remains the question of how the amount saved would be estimated and how it would be split between the State and Federal government. That matter would be determined in the negotiations between the DCH and CMS.

Conclusion

This proposal represents certainly the most significant change in Michigan Medicaid policy since the shift to managed care for physical and behavioral health and arguably the most significant change in publicly funded health coverage since the advent of the Medicare and Medicaid programs over 40 years ago.

The impact on the provider community could be substantial. During the initial process the Administration considered having all care, both physical and behavioral health, be provided by ICOs. That would have eliminated almost half of PIHP funding and led to a situation in which people in the same group home could see their services paid and coordinated by two completely different types of entities, depending on whether they were a dual eligible or a "regular" Medicaid client. The decision to maintain the PIHP system limits the potential impact on the PIHP and CMH community. However, the decision to reduce the number of PIHPs to five or six would result in a major restructuring of the behavioral health system, with an impact extending beyond the dual eligible community.

The long-term care system would face similar major changes. Instead of a fee-for-service model for nursing home care combined with a limited number of slots for home and community-based waiver services, the payment system would resemble a capitation model, with the providers being paid by a private ICO rather than the State. If the expansion of community-based care resulted in a diversion of individuals from nursing homes, then there could be a significant financial impact on the nursing home industry. Furthermore, the use of quality measures to evaluate payments to nursing homes could have an impact as well. Meanwhile, home and community-based services would likely expand, but not simply for those at risk of institutionalization. There likely would be an increase in the level of services available for frail elderly who are arguably underserved at present, with a corresponding increase in expenditures.

While other providers, such as hospitals and physicians, would not face the same potential challenges, a shift toward a broader managed care system would certainly affect their interactions with (and reimbursement for) the dual eligible population.

The Legislature's role in this process, barring direct intervention, is rather limited. The Administration provided 30 days for public comment on the proposal before starting the CMS process in early April, but, because of the waiver process, this issue is primarily between the Snyder Administration and the U.S. Department of Health and Human Services, with the Legislature acting as an interested observer.

As the proposal is considered, interested parties can be expected to express quite legitimate concerns on a number of fronts, such as: 1) How would the proposal affect the availability and quality of services to clients? 2) How would the proposal affect the public behavioral health system and its clients? Does the Administration intend to eventually replace PIHPs with ICOs? 3) What sorts of non-HMO organizations would serve as ICOs and what is their experience level? 4) Would the State be able to fully implement this proposal in one calendar year? 5) What would be the impact on State expenditures? 6) What would be the impact on institutional providers, in particular nursing homes? 7) What would be the impact on the availability of intermediate level long-term care? 8) How would the State be able to set actuarially sound ICO payment rates based on rather limited data? 9) How would the State be able to realize FY 2012-13 savings on a proposal that would not even begin a phased roll-out until July 2013? 10) How many people could be expected to opt out and would those opting out be less able to obtain intermediate level care such as home and community-based waiver services?