MICHIGAN MEDICAID'S BEHAVIORAL/MENTAL HEALTH CARVEOUT: SHARED VALUES AND COMMON GOALS FOR SYSTEM REFORM

The undersigned represent the interests of Medicaid recipients who receive services through Michigan's behavioral health system. This statement sets forth our shared values, concerns with the current system, and suggested reforms.

- **REDUCE UNNECESSARY ADMINISTRATIVE COSTS IN ORDER TO DIRECT MORE MONEY TO SERVICES**

In a publicly funded system, we believe that as much money as possible should go directly to medically necessary community-based services. Michigan's behavioral/mental health carveout, however, is one of the most administratively bloated Medicaid systems in the nation. The Michigan Department of Health and Human Services ("MDHHS") contracts with ten Prepaid Inpatient Health Plans ("PIHPs"), which then contract with forty-six Community Mental Health Service Programs ("CMHSPs"). The CMHSPs, in turn, usually contract with the providers who directly deliver services. There are thus *four* layers of Medicaid administration (excluding the federal government) above the beneficiary, three of which are primarily administrative. Three administrative layers is unnecessary and wasteful.

The ten PIHPs should be replaced by a limited number of Administrative Services Organizations ("ASOs"), which would assume the administrative tasks currently handled by the PIHPs and CMHSPs.[1] Medicaid ASOs are not a novel concept. When Connecticut abandoned its managed care system, it established non-risk-bearing ASOs for medical, dental, behavioral health, and emergency transportation services. The ASOs were paid a flat fee to take on many of the administrative functions currently handled by the PIHPs and CMHSPs, including, *inter alia*, authorization decisions, provider network development and monitoring, recipient rights, and customer service. The result of this administrative streamlining was a medical loss ratio of over 97.5%, meaning that over 97.5% of the state's Medicaid costs went directly toward providing services. More money going to services strengthened provider networks, which in turn increased access

[1] ASOs perform any number of administrative functions that would otherwise be handled by the state Medicaid agency or managed care entities. They are a way for the state to contract out administrative responsibilities that it would otherwise assume in a fee-for-service system.

to services. A robust provider network ensures that recipients have sufficient choice of services and providers. It also ensures that recipients can remain in their communities and receive services in the most integrated and least restrictive environment.[2]

- **ELIMINATE THE FUNDAMENTAL CONFLICT OF INTEREST INHERENT IN THE SAME ENTITIES AUTHORIZING AND PAYING FOR SERVICES**

The PIHPs and CMHSPs function as managed care organizations:[3] They receive capitation payments prior to providing services, and they are expected to authorize and provide all necessary services using those capitation payments. Accordingly, the PIHPs/CMHSPs, as the entities responsible for paying for the services in the plans they alone are charged with developing and monitoring, have a direct conflict of interest with the beneficiaries they serve. With a direct financial stake in the amount and type of service they authorize, the PIHPs/CMHSPs have a powerful financial disincentive to authorize and provide services.

This is true even though the PIHPs and CMHSPs are non-profit, quasi-governmental entities. Even without an express profit motive, the PIHPs and CMHSPs are perennially motivated to avoid *losing* money, and they have two primary means of balancing their budgets: reducing their own administrative costs or reducing services or reimbursement rates. Even with MDHHS bearing most of the risk, the PIHPs have repeatedly appeared to be incapable of managing the risk they do bear.[4]

Recipients have the right to individual plans of care ("IPOSs") developed by entities without a thumb on the scale, and they should not be placed in a directly adverse

[2] The recently announced DOJ investigation into unnecessary psychiatric hospitalizations highlights the consequences of recipients being unable to receive adequate services through the PIHPs and CMHs.

[3] Michigan's unusual specialty health system appears to be the result of Michigan forcing its pre-existing Community Mental Health system (mandated by state law since the 1970s) into a managed care model shortly after the advent of Medicaid managed care (1996). Michigan's prepaid inpatient health plans began functioning as specialty prepaid health plans in late 2002.

[4] As witnessed in the unsuccessful attempt to terminate the Lakeshore Regional Entity's contract, or in the attempted 2020 lawsuit brought by Region 6 against MDHHS. *See CMHPSM v. MDHHS*, 2021 WL 5405334 (Mich. Ct. App. Nov. 18, 2021).

relationship with the entities on whom they depend for life-sustaining services.[5] Decisions affecting services authorizations that are motivated by PIHPs'/CMHSPs' countervailing financial interests (for example, when CMHs place recipients on waitlists for services because they will not authorize sufficient rates to hire providers, or when utilization management operates behind closed doors to make medical necessity decisions that are properly part of the person-centered-planning process) are contrary to the philosophy, practice, and intended results of person-centered-planning and self-determination principles. PCP and self-determination are the heart of Michigan's behavioral/mental health system and should be actively promoted, not vilified, by the entities tasked with ensuring their implementation.

Recipients should have full access to their due process rights through Medicaid Fair Hearings, and to a meaningful ORR system. ORR complaints should not be resolved by the very entity that is the subject of the complaint,[6] and the implementation of Medicaid Fair Hearing decisions in favor of recipients should not depend on the actions of entities motivated *not* to implement them.[7]

Providers, for their part, should be paid the rates objectively necessary to provide high-quality services, not rates dictated by PIHPs'/CMHSPs' budgets. Inadequate rates make it difficult or impossible for providers to become and remain fully staffed, expand geographically, and consistently provide high quality services.

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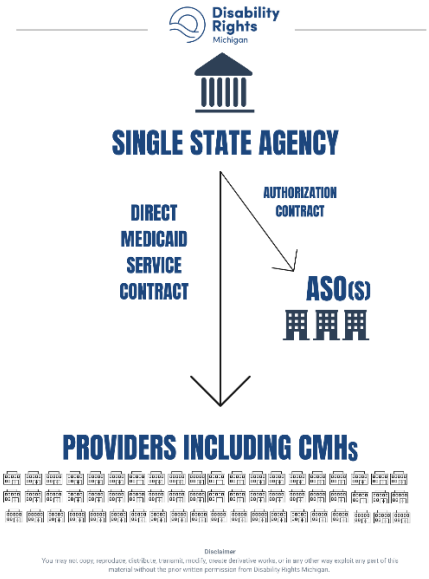
[5] Particularly because, despite the Medicaid Act requiring beneficiaries to have a choice between at least two managed care entities (42 U.S.C. § 1396u-2(a)(3)(A)), Medicaid behavioral health recipients in Michigan are legally handcuffed to one PIHP/CMHSP. This federal requirement was first waived in 1998, in part because Michigan asserted that recipients would at least have a choice of direct *providers*. In practice, that choice has frequently been between one provider and no providers.

[6] https://www.freep.com/in-depth/news/local/2022/09/09/built-conflict-hurts-michigans-most-vulnerable-advocates-say/9461250002/.

[7] *See Wiesner v. Washtenaw County Community Mental Health*, 340 Mich. App. 572 (2022) (CMH refused to comply with hearing decision and appealed it, resulting in court ruling that CMHs have no right to appeal Fair Hearing decisions) and *C.B. v. Livingston County Community Mental Health*, -- Mich. App. --; 2023 WL 8482984 (2023) (recipient forced to bring enforcement action following favorable hearing decision, eventually resulting in $100,000 settlement with the CMH). No recipient should be forced to go to such lengths to obtain the benefits of a system meant to vindicate recipients' due process rights and afford relief *without* attorney involvement.

Moving to a system like Connecticut's directly removes the core conflict in Michigan's system[8] by separating, and requiring the independent operation of, the entities providing services, paying for services, and authorizing services. The ASOs are paid flat rates to authorize services and have no financial motivation to deny or limit authorizations. The providers separately contract with the single state Medicaid entity and are paid rates that are based on the actual cost of providing services. Michigan's CMHSPs would return to their original role as direct service providers that do not manage care. Recipient rights complaints about providers would go to the ASOs, and the entities implementing Medicaid Fair Hearing decisions (either the ASOs or providers) would have no financial motivation not to comply.



Fee schedules could capture significant variations across service types, intensity of need, and geography. Even without the actuarial analysis underpinning capitation rates, actuarial expertise could (and should) still be brought to bear on rate development. Milliman, for example, has developed an Independent Rate Model ("IRM") to establish what various services cost in practice. The IRM builds up rates using expected staff wages, overhead, time off, and other component costs, resulting in service rates intended

[8] It also resolves the conflict-free case management issues that arise when the same entities authorize and provide services.

to reflect the actual cost of obtaining services. The IRM or similar models could be used to establish fee schedules. Indeed, Michigan's recent shift toward fee schedules *within* managed care (including for CLS and ABA) is suggestive of the advantages of such a model.

- **INCREASE ACCOUNTABILITY AT THE STATE LEVEL**

A central principle of federal Medicaid law is that each state must designate a "single state agency" to administer its Medicaid program (*see* 42 U.S.C. § 1396a(a)(5)). MDHHS, as Michigan's single state agency, bears absolute responsibility for the operation of Michigan's Medicaid program, and it "may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e).

Michigan's Medicaid system should operate in accordance with this principle. No managed care organization should have a monopoly on any given Medicaid service, such that MDHHS is unable to correct non-compliance via contract enforcement. "Local accountability" should *not* be considered an adequate safeguard. Nor should the boards of the entities tasked with controlling their subcontractors (the PIHPs vis-à-vis the CMHSPS) be controlled by those subcontractors, as the PIHPs' boards are. MDHHS should have direct Medicaid contracts with all of its contractors, and it should have the ability to meaningfully enforce those contracts.

We find it deeply disturbing that the directors of three statewide advocacy organizations were recently "told by officials in MDHHS that there is 'no way to hold the PIHPs/CMHSPs accountable.'" This reflects a system that is out of compliance with single state entity requirements.

Individual Medicaid recipients should not be forced to file lawsuits to make MDHHS hold its contractors accountable. Most recipients are not in a position to hire attorneys, and there is a dearth of attorneys representing recipients for free. And even when such lawsuits are brought, MDHHS's contractors have actively resisted MDHHS's efforts to resolve them. Adding to the overall administrative waste of the system, at least some county-affiliated CMHSPs are self-insured, meaning that their litigation defense is funded by taxpayer dollars.

The PIHP administrative layer in the current system operates to diffuse responsibility. MDHHS only has Medicaid contracts with the PIHPs, but the PIHPs never enforce contract requirements against the CMHSPs (who, again, do not have Medicaid contracts with MDHHS). Nor has MDHHS been able to enforce contract requirements against the PIHPs. MDHHS should have enforceable administrative contracts with the ASOs, with the ability to substitute new entities to fulfil those functions if necessary. The same goes for direct contracts with service providers. Such a system will ensure that, consistent with single state entity requirements, the buck stops with MDHHS: MDHHS can enforce its contracts, will have options when its contractors are unable or unwilling to fulfil their obligations, and will be directly answerable to recipients for its policy decisions. Additionally, the division between administration and service costs will be completely transparent.

Sincerely,

1in6 Support

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Disability Rights Michigan

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Michigan Care Council

Michigan Developmental Disabilities Council

Michigan Developmental Disabilities Institute

Michigan Disability Rights Coalition

Michigan Statewide Independent Living Council

The Arc of Bay County

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