Michigan Model

Context: The state's public funding for mental health and substance use disorder services is managed by the Michigan Department of Community Health (MDCH) division of Mental Health and Substance Abuse Services. General fund dollars support services for persons not eligible for Medicaid or non Medicaid billable services.

Services for individuals with developmental disabilities (DD) are funded almost exclusively by Medicaid. Persons under 26 receive most of their services and supports through educational funding; certain respite or summer-based services are financed by the mental health system.

Persons with DD that are 26 or graduated from school receive services through the CMH system. The funding for Medicaid comes through a capitated system that is managed by 18 local Prepaid Inpatient Health Plans (PIHPs). These PIHPs are either stand alone Community Mental Health (CMHs) boards (local single county or multiple county entities with a governance board appointed by local county commissions), or made up of 2 or more CMHs. When the state went to a capitated, managed care system, the PIHP concept was implemented to provide sufficient covered lives to manage the risk and provide for some economies of scale in administration and managed care functions.

The capitated funding comes as a monthly prepayment based on the number of enrolled Medicaid eligibles in that particular PIHP for that month. There are various rate cells based on age, sex, and categorical eligibility type. Annually, the state either rebases the Medicaid rates or provides an actuarially sound rate increase (either has to be approved by the feds prior to implementation for that fiscal year).

Except for a small outpatient benefit (20 visits annually - not usually relevant for persons with DD), the mental health services are carved out of Michigan's Medicaid health plans to the PIHPs/CMHs. The pharmaceutical costs are also managed by a single statewide pharmacy benefits manager and not capitated within the Medicaid rates to the PIHPs.

Services are provided either directly by the CMHs or contracted out to community providers (largely non profits). A few of the larger counties contract out all services; most of the rest are a combination of directly operated and contracted services.

Noteworthy Components:

- **Provider Eligibility and Oversight**: the individual PIHPs/CMHs set up their own provider panels based on guidance from Medicaid Provider Manual and their state contract requirements. The PIHPs establish an enrollment and credentialing process to add, maintain, and remove agencies/individuals from their provider panel. The individual PIHPs/CMHs are responsible for monitoring their provider network, again through standards/requirements established by state contract requirements.

- **Rate – Setting**: The state has a capitated rate system that provides monthly prepayments to each of the PIHPs based on the number of enrolled eligibles in each of the rate cells. The details of those rate cells and payments need to be actuarially designed and approved each year and then sent to CMS for approval. Sometimes this happens relatively quickly (i.e. the state proposes continuation of the previous year's system with an economic increase). At least every other year the state has to rebase the rates and will make some changes that have a more dramatic effect on Medicaid funding swings within/across PIHPs.

  There are two main eligibility groups for Medicaid eligibility – aged, blind, and disabled, and Temporary Assistance to Needy Families (TANF) – mostly single adults in poverty with minor

children. Counts from each of these groups go into the capitated prepayments as outlined above. The funding is based on the eligible (not the actual persons served).

There are some complicating factors in Michigan's rate setting methodology that I will not go into that relate to moving from a fee for service to a capitated funding system back in the late 90s. It does not seem useful to review that with you unless Pennsylvania's circumstances were to be similar.

- **Payment**: The PIHPs/CMHs receive the monthly capitated prepayments; they in turn have contracts with providers. There are different payment arrangements for these contracts. In the case of an affiliated PIHP (one larger CMH with several other smaller CMHs) they can pass the capitated payment for its counties' beneficiaries on (deducting managed care function costs), request and fund a net cost operating budget for that particular CMH's directly operated and contracted services, or reimburse on a fee for service basis. A limited few of our CMHs and PIHPs use case rate reimbursement mechanisms within their networks.

- **Who holds contracts**? The 18 PIHPs hold contracts with the state for provision of Medicaid financed services. The 46 CMHs hold contracts with the state for provision of the general fund services for non Medicaid eligibles. This is the pool of funds that has diminished significantly over the past 4 years.

- **Assessments**: there is NO STATEWIDE ASSESSMENT TOOL. They are done at the PIHP or CMH level. Most directly operate this function, then develop a person-centered plan and directly operate or contract for the components of the plan.

- **Fiscal**: Each PIHP has an internal service fund (ISF) that it can establish that allows it to finance additional costs beyond its annual Medicaid revenue. These ISFs are limited to 7.5% of the PIHPs annual Medicaid revenue. This is based on a shared risk model between the state and local PIHPs: PIHPs are responsible for 100 -105% of overspending Medicaid; state and PIHP share overspending 105 – 110%; state responsible for over 100%.

Ohio Model

Noteworthy Components:

- **Eligibility:** Individuals have to be Medicaid eligible and meet an ICF/MR level of care. For our waivers in Ohio, we expand Medicaid financial eligibility to 300% of the poverty level. The County Medicaid agency determines Medicaid eligibility, but staff that work for Ohio's County Boards of Developmental Disabilities (CBDD) gather the information; they also gather the medical and/or psychological evidence needed to prove the level of care. That information then goes to the Ohio Department of Developmental Disabilities (DODD), where a QMRP certified staff member confirms eligibility and completes the enrollment process.

- **Developing Individual Service Plans**: Service & Support Administrators (SSAs) who work for CBDD develop ISPs. Those SSAs are certified by the DODD, basically meaning they must have a certain level of post secondary education, plus specific experience and continuing education in developmental disabilities. The DODD has the authority to review plans and require CBDD to revise them, but the development of the plan is an SSA responsibility. In doing so, the SSA involves the individuals support team, which may include family members, other natural supports and/or providers (if they have been chosen yet).

- **Rate-Setting**: Waiver rates are set by the state and published in Administrative Rule. For our current waivers, it is all set on a fee schedule. There is a base rate for each service, then eight 'cost of doing business' categories that are based on the relative cost to do business in that specific county. How it is

done is through a combination of reviewing Medicaid rates for similar services, rates used in like states, wages for comparable business types in the state, so on. In 2011, we are to have our first "self-directed" waiver for DD; some of those will have services wherein the rate will be based on negotiation between the individual (or their individual representative) and the provider. There will be a 'floor' and a 'ceiling' set in Administrative Rule. The floor will be the federal minimum wage; the ceiling will take the ceiling of our most common waiver factor, multiplied by a factor yet to be determined (i.e., likely 125%). There is a different rate for independent providers than for agency providers. Independents are a little lower since they do not have all the overhead costs of an agency. The down side is, the higher rates eat more money away from units of service. That ultimately is not necessarily a good thing for the waiver enrollee. But CMS is well aware of all of that.

- **Payment**: Medicaid regulations require that payment for waiver services be made by the State directly to the Provider. Now, in reality it is not that simple. In many cases, and we discussed this a little bit with Dr. Ryan at the Texas Council Reception, a provider will actually sub-contract with a CBDD. In that scenario, the CBDD pays the provider of service, but the State still is paying the "provider of record", or the CBDD. The non-federal share of Waiver Expenditures is paid by the CBDD. Each quarter the DODD sends an invoice to the CBDD for their share of non-Medicaid expenditures. The state keeps a Rotary Account with 88 files (i.e., one for each county). The CBDD actually sends the DODD a check for their share of waiver costs.

- **Assessment**: Ohio Developmental Disabilities Profile - The ODDP is an assessment tool which calculates a funding range based on specific circumstances related to the individual. The ODDP allows individuals with similar needs and circumstances to access comparable levels of waiver services throughout Ohio. The ODDP does not replace nor is it to be used to develop an Individual Service Plan (ISP) that is based on the assessed needs of an Individual. The costs of the services outlined in the ISP are compared to the ODDP range assigned. When the cost of the assessed needs cannot be met in the assigned funding range further review is needed via a Prior Authorization process.

  There is also an Acuity Assessment Index, which is the standardized instrument used by Ohio to assess the relative needs and circumstances of an individual compared to other adults in a non-residential setting when receiving Adult Day Array Services. All individuals who receive or seek to receive any of the HCBS - funded Adult Day Waiver Services need to have this assessment completed. The assessment questions measure the amount of staff time required to assist individuals with personal needs and day activities. The score is used to assign the staff intensity ratio at which the services are to be provided and assign costs. Individuals who are not receiving HCBS – funded day services but receive day services along with waiver funded individuals may also have the assessment done. This will help to assure that the staff intensity ratios for the waiver individuals are maintained.

Virginia

Context: Community Service Boards/Behavioral Health Authorities are local government agencies created by the Code of Virginia in 1968. The Virginia Code requires that every local government jurisdiction form or, with other local governments, form a CSB/BHA. CSB/BHAs' responsibility is assuring, with allocated resources, the delivery of community-based mental health, intellectual disability, and substance use disorder services to citizens with those disabilities; Emergency services and case management are Code-mandated services; All other services are promoted state regulations of the Department of Behavorial Health and Disability Services (DBHDS), the Department of Medical Assistance Services (DMAS), and other human services agencies.

CSB/BHA services are licensed by DBHDS, subject to the DBHDS Human Rights Regulations and to state and local Human Rights Committees. DBHDS, under the oversight of DMAS, has specific roles in the operation of the Medicaid MR Waiver. All CSB/BHAs have provider agreements with DMAS for Clinical, Rehabilitation, and MR Waiver services. Services are delivered through a network of CSB/BHAs, private providers, and other public providers, licensed by DBHDS. Many of these providers also have agreements with DMAS.

Virginia has a Mental Retardation waiver established in 1990, and a developmental disabilities waiver established in 2002-2003. The first serves 8000+ people, the second serves approximately 1000. The MR waiver costs $65,000 combined state and federal shares, DD waiver costs $30,000 combined state and federal shares. There had been a local share until 2000, when management of the MR waiver was shifted to the Virginia Department of Medicaid Assistance Services and the Department of Behavioral Health and Development Services. All match dollars were shifted to DMAS, CSBs no longer required to provide local match.

The MR waiver includes residential and congregate care, while the DD waiver excludes these services. Both waivers include consumer directed services. The MR waiver serves individuals with severe intellectual disabilities, physical and sensory disabilities, autism, mental illness, cerebral palsy, digestive issues, other syndromes that impact physical health, and many other developmental conditions. The DD waiver serves individuals with autism, physical and sensory disabilities, cerebral palsy, digestive issues, other syndromes that impact physical health, and many other developmental conditions that do not involve cognitive functioning.

Noteworthy Components:

- **Determining Eligibility**: Local CSBs conduct assessment for MR Waiver eligibility and provide case management. Using assessment of IQ and functional level. Individuals meeting DMAS Urgent Care Criteria are placed on the Urgent Care Wait List. Information communicated to DBHDS, which maintains the Urgent Care List statewide. If eligible for ID Waiver but not Urgent Care, individuals placed on the local Urgent Care Wait List or the Non-Urgent Wail List. Individuals receive TCM from CSBs.

  For the DD waiver, assessment conducted by Health Department. Results sent to DMAS. DMAS compiles statewide list of eligible individuals. Individuals are notified of standing on the list each year by DMAS.

- **Developing Individual Services Plans:** Under the MR Waiver, ISPs are developed in conjunction with consumer, family and CSB involvement through the Case Manager. Plans are developed, approved locally, sent to DBHDS for review and authorization and then to DMAS for review and final authorization. Under the DD Waiver, ISPs are developed in conjunction with consumer, family and case manager involvement. Plans are sent to DMAS for authorization. If a service cannot be developed within 90 of slot award, service is deleted from the ISP.

- **Rate-Setting:** In Virginia, rates are set in law (Appropriations Bill) and are approved by the Virginia General Assembly. There is a CMS-determined Northern Virginia differential for all Medicaid services provided in that region.

- **Provider Eligibility and Oversight:** Providers are licensed by DBHDS for services and requires a provider agreement with DMAS. Locally, the CSB case manager provides oversight, along with. Statewide office of Licensure, office of Human Rights and DMAS UR.

- **Payment:** All payment comes from the state DMAS.

- **Service Delivery:** Under the MR Waiver: Services provided and managed by CSBs as the public local service delivery system in conjunction with a network of experienced private providers. As a result, most MR Waiver services exist in every area of the Commonwealth due to CSB and private provider investment. Local assignment of slots allows CSBs and private providers to develop needed services based on a known group of individuals who need similar services and allow for individualized plans.

- **Waiting List Management**: For MR Waiver, CSBs maintain local wait lists. DBHDS maintains the statewide urgent care list. New waiver slots are allocated one to each CSB and a percentage of the number on the local urgent care wait list. Local review and allocation protocols are followed to assign waiver slots. Health and safety are the primary concerns.