LAKESHORE REGIONAL ENTITY

Meeting Agenda
Board of Directors Work Session
October 23, 2024, 11:00 AM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Opening Comments – Ms. Gardner
2. Public Comment
3. Components of a Capitated System – Bob Sheehan
4. Public Comment
5. Adjourn

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Community Mental Health Association of Michigan

Components for system design: Clinical and fiscal flexibility, risk sharing, and risk management within Michigan's Medicaid provider/CMHSP-sponsored managed care system

July 2023

Relevant documents:

- Advancing value-based care within health care strategy:
  Provider-sponsored health plans [1]
  Stephanie Beever, Deloitte
  2023

- An Introduction to Capitation and Health Care Provider Excess Insurance [2]
  Theresa W. Bourdon, FCAS, Keith Passwater, and Mark Riven, FCAS
  Developed for the Casualty Actuarial Society

- Subcapitation, managed care functions, and risk management
  Community Mental Health Association of Michigan
  (with link to United Hospital Fund in its report, "Capitation and the Evolving Roles of Providers and Payers in New York) [3]
  July 2023

Background to structure of Michigan's Medicaid behavioral health system: Michigan moved to a managed care system, in 1997, with the state's CMHSPs and, over time, public Prepaid Inpatient Health Plans (PIHPs, formed and governed by the CMHSPs), taking on the role of the managed care organization for the state's Medicaid behavioral health benefit.

This managed care system has the characteristics of a number of managed care and risk-sharing and risk management models. Because of this mix of characteristics, drawn from a number of models, each PIHP and its CMHSP sponsors (and, if possible, the Michigan Department of Health and Human Services) must weave together these characteristics into a Michigan-based model that is sound in its clinical/service delivery, fiscal, legal, and governance components.

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[1] https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/provider-sponsored-health-plans.html This article is part of a multi-part series on provider-sponsored plans. Download the blog to learn more.

[2] https://www.casact.org/sites/default/files/2021-02/pubs_dpp_dpp97_97dpp097.pdf

[3] https://uhfnyc.org/media/filer_public/7d/10/7d10a651-17a1-454a-b562-7c11e242822f/capitation-final_05052016.pdf

The Michigan system possesses the characteristics of the following managed care models:

- **Provider/CMHSP-sponsored health plans** (the state's PIHPs, whether sponsored by one or more CMSHPs)
- That use **sub-capitation payments** to finance its provider/CMHSP sponsors
- These CMHSPs **directly provide some services** (akin to a staff-model HMO) and **purchase other services** (akin to a network-model HMO).
- The latter are typically **purchased**, by the CMHSP (and for substance use disorder services, typically by the PIHP) via a **fee-for-service financing approach**.

Design of regional model: The risk sharing and risk management approaches inherent in these models must be integrated into a sound and sustainable design that captures the clinical and fiscal flexibility made possible through a capitated provider system while using a risk sharing/management approach that reflects the fact that the PIHPs are provider-sponsored plans.

The key components of such a design must address the key dimensions of the four components listed above.

1. **Governance of the provider-sponsored plan**: Determine the governance and decision making roles of the plan's provider/CMHSP sponsors: (**Note, the greater the risk held by the plan's CMHSP sponsors, the greater the governance and decision making roles of the CMHSPs**)
   - Considerable governance role by the plan's provider/CMHSP sponsors
   - Minimal to moderate governance role by the plan's provider/CMHSP sponsors
   - No governance role by the plan's provider/CMHSP sponsors

2. **Risk sharing arrangement**: Determine the risk bearing assumptions imbedded in the sub-capitation payment model:
   - Full financial risk assumption by CMHSP
   - Shared risk, between the PIHP and CMHSPs
   - All of the risk is assumed by the PIHP and none by the CMHSP sponsors

3. **Risk management tools held by CMHSPs**: If some level of risk is borne by the CMHSPs, which risk management tools are to be used by/available to the plan's CMHSP sponsors: (**Note, the greater the risk held by the plan's CMHSP sponsors, the more of these tools are needed to be held by the CMHSP**)
   - CMHSP assumes managed care functions required of a risk bearing health care organization
   - Joint risk pool held by the PIHP, with decisions relative to its use to be made, collectively, by CMHSP sponsors
   - Risk reserves held by PIHP (as above) and risk reserves held by risk-bearing CMHSP

4. **Risk management tools held by PIHP**: If some level of risk is borne by the PIHPs, which risk management tools are to be used by/available to the PIHP: (**Note, the greater the risk held by the PIHP, the more of these tools are needed to be held by the PIHP)**
   - PIHP assumes managed care functions required of a risk bearing health care organization
   - Risk pool held and managed by the PIHP, with or without decision-making role by plan's CMHSP sponsors

Excerpts from:

Advancing value-based care within health care strategy: Provider-sponsored health plans [1]

Stephanie Beever, Deloitte

2023

Market forces, the uptake of value-based care throughout the industry, and payer encroachment on traditional provider activities are placing additional stress on providers' financial performance. Can a move into health insurance help alleviate these pressures?

Increasing provider interest in health insurance: Why now?

The first part of our four-part blog series on value-based care payment models discussed the motivating factors for providers to take on increased risk, including consumer expectations, cost pressures, regulations, and COVID-19. Providers, driven by these pressures, are shifting from traditional fee-for-service payment models to value-based ones, with those most committed attempting to shift upward of 40% of their revenue to be managed under value-based contracts. This is fueling increased alignment between payer and provider incentives, and encouraging providers to build capabilities, traditionally held by payers, to enable success in such contracts.

As providers continue to build capabilities for success in value-based care and invest significant dollars, they are realizing that value-based contracts, and even partnerships with payers, may not maximize their capture of the premium dollar. Furthermore, payers are actively building or acquiring care delivery assets and capabilities such as primary care, home health, and pharmacy services.

Although, provider-sponsored plans (PSPs) are not a novel concept, with many PSPs existing and successful for decades, the industry's acceleration toward value-based care is pushing more health systems to explore the development of their own health insurance business or further integrate existing plan assets.

Benefits of having a provider-sponsored plan

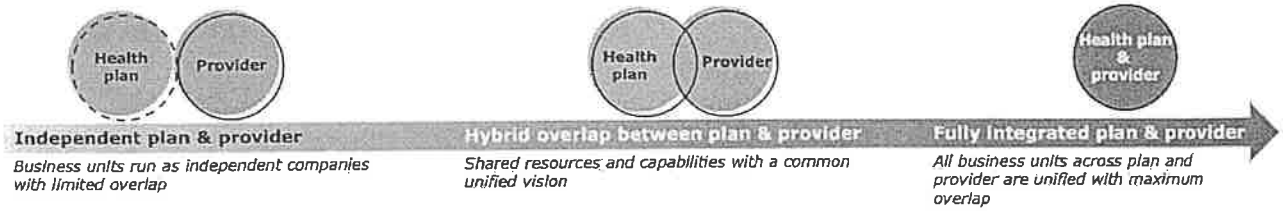
As providers and the industry head toward taking on additional financial risk, providers can anticipate several benefits from entering the plan space including:

- A more sustainable and predictable revenue flow
- The ability to fully capitalize on current population health capabilities
- Leveraging a potential plan as a growth tool to enter new markets and grow attributed lives within current markets
- The ability to maintain greater control over their network, patient experience, quality of care, and care model

[1] https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/provider-sponsored-health-plans.html This article is part of a multi-part series on provider-sponsored plans. **Download the blog to learn more.**

Expanding into the provider-sponsored plan space

Providers have a multitude of options to expand into the provider-sponsored plan space, with varying degrees of integration seen between payer and provider functions of organizations with plans currently. These varying degrees of integration have all demonstrated success, leading to multiple case studies of successful provider-sponsored plans.



Regardless of the integration model, successful provider-sponsored plans tend to have a 50-50 revenue split, or greater, of plan-to-provider revenue. This represents a tremendous long-term growth opportunity for providers that have stagnated growth due to physical and geographical limitations.

Successful plans identified by Deloitte have 500,000 to 12 million insurance lives. However, this growth did not occur overnight; most of these plans have been established for more than 30 years. Opportunities for providers to enter this space often occur in areas where they already share financial risk: their own employee base, Medicare/Medicare Advantage, and Medicaid.

Achieving 100,000 enrollees in one line of business typically achieves economies of scale in health plan capabilities, crossing a key threshold to be competitive with regional and national carriers in the markets the provider serves.

Key questions to ask before launching your own provider-sponsored plan

It is critical that providers enter the health insurance market with a targeted approach to reduce and manage financial volatility. The following are a few key questions providers can ask prior to launching their own provider-sponsored plan:

1. What insured populations does our provider system currently manage well, from both a care delivery and financial lens? What lines of business would our system like to target from a health plan lens, and why? What geographies can we serve with influence on care model, provider network, and incentive structures?
2. Does our organization have an existing network strategy? How do we assess the performance of our network? How will future partners fit in with the line of business/geographical strategy for our health plan vision?
3. How does a health plan strategy align with and assist in achieving enterprise goals?

Excerpts from:

An Introduction to Capitation and Health Care Provider Excess Insurance [1]

Theresa W. Bourdon, FCAS, Keith Passwater, and Mark Riven, FCAS
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CAPITATION

Defined formally, capitation is a fixed sum per person paid in advance of the coverage period to a healthcare entity in consideration of its providing, or arranging to provide, contracted healthcare services to the eligible person for the specified period.

For example, a hospital may receive a capitation premium of $50 per month for every member of a particular health plan. In return for this capitation (or per capita rate), the hospital agrees to provide hospital services to all members of that health plan, regardless of what the actual cost of these services ends up being.

In the example above, the risk to the hospital should be clear: it receives a fixed premium ("capitation") in return for services which may cost more or less than that premium. In effect, the hospital has become a mini-insurance company which receives a guaranteed cost premium in return for an agreement to provide services whose value is not initially known.

Among the different types of health insurance plans, capitation and its attendant risks can be pushed down to various levels. For instance, in a classic PPO structure, the PPO insurance company assumes and retains all insurance risk. The healthcare providers are paid on a fee-for-service basis, typically pre-negotiated at a discount off of normal charges, The providers bear little risk except for the fact that they have agreed to receive lower rates in the hopes that their volume of business will increase.

In a **staff model HMO**, the healthcare providers assume no insurance risk. Under this model, healthcare providers are employees ("staff) of the HMO. Th6 HMO collects a fixed premium per member in return for a promise to provide healthcare services to those members. **The HMO assumes and retains all insurance risk.**

In contrast to a staff model HMO, other types of HMOs may pass HMO-assumed insurance risk on to healthcare providers. This is similar to ceding risk in the property and casualty industry. In the context of our capitation example from above, let us assume the HMO receives $120 per member per year for healthcare. The HMO may cede some of the insurance risk by entering into a capitation arrangement with a hospital. Under this arrangement, the hospital agrees to provide hospital services to each member for $50 per member.

Additionally, the HMO may cede the remainder of its insurance risk to various primary care physician groups by offering them a capitation of $40 per member per year. This leaves the HMO with no insurance risk and $30 per member per month for ancillary services and administrative costs.

Continuing with this example, the hospital or physician group may in turn cede insurance risk by entering into capitation arrangements with healthcare specialists. The possibilities are almost endless. This transfer of insurance risk to small and often inexperienced entities has generated a need for a variety of products

[1] https://www.casact.org/sites/default/files/2021-02/pubs_dpp_dpp97_97dpp097.pdf

and services which are similar to those which exist in the property and casualty industry. These are discussed in detail below.

MANAGING CAPITATION RISK

The financing vehicles and risk management strategies being developed to respond to the increased use of capitation contracts by providers are not unlike those that have addressed property, casualty, and liability risk. Similar to the property and casualty industry, products and strategies are being developed to meet the specific risks of each unique provider group. Specific excess loss insurance, aggregate stop loss protection, alternative risk financing vehicles (including **self-insurance, pools**, and captives), and **administrative management services** all have come to the forefront in response to the great demand that providers have for financing and managing their exposure to the financial risk associated with capitation.

Subcapitation, managed care functions, and risk management

Community Mental Health Association of Michigan
July 2023

CMHSPs as Comprehensive Specialty Services Networks (CSSN) receiving advanced APM sub-capitated payments: Michigan's managed behavioral health Medicaid program is built on a structure that designates Michigan's CMHSPs as comprehensive providers receiving sub-capitation payments.

Since the 1998 implementation of the Michigan Medicaid Managed Specialty Supports and Services Program and subsequent federal waiver authorities, CMHSPs were designated as Comprehensive Specialty Services Networks (CSSNs) and are expected to create and maintain Provider Specialty Services Networks (PSSNs). This has been the state's expectations for all CMHSPs and is the very foundation for Michigan's unique managed care "carve-out" sole source contractual arrangement with the public community mental health system.

These roles are outlined in a number of foundational documents of Michigan's behavioral health Medicaid program, excerpts of which are provided below:

Michigan Department of Community Health; Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans; Final Version; September 2000

> ... CMHSPs in the affiliation would be eligible for a special provider designation – that of **"Comprehensive Specialty Service Network" (CSSN)** – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PHP or hub-CMHSP.

Michigan Department of Community Health; Specialty Pre-Paid Health Plan 2002 application for participation; January 2002

> Sub-capitation: An applicant **may sub-capitate for shared risk with affiliates** or established risk-sharing entities.

Advanced Alternative Payment Method (APM) financing Michigan's CMHSPs: Michigan's CMHSPs receive their Medicaid funding via a capitation method, for those CMHSPs who also serve as PIHPs, and via a sub-capitation or global budget, for those CMHSPs working within Regional PIHPs.

Providers in these advance alternative payment methods (APMs), take on a number of clinical and fiscal functions that are core to their work as advanced APM providers. These functions include:

- Utilization management (including eligibility determination, level of care determination, authorization, Utilization review)
- Network management (including staff/provider credentialing, network development, contract management)
- Quality Improvement (including standard setting, performance assessment, corporate and regulatory compliance, evaluation, and provider training)
- Financial management (including claims payment, fiscal risk management, and organizational fiscal management)
- Customer services (including complaints, grievances and appeals)
- Information services (including data aggregation and reporting)

As with all MCO-to- provider relations, the **PIHP retains the responsibility for ensuring that these functions are carried out by the comprehensive service provider** – by the receipt of reports from the comprehensive advanced

ABP provider, reviews of samples of work products and processes, audits, and the implementation of corrective action plans as needed.

These functions are those of a comprehensive APM-financed provider and not those of a managed care subcontractor.

One of the clearest descriptions of the roles that sub-capitated comprehensive provider networks is provided by the United Hospital Fund in its report, "Capitation and the Evolving Roles of Providers and Payers in New York". The most relevant segments of the roles that provider organizations take on to fulfill their obligations under a sub-capitated payment arrangement are included in Appendix A.

Appendix A:

Excerpts from the United Hospital Fund report: Capitation and the Evolving Roles of Providers and Payers in New York

Through our interviews with the outside experts, we developed a framework that identifies some of functions provided by payers under traditional payment schemes. In Table 1, we grouped those functions into four broad categories. **The experts whom we interviewed suggested that a (comprehensive provider) operating under a capitation contract would likely want to control or strongly influence those functions that have the greatest impact on the measures of the (comprehensive provider's) success: whether it improves quality, provider experience, and member experience, and whether it controls costs. They suggested that (comprehensive providers) themselves might want to assume responsibility for these functions, indicated by the areas (boxed) in the table.**

Table 1. Migrating (Comprehensive Provider) Administrative Functions from Payers
Boxed areas indicate functions for which (Comprehensive Providers) might assume responsibility.

Product design, sales, and regulatory compliance

Product Design
Actuarial soundness
Network design
Co-insurance and deductibles
Premium rate-setting

Marketing
Specify population covered
Purchaser relations
Advertising and sales

Provider-facing functions

Compliance & Risk Management
Insurance rules, regulations
Policies and procedures
Risk management

Provider Relations
Network management
Credentialing
Provider contracting
Provider communications

Medical Management
Quality reporting and improvement
Utilization management
Disease management
Care management

Care coordination

Member-facing functions
Customer Service
Member communications
Call center and member services
Health education
Track and report on member experience
Appeals and grievances

Finance, Planning, and Analysis
Finance
Pricing services
Receive, adjudicate, pay claims
Tracking expenditures
Monthly, regular reports to providers
Monitor and report to plan / purchaser
Reinsurance and stop-loss

Planning and Analytics
Planning
Claims data and analytics
Monitor, report on quality
Monitor utilization, expenses, costs
Track provider and network performance

(Underlined bold-faced text, in the following excerpts, is provided for emphasis)

Provider-Facing Functions. (Comprehensive providers) are responsible for the performance of an entire provider network in caring for their attributed population. To do so effectively, they must be prepared to assume or oversee a series of new functions that affect their relationships with participating providers, including credentialing, contracting, communications, and network management. **Most important, they will need to control processes for medical management,** including care management, quality improvement (identifying and spreading best practices and reducing variation), and **sensitive functions like pre-authorization and utilization management, which can greatly influence both costs of care and provider satisfaction.**

Finance, Planning, and Analytics. Perhaps the greatest challenge facing (comprehensive providers) **under capitation is in the broad category of finance, planning, and analytics.** Under shared savings and shared risk arrangements, (comprehensive providers) need to develop basic capabilities in some of these areas; but since most of their provider payments are still tied to fee-for-service billing (and only a small portion to the year-end bonuses based on the shared savings they may generate), their performance in these areas may not be perceived as critical.

Under capitation, however, (comprehensive providers) need robust health information and planning capacities, including the ability to assess and adjust for risk, to promptly produce clinical and claims data analytics needed to support quality improvement, to track performance against budget, and to mitigate the potential impact of the increased risk they are assuming. (Comprehensive providers) will also need to develop or acquire new financial, actuarial, and accounting systems, including the capacity to negotiate payment rates, and pay bills received from providers.