



MICHIGAN ASSOCIATION  
OF HEALTH PLANS

2012

## **Performance, Value, Outcomes: Medicaid Managed Care**

### **FY 2012-2013**

*The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.*

#### **Medicaid White Paper: FY 13**

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## **EXECUTIVE SUMMARY**

### **MEDICAID RECOMMENDATIONS FOR FY 13 AND BEYOND**

1. **Continue to assure actuarial sound rates** for all beneficiaries enrolled in Medicaid health plans.
2. **Assure the full six years of the Medicaid Health Plan Contract Term** (3 year contract with 3 one year extensions available) are completed. There is no need to establish a re-bid until the calendar year of 2015 with an effective date of 10/1/2015 (FY2016).
3. **Continue the process of moving more fee for service beneficiaries into managed care, including:**
  - a. Persons with Dual-Eligibility (see MAHP White Paper on initiative for Integrated care).
  - b. Children eligible for MI CHILD (enroll into Medicaid managed care and implement single contract).
  - c. Persons eligible for Children's Special Health Care Services.
4. **Reform Medicaid eligibility**
  - a. Implement the option to delink Medicaid application from other human services program applications.
  - b. Start planning now for a faster, cheaper and more user-friendly system for determining Medicaid eligibility to go into effect in 2014.
  - c. Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.
5. **Streamline and Coordinate the Administration and Oversight of Medicaid Health Plans and related contracted entities.**
  - a. Focus on coordination of an integrated benefit.
  - b. Implement performance standards documented by audited data, and supported by actuarial sound rates.
  - c. Focus on health outcomes using common metrics and objective and audited performance requirements.
  - d. Streamline unnecessary administrative costs by reducing or eliminating paper requirements in lieu of electronic documents and web-based information sites, requiring the use of deemed compliance by virtue of national accreditation such as NCQA or URAC, and changing the perspective to a "regulation by exception"—that is focused on contractors who are not meeting standards established in the contract.
6. **Maximize all levels of non-state General Fund support (Federal, special use and local revenue) to protect Michigan's Safety Net.** This would continue efforts for:

- a. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries
- b. Options to additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid.
- c. Increasing third party collections for Medicaid Managed Care Plans by providing access to other carrier data, including auto and BCBSM.
- d. Improved fraud and abuse coordination through the Medicaid Inspector General Office.
- e. Collaboration on efforts to reduce “waste” in our health system that will benefit all payers, including Medicaid.

**7. Move the Medicaid Program and Medicaid eligibility responsibility into a separate program linked to Michigan’s new Insurance Exchange**

**Recommendation Principles**

Without an underlying basis for reform in Medicaid—or other programs, the long-term sustainability will be weakened and opportunity for gaining public support will be missed. MAHP believes the following principles can be used to guide the changes necessary to transition Michigan’s Medicaid program through the next year(s):

- Enroll current beneficiaries into managed care rather than reducing optional benefits;
- Focus on ways to integrate benefits rather than reducing provider reimbursement;
- Identify ways to streamline and consolidate state agency bureaucracy, eliminate regulatory redundancy, and focus on contract performance; and
- Promote those administrative rules and Medicaid policies that make fiscal sense to Michigan and not focus on revenue neutrality.

**Savings Potential**

Taking the above principles and assuming implementation can occur over the next 2 years, Michigan can begin to realize significant program savings while fostering a more accountable and cost-effective program. For instance:

- **Savings from movement of populations into managed care.** There is an underlying rule of thumb that at least 5 percent of medical care treatment costs can be saved by movement into managed care. The tools, techniques, programs, and results of using Medicaid managed care are listed later in the MAHP White Paper.
- **Savings from Administration Efficiency.** There is no question that Michigan’s effort to serve the most vulnerable population has resulted in multiple initiatives and programs—all with administrative costs. By moving toward a comprehensive Medicaid benefit contract, Michigan can begin to reduce administrative cost and create a more seamless delivery of health care services.

- **Savings from State Administration.** Coupled with the development over the years of a number of initiatives to deliver various categorical or limited benefit programs, is the state oversight responsibility and contract management or administration. Consolidation will likely minimize or eliminate the need to replace vacancies that took place in the last state early retirement program and will enable the MDCH to utilize existing staff in new and important key roles. These savings are cost avoidance as early retirement savings have already been realized. However, a new contract management program would also utilize electronic submission, the deeming of national accreditation and establishing a program of regulation and oversight by exception. This will result in savings to contractors that can be realized in the cost of contracts.
- **Savings from Enabling Contractors to access data and Third Party Liabilities for recoveries.** While Michigan has been very innovative in development of the managed care performance based contract, there has been notable exception in the designation by the State to the Contractors to access Third Party Liability (TPL) and recovery information. It is estimated that many Medicaid beneficiaries have other insurance coverage through a spouse or family member. In addition, services may be covered by financial recoveries made of estates or related to accidents and auto related injuries. The monthly capitation payment premium established under actuarial sound principles makes assumptions regarding the amounts that will be recovered and inserts that amount as a credit in the overall calculation. If Michigan enabled Medicaid contracting health plans to be considered a part of the Medicaid Program for purposes of recovery, then the amount of the credit can be increased and amount of the necessary capitation reduced over time.
- **Savings from development and implementation of policies addressing “waste” in our health system.** There has been extensive research and studies regarding waste in the U.S. Health System compared to other countries. Further, there is ample documentation of regional variations within each state and between states. By starting to apply best practices models to the underlying Medicaid reimbursement model, Michigan can create significant health care savings without compromising quality of care or access. These savings will be more difficult to generate as much of it is embedded in current practice management and protocols and in some instances supported by existing state policies. One simple measure that we know is the number of admissions to an inpatient stay that could otherwise be treated in the community with an effective coordination and reimbursement policy. Later in this paper we show an illustration that Medicaid hospital utilization is 62% higher than commercial utilization. If we could lower that difference by half, Medicaid and Medicaid health plans could save millions. The development of an appropriate observation stay policy in lieu of hospital admission is another cost saving effort. There are many more that will be identified over the coming months provided the legislature and administration create a receptive environment to not just receive but act on such recommendations.

The above are examples of some of the major savings that Michigan could begin to realize by fundamentally changing the nature of the Medicaid program to one of contract management of a performance based comprehensive Medicaid benefit contract rather than the ongoing

bifurcation between that of fee for service and managed care. The focus could then be on outcome, performance and customer service. This agenda is doable, but will require action to:

- Amend state Medicaid waivers,
- Develop new waiver/state plan amendments,
- Develop enabling state legislation in such areas as TPL, and various mental health, public health and insurance code, and
- Re-deploy state employees into a consolidated administrative structure to administer and conduct appropriate oversight of the new contract mechanism.

It is all too easy to say we cannot make the changes and list countless reasons for that answer. We believe the current environment must emphasize support for developing a plan for **how** such changes can be made.

As the first year of the Snyder administration drew to a close, it was evident a substantial part of the agenda was to re-invent government in order to be more efficient and fiscally prudent in all areas of state government. Sustaining support for Medicaid during the past year was not only a clear objective of the administration; it was embraced by the Legislature as sound policy. This has historical roots in the reputation that Michigan has for its forward thinking in Medicaid. Michigan's approach is not only far ahead of other states but is fully matured—a large part of this is due to the economic efficiency of its fully developed managed care program. We should all expect that the executive and legislative decisions that will be made will not be marginal—but will be far reaching and purposeful in order to achieve agreed upon objectives and sustain the Medicaid program within available resources.

*From the perspective of MAHP, the undisputable key facts are:*

- **Nearly 3/4 of the cost of Medicaid still resides with the remaining fee for service Medicaid population not enrolled in managed care.** MAHP believes that the state can achieve significant cost savings, extend the value, (already documented by managed care), through further expansion and/or the application of managed care principles with other Medicaid eligible population and/or programs.
- The usual “strategy” in Medicaid reductions is to reduce provider rates. However, reducing provider reimbursement (which is among the lowest in the United States) increases the **cost shifting** to commercial carriers—that issue combined with **uncompensated care** for the uninsured has already pushed additional commercial annual premium costs by over \$1000 for families and nearly \$400 for individuals and is growing.
- **The familiar admonition of “first, do no harm” would suggest that we take great care in making decisions in Medicaid as overall access for all citizens is at risk** if we fail to adequately support Medicaid. If a physician closes his or her office, they are no longer there for everyone and if a hospital closes a unit, service, or program, it is no longer available regardless of payer status.

We can all agree that it is far preferable to develop a Medicaid solution that will maintain eligibility and support essential networks of providers than to cut either eligibility or reimbursement or both. However, in this economic environment, can we achieve this objective within the available revenue? MAHP believes we can, if the decisions are to work from a managed care environment. If not, then the only other solutions is to reduce provider payments and eliminate optional benefits—solutions that have far reaching consequences to Michigan’s overall health care.

### **Continue to focus on Value**

Policy makers, administrators and the public expect (and receive) value from the Michigan’s Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. The most obvious strength is cost savings.

However, there are still too many large populations that remain served in costly and poorly managed settings and programs and should be brought into the folds of the existing managed care programs. While the challenge will be great, the potential results in improved health care status, more accountable care, and economic savings are too great to ignore. Michigan’s Medicaid Managed Care Program has demonstrated that the effectiveness and efficiencies are in place to accomplish the expectations set forth by the Governor Snyder, namely wellness and prevention.

Based on prior economic studies the cost-effectiveness of Medicaid managed care continues to bring huge value to the state and federal government--minimally, over \$5 **billion in total savings** has been realized due to Medicaid Managed Care between FY 00 and FY 12 or about **\$400 million each year**. The savings (compared to fee-for-service) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state in exchange for actuarially sound funding. This return on investment enabled both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas while preserving the Medicaid program.

MAHP appreciates and supports the policy determination that is based on facts, performance and demonstrated outcomes. These are the successful building blocks of Medicaid managed care and it is a reasonable expectation that future executive and legislative decisions will similarly be based in order to achieve desired outcomes and stretch available state resources. Moreover, it is time to move forward with the Governor’s objective of having a patient centered model to achieve improvement in quality, promotion of wellness and realization of cost savings.

### **Current Opportunity**

One of the greatest cost saving opportunities for Michigan is to better manage two unique Medicaid populations of vulnerable Michigan citizens. The first group includes a population, which is eligible for both Medicare and Medicaid, and is better known as the “persons with dual eligibility.” These beneficiaries are generally the most chronically ill patients within both Medicare and Medicaid. They suffer from health problems such as diabetes, heart disease, Alzheimer’s disease and often from some degree of cognitive impairment or disability because

of their illness. Persons with dual eligibility require an array of services from multiple healthcare providers. This often leads to treatment silos, where physicians are unaware of ongoing treatment for other conditions which can result in duplication of services and a lack of continuity in patient-centered care planning.

Although Medicare covers basic healthcare services, including physician and hospital care, Medicaid covers long-term care and services as well as Medicare premiums and cost sharing. Nationwide, persons with dual eligibility represent just 18% of the Medicaid population but account for 46% of Medicaid expenditures. The Medicaid and Medicare programs pay fee-for-service for all health procedures performed for participants in these Medicaid groups which add significant cost – over \$7 billion annually. The second group is beneficiaries enrolled in the Children’s Special Health Care Services program which will be discussed in detail below.

### **Examples from Past**

In the past, responding to similar challenges and pressures, the Medicaid Administration mandated that all pregnant women and foster care children enroll into the existing managed care plans. This development has been effective and continues to assist with the savings Michigan realizes with the managed care programs. The partnership between the Medicaid Health Plans (contracted with the state) and the Medicaid Administration has been instrumental in the development of the operations to enroll these new populations and in the work to create an atmosphere that will “do not harm.” Because these populations came with a unique set of health care issues, thoughtfulness and care was taken to make sure the transition into managed care was accomplished with the well- being of the beneficiary at the pinnacle of the decision making process. This process should serve as the model for bringing additional populations in managed care.

### **Persons with Dual Eligibility**

MAHP expects that the enrollment of the persons with dual eligibility population into the managed care arena and the integration of all services should become a reality in 2013— following the development of a strategic plan, submission of a comprehensive waiver, negotiations with the federal government and completion of a request for proposal to select qualified managed care plans. Additional cost savings will be limited in the initial years but the potential overall savings as well as the overall provision of much needed services will be met. MAHP applauds the thorough stakeholder engagement process and believes the Medicaid health plans stand ready and able to assist in this transition and provide the necessary safety net for this vulnerable population. Working with other agencies responsible for the care of this population and developing an integrated model of care will be a major goal for the fiscal years 2013 and beyond. (MAHP has developed separate recommendations for this initiative and will have a separate “White Paper” for interested parties to review.)

### **Children with Special Health Care Needs**

The next population that should be enrolled into managed care is the Children with Special Health Care Needs. This is a very unique population funded by the Title V program of the Federal Government as well as State General Fund dollars in addition to Medicaid. This group usually has very complicated and unique health care issues which requires a team of providers to care for the individual. Therefore, the case management and special guidance from the health

plan representatives will be a strong functional arm for this population. Assuring the families of these children that their needs will continue to be met and the sub-specialty providers will be available for the care of the children will be of utmost importance. Therefore, a group effort between the Health Plans, providers and the department will be needed to preserve these assurances.

### **MI CHILD**

Another population to be considered is the MiChild Population. Michigan should combine the administration and contracting of this program and direct enrollment into the Medicaid Health Plans. This effort will eliminate the annual payments of at least \$12 million paid by State Government associated with a costly and unique settlement agreement with BCBSM. Other positive features of this consolidation will be to improve and document performance consistent with the proven record of Michigan's Medicaid health Plans. Moreover, it will provide a continuity of care for children and adolescents and their families and capitalize on Medicaid outreach efforts to reach those children eligible but not yet enrolled in MiChild. The federal reauthorization of the Child Health Insurance Program permits increasing the eligibility level for MICHILD in Michigan. It is possible through implementation of the recommendations, including redirecting the Blue Cross cost settlement dollars to raise enough new revenue to provide the necessary state match for MI CHILD and increase eligibility to 300% of poverty. This is a key recommendation made by many advocates.

### **Further Opportunity for Efficiencies and Reduction of Waste**

Without a doubt, waste in the Medicaid program must be addressed. There has been extensive research and studies regarding the waste in the U.S. Health System compared to other countries and there is ample documentation of regional variations within each state and between states. By starting to apply best practices and models and tying it to the underlying Medicaid reimbursement model, Michigan can create significant health care savings without compromising quality of care or access. Clearly, savings will be more difficult to generate as much of it is embedded in current practice management and protocols and in some instances supported by existing state policies. As an illustration, Medicaid hospital utilization is 62% higher than commercial utilization. If efforts can lower that difference by half, Medicaid and Medicaid health plans could save millions of dollars for taxpayers of this state.

The development of an appropriate observation stay policy in lieu of hospital admission is another cost saving effort. Additionally, avoiding hospital readmissions within 30 days of initial admission could prove to save health care dollars. .

Finally, MAHP and other organizations must continue to advocate for the immediate efforts to develop and implement the MI Health Marketplace (Michigan's Health Insurance Exchange). This effort will assist in the management and efficiency of administering the change in eligibility for Medicaid beneficiaries taking place in 2014.

## **Avoid Costly Rebid**

The Department of Community Health has many initiatives commencing in the current year and to continue into FY 13 which include:

1. Development of the plan for the Integrated Care for the persons with dual eligibility Project to send to CMS along with Waivers prepared for CMS and an RFP prepared for the procurement process of this plan
2. Preparing for the advent of the Michigan Market Place (the Insurance Exchange) which will change the face of insurance procurement for the citizens of Michigan
3. Preparing for the potential of 500,000 more Medicaid beneficiaries
4. The development and deployment of a new version of diagnoses codes, namely the ICD-10, an enormous system change undertaking

All of these initiatives require a tremendous amount of staff resources and expertise of both the state of Michigan and its consultants and the current and interested health plans who would submit proposals for review. Therefore, the MAHP recommends that Michigan utilizes the full option of 3 one-year extensions and until the scheduled end date of September 30, 2015 for the current Medicaid health plans contract. As documented in this White Paper, the quality of the services provided by Medicaid health plans continues to be high as evident in the national rankings of the health plans. The *2010-2011 National Committee on Quality Assurance (NCQA) Health Insurance Plan Rankings* rated the MAHP member health plans among the highest rated in Medicaid plans, (10 MAHP member health plans were in the top 50 Medicaid plans in the nation). In addition, Medicaid health plans have and continue to document that they have adequate capacity to fulfill the needs of the current Medicaid population as well as the anticipated growth. Therefore, there is no need to re-bid this contract until the full contract period is completed—this decision by itself will save Michigan government millions in resources that can otherwise be used for priority purposes.

## I. Creating Value for the State of Michigan

### Expectation of Performance

***In this environment, MAHP believes it is not possible to view the Medicaid program separate from overall delivery of health care in Michigan. Similarly, those who advocate for federal and state reform must include a vision of the future of Medicaid. The longstanding expectation of MAHP is that overall health care (including Medicaid) will reflect the following elements:***

- Improved access to affordable choices for all citizens.
- Protection of the safety net (Medicaid and MICHild)
- Linking payment to quality and performance outcomes.
- Cost containments that address overuse /underuse/misuse of health care resources.
- Transparency in pricing and provider rates.
- Personal accountability and wellness as part of a “value based benefit design” model
- Standardization and efficiency through technology

The value of Managed Care results from providing the right amount of health care, at the right time, in the right setting. Focusing on prevention and providing alternatives to high cost services and settings while maintaining quality are among the objectives of all managed care organizations — and particularly the focus of Medicaid health plans.

Unlike other service providers or contracts in the Medicaid program, Medicaid managed care operates in a performance-based environment under a full risk model. Medicaid health plans rely on data from their encounter and claims systems to identify high-cost conditions and cases and then target these conditions through programs and interventions designed to ensure quality care while at the same time reducing costs. Attachment 3 of this White Paper lists a variety of the administrative tools used by Medicaid health plans in quality assurance and improvement initiatives. The development of quality improvement initiatives, led by health plan medical directors and quality improvement directors, are predicated on evidence-based<sup>1</sup> models of care and guidelines. It is these guidelines and protocols that improve quality and access and, most important in today’s environment, save dollars.

Medicaid health plans either participate in the Michigan Quality Improvement Committee (MQIC), a consortium of medical directors of health plans organized to establish a common set of guidelines, or use the outcomes of MQIC<sup>2</sup>. Other evidence-based guidelines come from the United States Preventive Health Task Force, whose work can be found on the following website: <http://www.ahrq.gov/clinic/uspstfix.htm>

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<sup>1</sup> MAHP White Paper: The Value Of Evidence Based Medicine:  
<http://www.mahp.org/resources/MAHPEBMfinalNov2011pdf.pdf>

<sup>2</sup> The MQIC website is located at: <http://www.mqic.org/guid.htm>

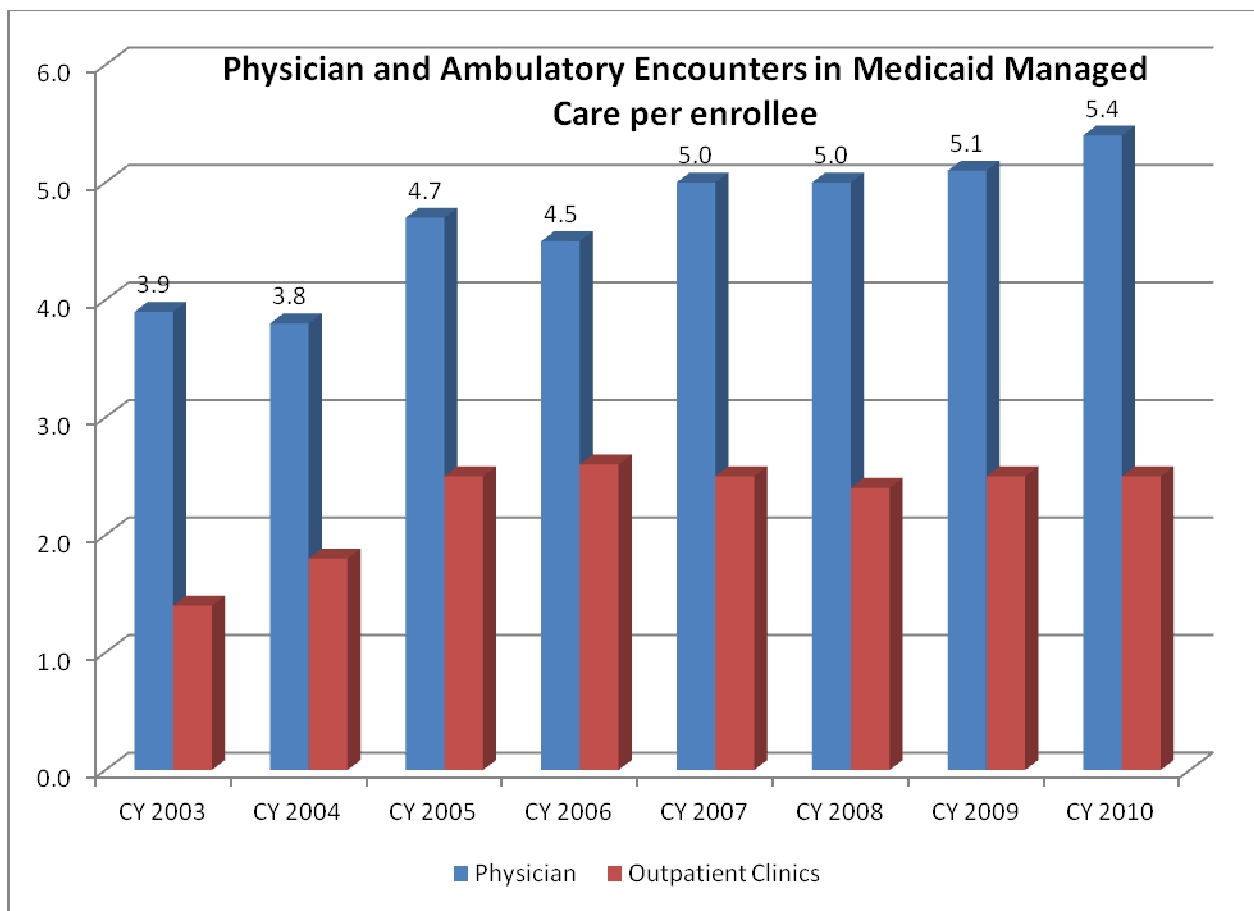
It is therefore no surprise that the business plans of Medicaid health plans are based on key strategies that emphasize the following:

- A focus on preventive health care;
- Coordinated disease management;
- Effective management of utilization;
- Key indicators for improved health status of beneficiaries;
- Assurances that access to care for members is available;
- Quality monitoring of performance;
- Preferred pricing arrangements that emphasize improvement in care; and
- Claims management, coordination of Benefits, and protection against fraud and abuse.

### Reducing Hospital Utilization

Providing the right amount of care in the right setting often means more physician and ambulatory visits. Chart 1 outlines the trend in utilization in those settings for Medicaid Health plan and also is a clear indication of the access for services by Medicaid beneficiaries.

Chart 1



The potential for moving further in this direction is highlighted by data produced by the Michigan Department of Community Health<sup>3</sup>. This data has documented the extent of preventable hospitalizations in Michigan by condition, age and gender. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care.

This set of preventable hospitalizations is further illustrated by the conditions listed below in Table 1. The information is not intended to indicate that the hospital care was not appropriate — this information is intended to indicate that the admission itself was not necessary — IF — appropriate alternatives had been in place. While this represents a snapshot of all of Michigan’s population and hospitalizations in 2008, it is not difficult to picture the targeted areas for Medicaid that would include such conditions as asthma and diabetes, (conditions that already have well-developed case management programs used in managed care programs).

**TABLE 1**  
**Ambulatory Care Sensitive Hospitalizations and Rates per 10,000 Population**  
**for Patients of All Ages Michigan Residents, 2004-2009**

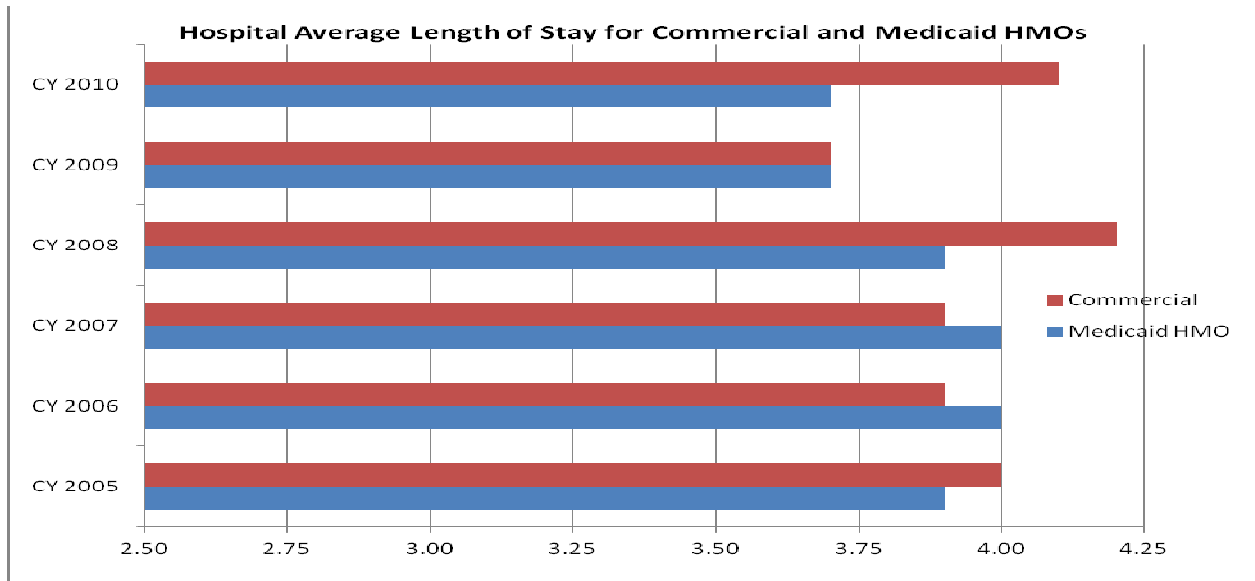
<b>AMBULATORY CARE SENSITIVE CONDITIONS</b> <a href="#">View ICD-CM Codes</a>	<b>HOSPITALIZATIONS</b>		<b>RATE PER 10,000 POPULATION</b>	
	<b>Average Annual Number for 2004-2008</b>	<b>2009</b>	<b>Average Annual Rate for 2004-2008</b>	<b>2009</b>
ALL AMBULATORY CARE SENSITIVE CONDITIONS	264,601	270,436	262.5± 0.4	271.3± 1.0
Congestive Heart Failure	40,852	38,230	40.5± 0.2	38.3± 0.4
Bacterial Pneumonia	35,899	31,715	35.6± 0.2	31.8± 0.3
Chronic Obstructive Pulmonary	22,841	26,916	22.7± 0.1	27.0± 0.3
Kidney/Urinary Infections	15,601	17,469	15.5± 0.1	17.5± 0.3
Asthma	16,310	16,871	16.2± 0.1	16.9± 0.3
Cellulitis	14,499	15,273	14.4± 0.1	15.3± 0.2
Diabetes	12,060	13,231	12.0± 0.1	13.3± 0.2
Dehydration	9,239	8,894	9.2± 0.1	8.9± 0.2
Grand Mal & Other Epileptic Conditions	3,833	7,240	3.8± 0.1	7.3± 0.2
Gastroenteritis	3,972	3,828	3.9± 0.1	3.8± 0.1
All Other Ambulatory Care Sensitive Conditions	89,495	90,769	88.8± 0.3	91.0± 0.6

<sup>3</sup> See MDCH Web site Report for Preventable Hospitalizations at:  
<http://www.mdch.state.mi.us/pha/osr/CHI/HOSP/PHT7TT.ASP>

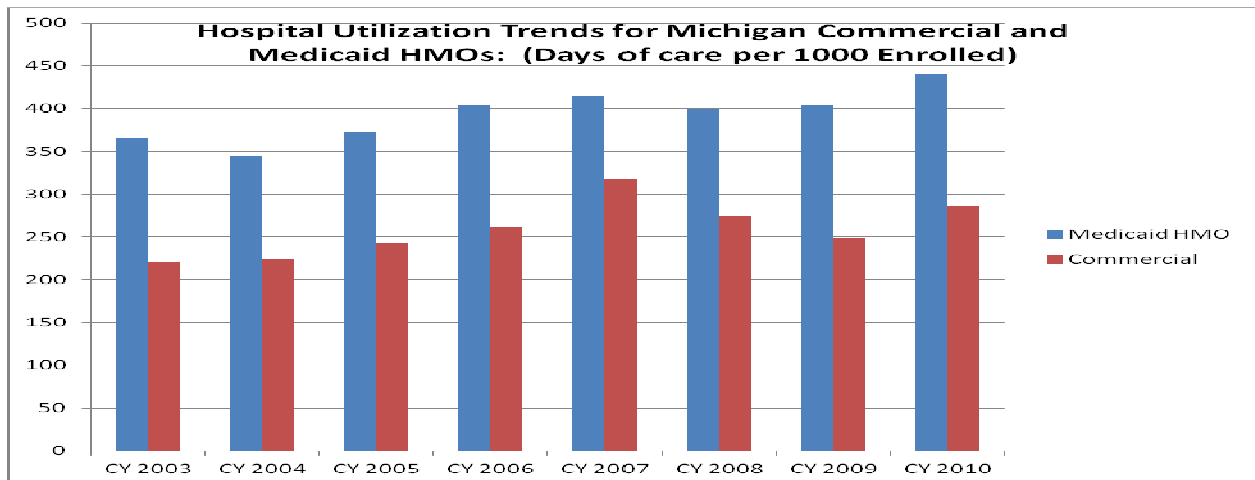
Overall, the Department has projected in its most recent update that many of hospitalizations are preventable. That is, the hospitalizations taking place are for conditions where timely and effective ambulatory care can decrease the number of admissions by preventing the onset of an illness or condition, controlling an episode, or proactively managing chronic disease/condition.

Chart 2 and 3 also illustrates a point that bears repeating—that is, the Medicaid population has generally more acute illness and while overall admissions may be less than commercial populations—overall days of care are much more. Therefore, while access to Michigan’s hospitals for appropriate use of care is part of overall management of care, a more cost effective approach will require the development and use of community based outpatient alternatives.

**Chart 2**



**Chart 3**



## II. Building the Infrastructure for Medicaid Managed Care

Cost-effective health care, high quality health care and improved access to health care: these are terms that continue to describe the demonstrated and audited outcomes of the Michigan managed care program. Translated into monetary terms, this means almost \$400 million in annual savings for Michigan tax payers, improved health status measures for adolescents and adults, and greater access to needed health care services.

### Recent History

Through competitive bidding (that began in 1997 in SE Michigan; in 1998 for the remainder of state; 2000, 2004 and again 2009 statewide), the Medicaid managed care program has provided the following results:

1. Medicaid managed care expenditures are managed and predictable. An immediate savings of about \$120 million to the state occurred for the FY 1997-1998 budget — a savings that has grown to an estimated \$400 million annually as nearly 2/3 of all Medicaid beneficiaries are now enrolled in this program. Despite the fact that Medicaid remains an entitlement program, beneficiaries' expenditures are capped in Medicaid managed care and total payments may only increase by caseload changes. While rates have been adjusted over time to assure actuarial sound funding, the savings to the state compared to the previous program (fee-for-service) have grown.

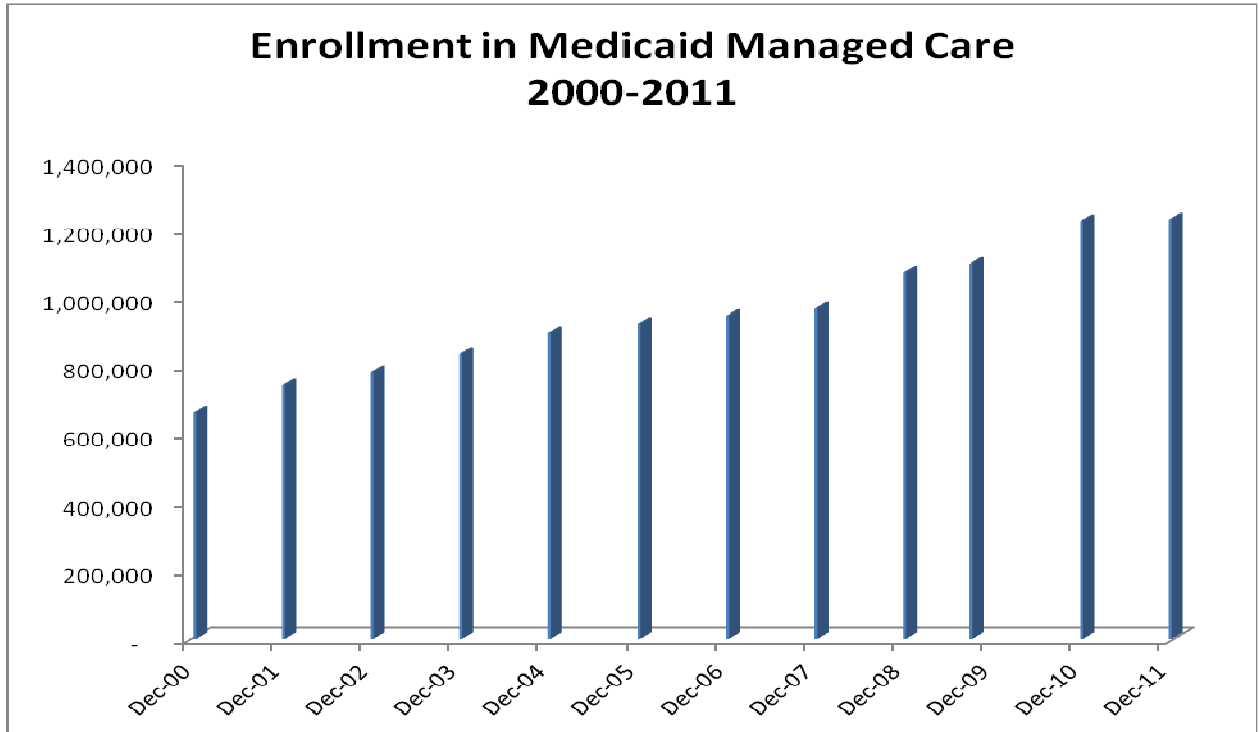
### Per Member Per Month Increases: Managed Care vs. Fee-for-Service

Unlike Medicaid managed care program, the state has little or no ability to control utilization, technology and other health care cost “drivers” in fee-for-service that result in increased and uncontrollable expenditures.

Due to the growth in managed care enrollment, the percent of managed care expenditures has grown to over 25% of total Medicaid expenditures. However, without the cost-effectiveness of Medicaid managed care, the expenditures in fee-for-service would have increased substantially (more than \$400 million each year) over the amount currently allocated to Medicaid health plans — and without the improved health status, access and accountability.

Is there opportunity to extrapolate the principles of managed care to other segments of the Medicaid program? The answer to that question is “yes,” most notably in long-term care and disabled populations. As noted by many observers, the most significant cost increases in Medicaid are taking place in these two areas. The two-thirds of Medicaid beneficiaries enrolled in managed care (see Chart 4) are now in an environment that provides predictable savings to the state by virtue of being enrolled in Medicaid health plans. The remaining 1/3 of beneficiaries are in settings that present significant opportunity for additional cost control and savings comparable to those implemented by managed care for the State of Michigan.

Chart 4



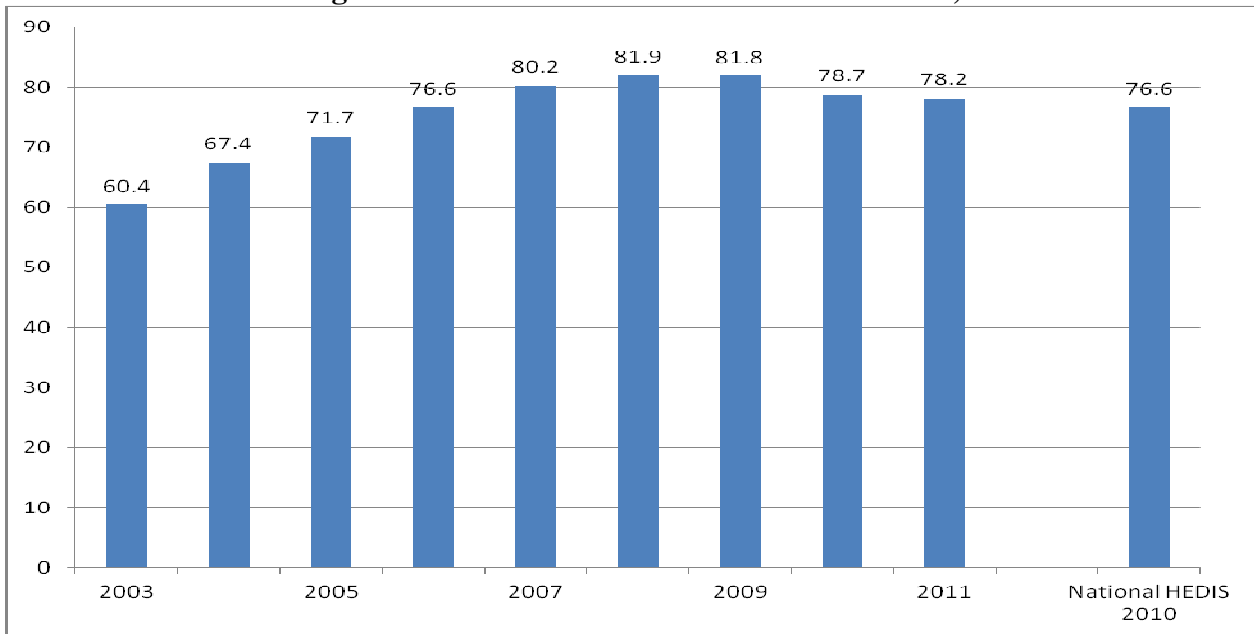
2. Services provided by Medicaid health plans are accountable under terms of both the state's contract and the HMO requirements in the Insurance Code.

There are five major elements to the Medicaid managed care program that give meaning to “accountability.” The first element is the use of audited data related to the clinical quality of care. Among the sources for this is the data developed for the National Committee on Quality Assurance (NCQA). This data is known as the Health and Employer Data Information Set (HEDIS®). HEDIS® data is collected for both commercial and Medicaid products provided by health maintenance organizations. External auditors, certified by the NCQA, are used by HMOs to process administrative and medical record data for various key measures.

Through the use of HEDIS® data, comparisons are made regarding the relative performance of Medicaid managed care programs to the industry average in Michigan as well as to national Medicaid averages. No other segment of the health care industry reports on as broad a range of clinical measures. The most current HEDIS® reports are available on following URL: [http://www.michigan.gov/mdch/0,4612,7-132-2943\\_4860---,00.html](http://www.michigan.gov/mdch/0,4612,7-132-2943_4860---,00.html)

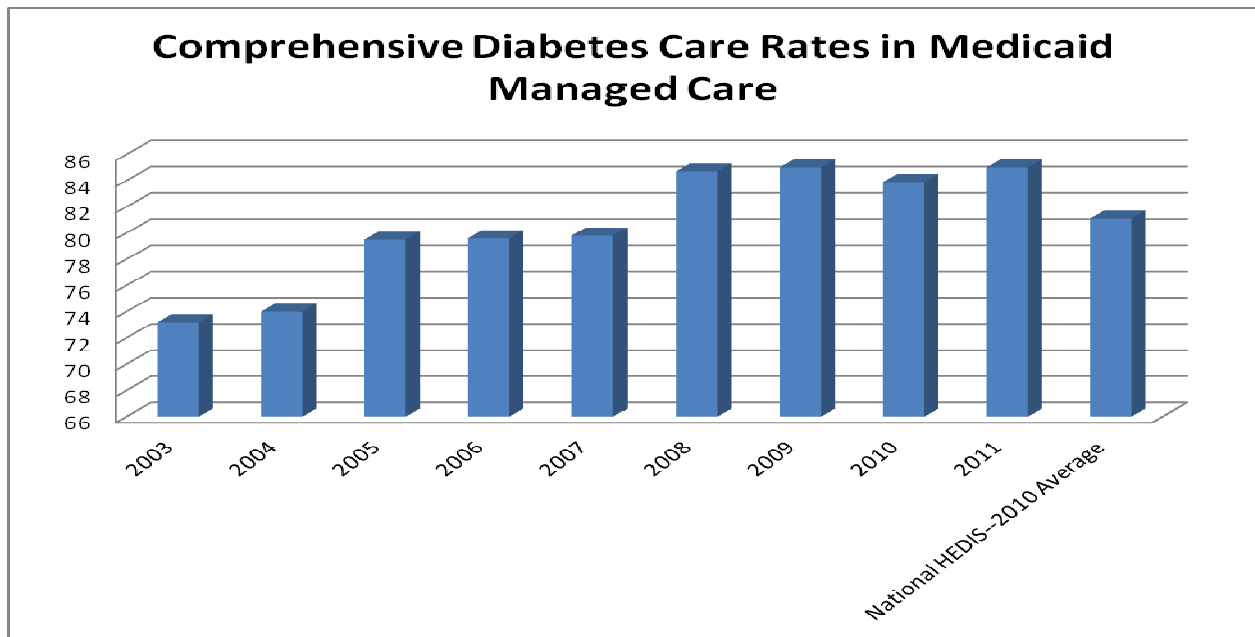
An illustration of the improved performance of Medicaid health plans has been in the area of immunizations. Under the HEDIS® analysis, key areas are reviewed each year — immunizations being one area. NCQA has now developed national Medicaid averages that states can use for comparison purposes. As displayed in Chart 5 below, the Michigan Medicaid managed care average immunization rate has increased by nearly 33% since 2003.

**Chart 5**  
**Medicaid Managed Care and Childhood Immunization Rates, Combo 2**



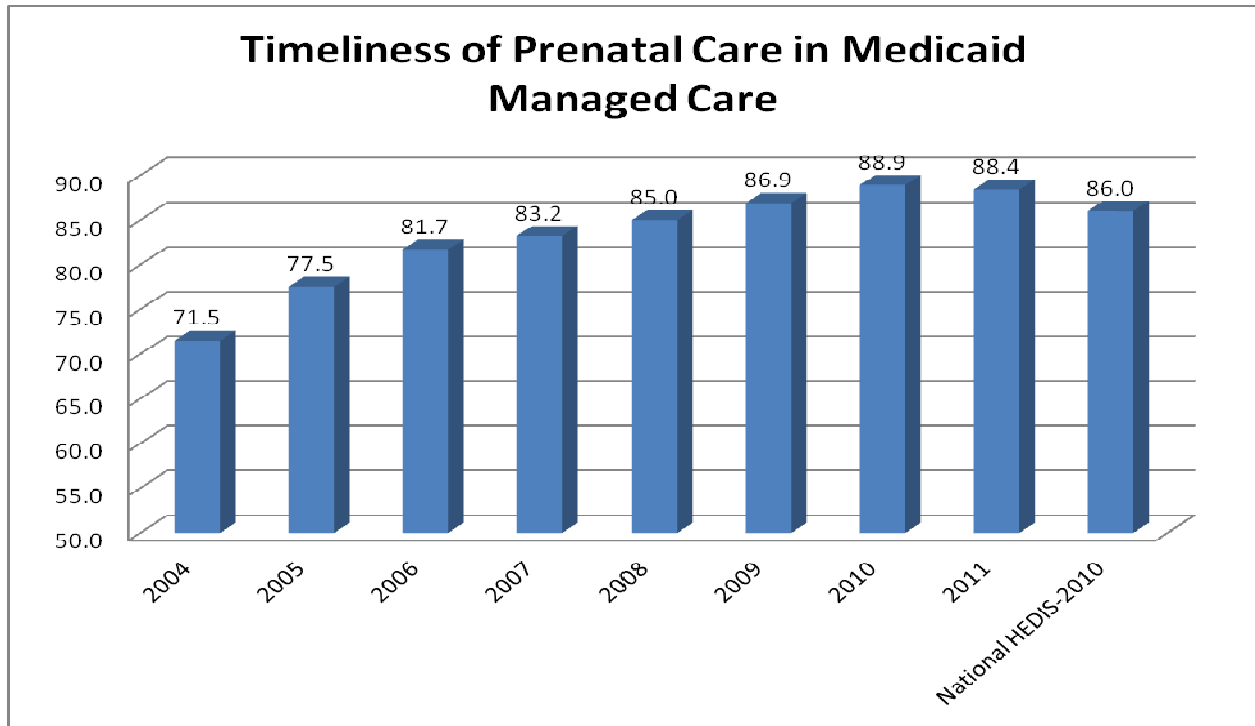
Further, the performance by Medicaid health plans enabled Michigan’s overall performance in immunizations to leap forward over the past several years from nearly last in the United States to being one of the top performing states. Another example of audited data showing clinical quality outcomes is *diabetes*. As Chart 6 illustrates, the basic diabetic testing rate has increased substantially over the past several years and is above the comparable Medicaid national average.

**Chart 6**  
**Comprehensive Diabetes Care Rates in Medicaid Managed Care**



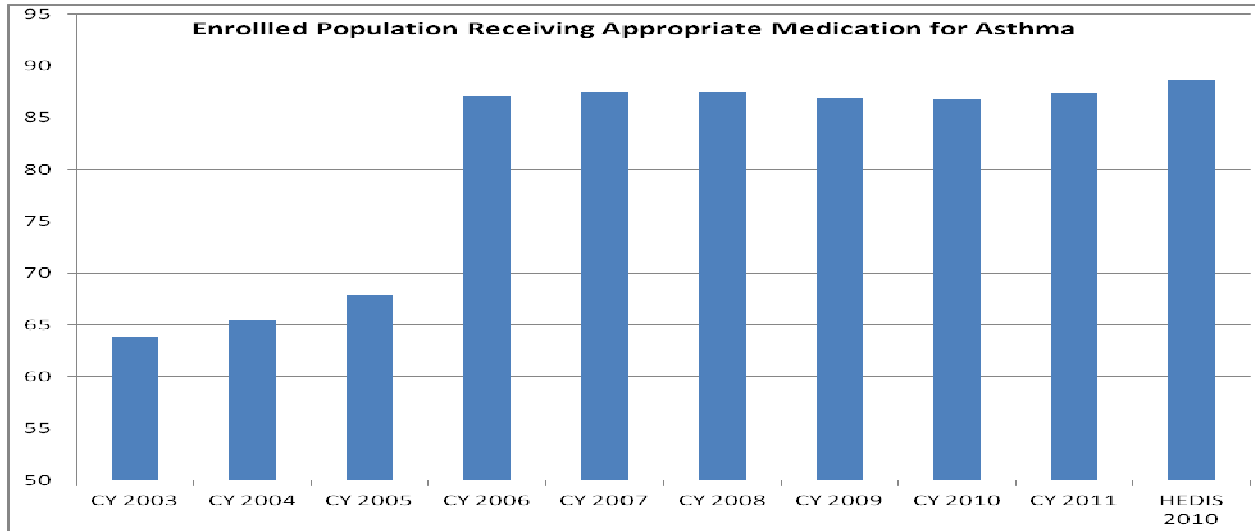
Another area is prenatal care which has always been a marker in the determination of safe and healthy deliveries and reducing infant mortality rates. Medicaid Health Plans have emphasized prenatal care, and the results are illustrated below in Chart 7.

**Chart 7**



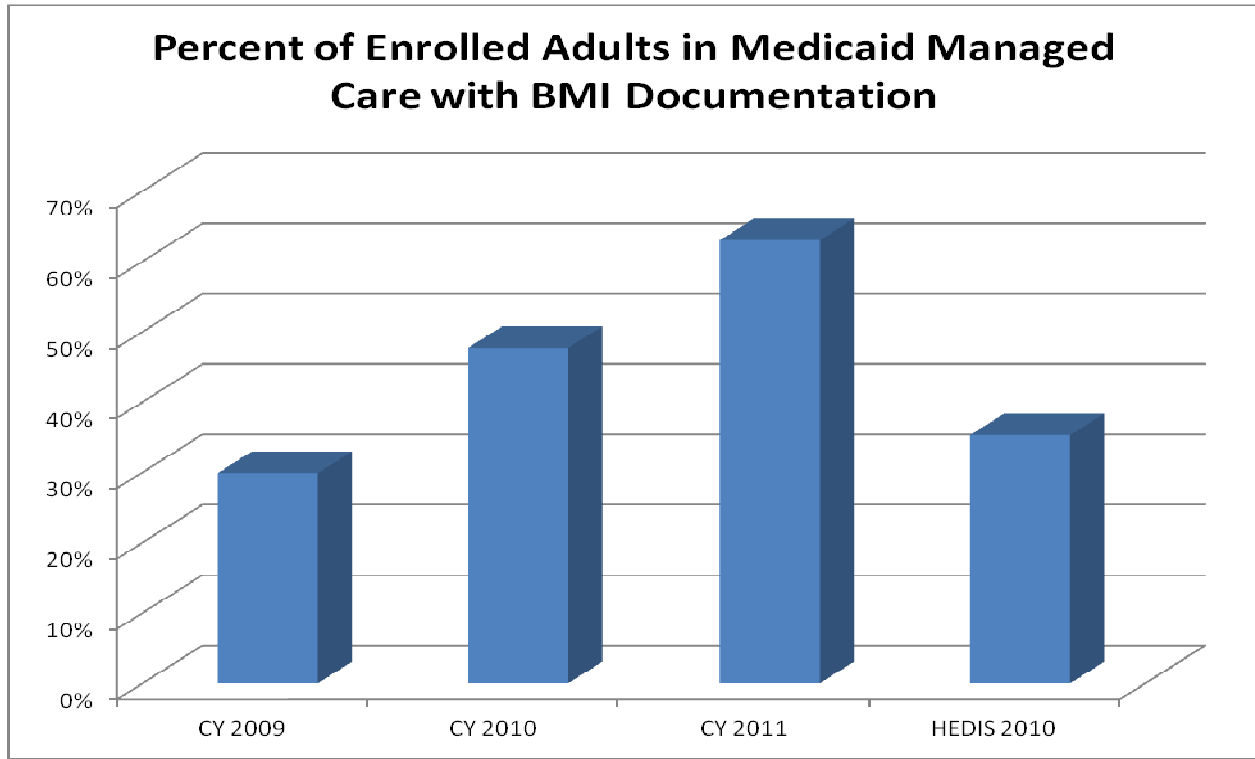
Another example that illustrates improvement in services for a condition that is common for Medicaid, particularly for children — asthma — is displayed below in Chart 8.

**Chart 8**



Finally, and consistent with Governor Snyder’s dashboard objective for obesity in Michigan, is the measurement of the percent of adults who have their BMI documented during a physician or ambulatory encounter during the enrollment year. As indicated in Chart 9 below, significant progress has taken place in this measure. Having access to the data on the MCIR will further assist in the management of this health care issue.

Chart 9



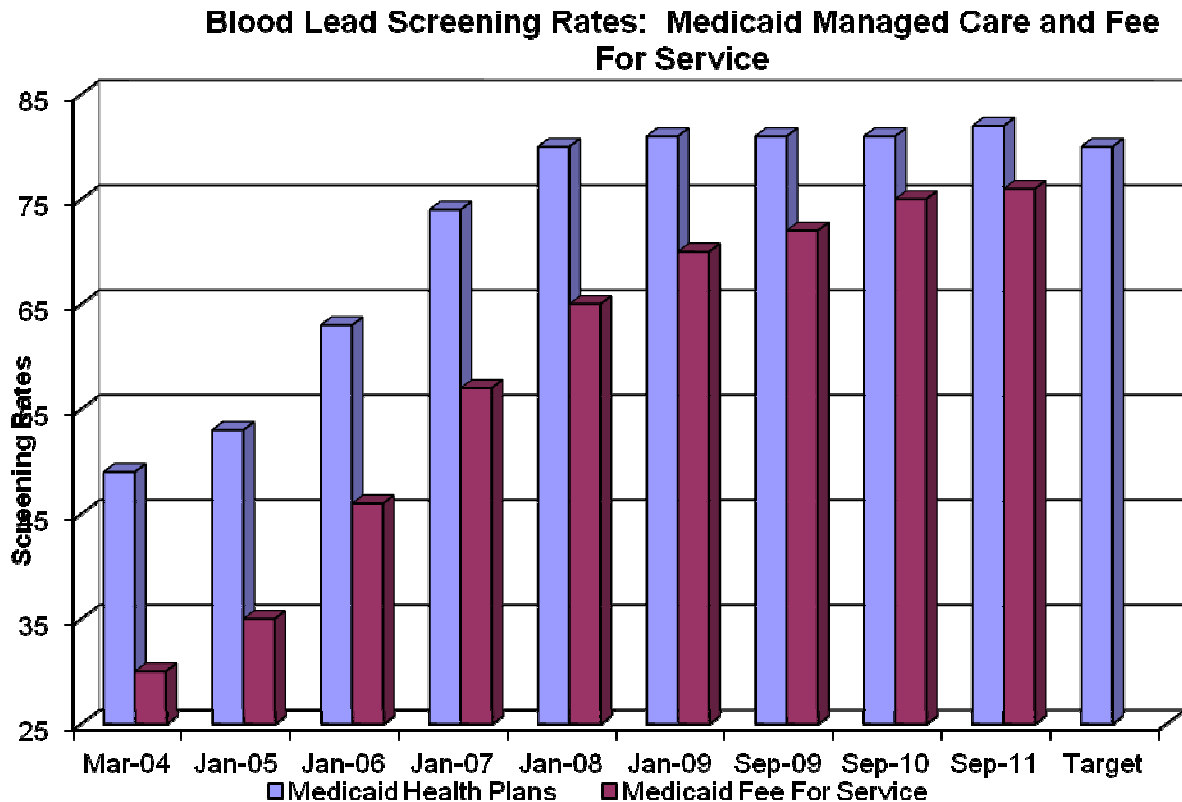
The second element is the use of external measures to determine customer satisfaction. Again, the standard used in Michigan is the customer services satisfaction survey of the NCQA. This survey is known as Consumer Assessment of Health Plan Survey, (CAHPS). This is a tool that is used for both commercial and Medicaid products; however, the child component of CAHPS is only available for the Medicaid program and is now conducted every other year.

MDCH summarizes all of this information into a Consumer Guide provided to new beneficiaries in Medicaid who are then presented with choices for health plan selection.

The third element for accountability is the use of performance standards. These standards are specific to Michigan and are reviewed and revised each year by the MDCH to reflect important categories of service. An example of the dynamic nature of this area, MDCH developed a new performance standard for blood-lead screening rates for health plan performance consistent with the standard specified in recent legislation.

As outlined in Chart 10, Medicaid health plans have recorded over a 60% increase in the screening rate objective established under legislation **and continue to meet the targeted 80%**.

**Chart 10**



Accountability to the state under terms of the contract has made a difference in this area. This is more outstanding when compared to measures in the fee-for-service environment of Medicaid at the same time. The illustration demonstrates the power of accountability. Unfortunately, we have no similar measures in other programs, such as the MI-CHILD program — although many of those enrolled in MI-CHILD live in the same targeted zip codes of Michigan that have the same high levels of exposure to lead as Medicaid beneficiaries.

This accountability has also been recognized nationally as Michigan’s Medicaid health plans were recognized again by the NCQA in October of 2011 as having 10 of the 50 top ranked Medicaid plans in the United States based upon performance scores.

<http://www.consumerreports.org/health/insurance/medicaid-1.htm> for Medicaid HMO rankings

The fourth element for accountability is the reporting requirements established under the state contract — coupled with reporting requirements required as a licensed HMO. Unlike other health care providers, the reporting requirements are significant and are a matter of public record. The reporting addresses such major areas as:

- utilization of services of enrolled members (monthly encounter reporting);
- customer satisfaction (semi-annual Complaint and Grievance Reports);
- claims payment (monthly claims reporting to DCH and quarterly reporting to OFIR relative to denied claims, and Third Party Liability Reports);

- financial reporting (quarterly and annual filings with OFIR — available on the OFIR Web site)

The fifth element is external accreditation from national organizations. All Medicaid health plans are nationally accredited by either the National Committee on Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). This assures the public that Medicaid health plans are providing value and accountability and are subject to the external auditing process of the national accrediting bodies.

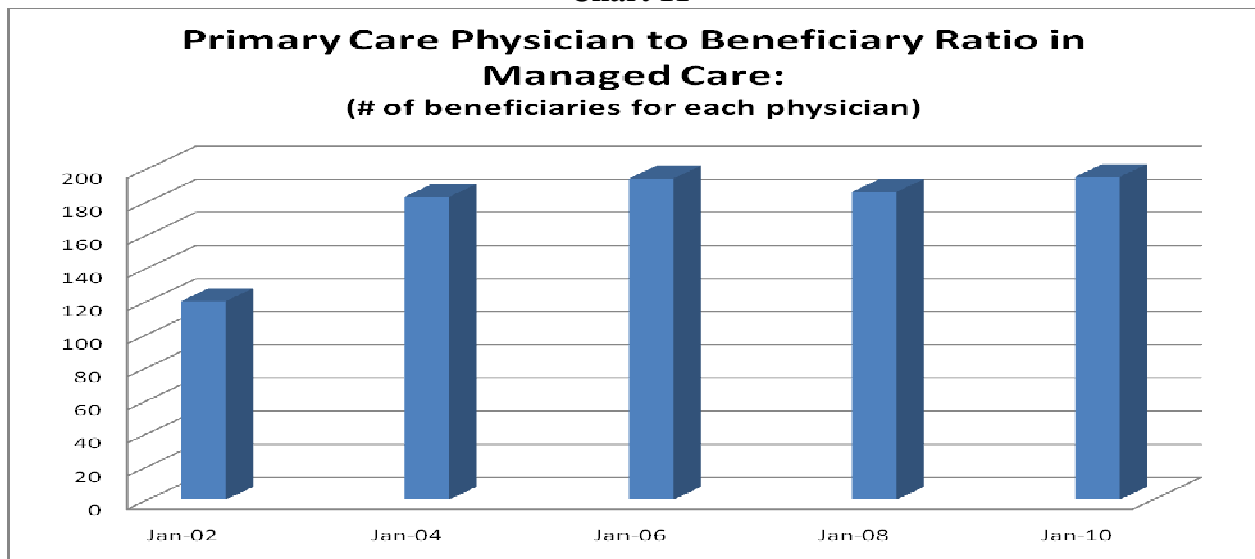
Additional accountability is provided through:

- external quality reviews under contract from MDCH, (medical record reviews provided by a vendor approved by the federal government);
- annual site visits by both DCH and OFIR;
- program audits performed by the Michigan Auditor General’s Office;
- federal waiver review conducted by the Federal Centers for Medicare and Medicaid Services (CMS);
- federal audits performed by the United States Office of Inspector General and the United States General Accounting Office.

3. Greater access to care is provided for enrolled beneficiaries and customer service is assured.

It is essential that each Medicaid beneficiary have a “medical home.” Access to primary care providers (PCPs), as well as choice among PCPs, are the hallmark of the managed care program and provide this “medical home.” Also, as shown below, and earlier in Chart 1, beneficiaries have increased access to primary care physicians, indicating continued access to care.

**Chart 11**



The state documents voluntary and mandatory enrollment rates and beneficiary choices of PCPs among the measures used to assess whether needed care is available — even care for specialty services that may require the use of transportation services. Medicaid beneficiaries today have access to about 40% more physicians when compared to the physicians enrolled in the former Medicaid Physician Sponsor Plan in operation during the mid-1990s prior to the implementation of Medicaid managed care. This is due to the ability of health plans to contract with systems and physician organizations that bring more physicians to participate with Medicaid compared to fee-for-service.

Provider participation should not be taken for granted and recent provider cuts are beginning to erode overall Medicaid participation. A clear signal of support for providers in Medicaid is necessary and no stronger message can be sent than support to raise provider reimbursement to Medicare levels.

Chart 11, above, displays the ratio of contracted physicians over the past several years. The overall ratio of PCPs has remained relatively constant over the past several years, but there is growing anxiety regarding issues relative to overall physician supply that will affect all health care delivery in Michigan. Finally, readers should view these ratios in the context of the standard ratio of 1:1500 used by state and federal government regarding a definition of shortage area.

#### 4. Administrative functions are built into state contract.

To gain cost predictability and control without sacrificing medical benefits and to improve quality, the state engaged Medicaid health plans *to perform functions that had previously never been performed for Medicaid beneficiaries*. The underlying administrative infrastructure that is required for each HMO must be understood as critical to their ongoing performance and part of what insulates the state from open-ended expenditures. More simply put, it is this structure that continues to generate the state's savings realized through Medicaid managed care.

Administrative costs savings have been created through efficiency in operations and continuous quality improvement practices. Because the state's contract allocates the number of approved plans for each of the ten regions, the number of health plans selected in each region is limited to the capacity sought by the state. That capacity is established each time the contract is bid as illustrated in the graph below. Moreover, due to Michigan's unique development of health care systems, there is more of a reliance on regional health care delivery than statewide or national health systems.

Historically, in the Medicaid fee-for-service program, the state's major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed either as to unit or utilization cost increases and as a result, state budget expenditures increased significantly from year to year and were unpredictable. Additionally, the state under fee-for-service does not provide case management services to managed high-cost cases and facilitate improved health outcomes.

An Administrative Function Table is attached to the end of this paper (Attachment 3). It describes administrative "functions" required under the Medicaid contract. Costs associated with these "functions" are not included in those costs labeled "medical costs" or "medical loss ratio;"

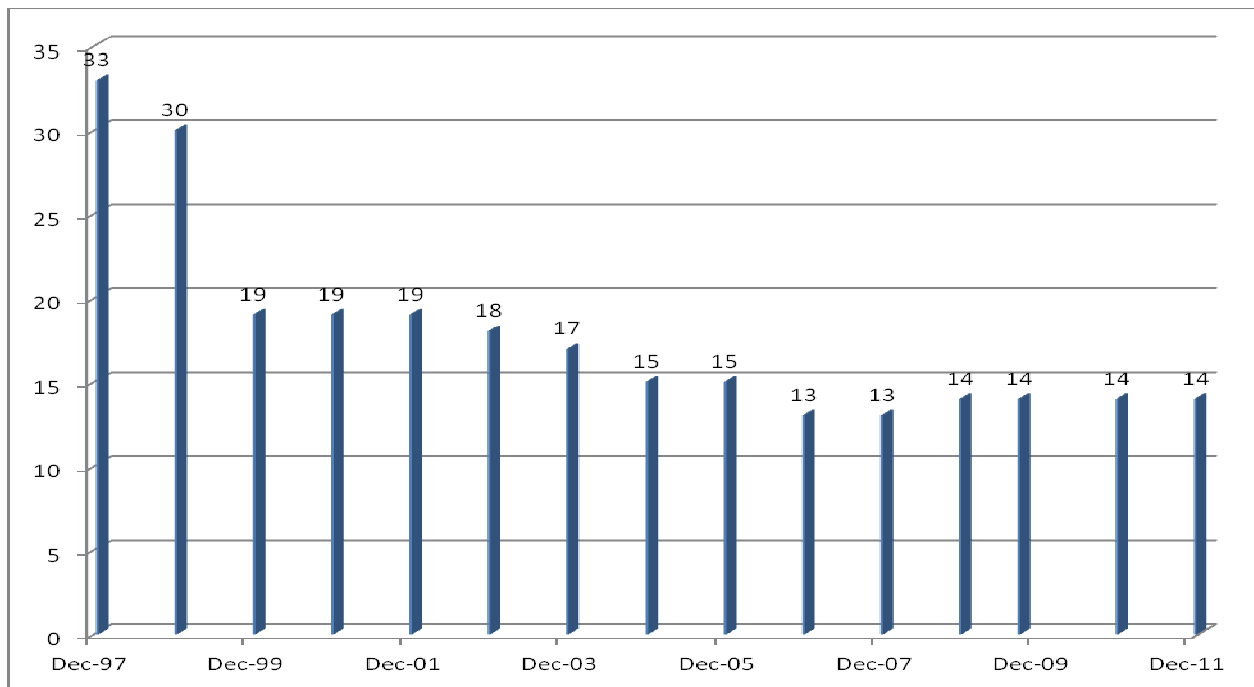
those measures typically are used to identify how much of the premium dollar received by an HMO is spent on direct health care delivery services.

The cost for the “administrative functions” outlined in Attachment 3 is inherently necessary in order to establish and sustain the improved delivery of services for Medicaid beneficiaries. These functions are consistent with the objectives prescribed by the state and to continue to provide the best value for the State of Michigan. Reporting on administrative costs is part of the annual filings with the Office of Financial and Regulatory Services. It is well known that there are more required administrative services for the Medicaid program than other insurance products — therefore, comparisons with other carriers or models should be carefully made.

By virtue of the state’s contract, each Medicaid health plan has “purchased” all of the risk from the State of Michigan to provide all services and meet the technical and quality requirements of the contract. While most observers are familiar with the medical benefits included in the HMO contract, many have not linked the essential fact that the costs and expenditure savings results that have been achieved **are the product of “administrative costs.”**

**Chart 12**

**Number of Contracting Plans at the end of Each Calendar Year**



In other words, the state’s return on investment — the improved health status and access to care as documented in this paper and the hundreds of millions of dollars in savings compared to Medicaid fee-for-service — would not be possible without the investment in the Medicaid managed care infrastructure supported by administrative costs.

## Summary

The information and data in this White Paper are intended to provide an overall illustration of how the Medicaid health plans are able to achieve both cost savings and outstanding quality of care ratings. The reader should also understand that this program has achieved a benchmark status not only in terms of its value by any measure — but also by its potential to serve as a guide for further improvements in the overall Medicaid program.

It is critical that this benchmark remain viable in its partnership with the State of Michigan. The state's obligation to administer this program in an actuarial sound manner is of paramount importance. The Michigan Association of Health Plans and its members recognize the resource constraints facing the state and have proposed recommendations found on the following pages that can permit this program to be continued funded under the federal requirements.

### **III. MAHP FY 13 Recommendations for FY 13 and Beyond**

- 1. Continue to assure actuarial sound rates for all beneficiaries enrolled in Medicaid health plans.**
- 2. Assure the full six years of the Medicaid Health Plan Contract Term (3 year contract with 3 one year extensions available) are completed.** There is no need to establish a re-bid until the calendar year of 2015 with an effective date of 10/1/2015 (FY2016).
- 3. Continue the process of moving more fee for service beneficiaries into managed care, including:**
  - a. Persons with Dual-Eligibility (see MAHP White Paper on initiative for integrated care).
  - b. Children eligible for MI CHILD (enroll into Medicaid managed care and implement single contract).
  - c. Persons eligible for Children’s Special Health Care Services.
- 4. Reform Medicaid eligibility**
  - a. Implement the option to delink Medicaid application from other human services program applications.
  - b. Start planning now for a faster, cheaper and more user-friendly system for determining Medicaid eligibility to go into effect in 2014.
  - c. Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.
- 5. Streamline and Coordinate the Administration and Oversight of Medicaid Health Plans and related contracted entities.**
  - a. Focus on coordination of an integrated benefit.
  - b. Implement performance standards documented by audited data supported by actuarial sound rates.
  - c. Focus on health outcomes using common metrics and objective and audited performance requirements.
  - d. Streamline unnecessary administrative costs by reducing or eliminating paper requirements in lieu of electronic documents and web-based information sites, requiring the use of deemed compliance by virtue of national accreditation such as NCQA or URAC, and changing the perspective to a “regulation by exception”—that is focused on contractors who are not meeting standards established in the contract.
- 6. Maximize all levels of non-state General Fund support (Federal, special use and local revenue) to protect Michigan’s Safety Net.** This would continue efforts for:
  - a. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries

- b. Options to additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid.
- c. Increasing third party collections for Medicaid Managed Care Plans by providing access to other carrier data, including auto and BCBSM.
- d. Improved fraud and abuse coordination through the Medicaid Inspector General Office.
- e. Collaboration on efforts to reduce “waste” in our health system that will benefit all payers, including Medicaid.

## **7. Move the Medicaid Program and Medicaid eligibility responsibility into a separate program linked to Michigan’s new Insurance Exchange**

### **MAHP Recommendation Principles**

Without an underlying basis for reform in Medicaid—or other programs, the long-term sustainability will be weakened and opportunity for gaining public support will be missed. MAHP believes the following principles can be used to guide the changes necessary to transition Michigan’s Medicaid program through the next year(s):

- Enroll current beneficiaries into managed care rather than reducing optional benefits;
- Focus on ways to integrate benefits rather than reducing provider reimbursement;
- Identify ways to streamline and consolidate state agency bureaucracy, eliminate regulatory redundancy, and focus on contract performance; and
- Promote those administrative rules and Medicaid policies that make fiscal sense to Michigan and not focus on revenue neutrality.

### **Savings Potential**

Taking the above principles and assuming implementation can occur over the next 2 years, Michigan can begin to realize significant program savings while fostering a more accountable and cost-effective program. For instance:

- **Savings from movement of populations into managed care.** There is an underlying rule of thumb that at least 5 percent of medical care treatment costs can be saved by movement into managed care. The tools, techniques, programs, and results of using Medicaid managed care are listed later in the MAHP White Paper.
- **Savings from Administration Efficiency.** There is no question that Michigan’s effort to serve the most vulnerable population has resulted in multiple initiatives and programs—all with administrative costs. By moving toward a comprehensive Medicaid benefit contract, Michigan can begin to reduce administrative cost and create a more seamless delivery of health care services.
- **Savings from State Administration.** Coupled with the development over the years of a number of initiatives to deliver various categorical or limited benefit programs is the state oversight responsibility and contract management or administration. Consolidation will likely minimize or eliminate the need to replace vacancies that took place in the last state

early retirement program and will enable the MDCH to utilize existing staff in new and important key roles. These savings are cost avoidance as early retirement savings have already been realized. However, a new contract management program would also utilize electronic submission, the deeming of national accreditation and establishing a program of regulation and oversight by exception. This will result in savings to contractors that can be realized in the cost of contracts.

- **Savings from Enabling Contractors to access data and Third Party Liabilities for recoveries.** While Michigan has been very innovative in development of the managed care performance based contract, there has been notable exception in the designation by the State to the Contractors to access Third Party Liability (TPL) and recovery information. It is estimated that many Medicaid beneficiaries have other insurance coverage through a spouse or family member. In addition, services may be covered by financial recoveries made of estates or related to accidents and auto related injuries. The monthly capitation payment premium established under actuarial sound principles makes assumptions regarding the amounts that will be recovered and inserts that amount as a credit in the overall calculation. If Michigan enabled Medicaid contracting health plans to be considered a part of the Medicaid Program for purposes of recovery, then the amount of the credit can be increased and amount of the necessary capitation reduced over time.
- **Savings from development and implementation of policies addressing “waste” in our health system.** There has been extensive research and studies regarding waste in the U.S. Health System compared to other countries. Further, there is ample documentation of regional variations within each state and between states. By starting to apply best practices models to the underlying Medicaid reimbursement model, Michigan can create significant health care savings without compromising quality of care or access. These savings will be more difficult to generate as much of it is embedded in current practice management and protocols and in some instances supported by existing state policies. One simple measure that we know is the number of admissions to an inpatient stay that could otherwise be treated in the community with an effective coordination and reimbursement policy. Later in this paper we show an illustration that Medicaid hospital utilization is 62% higher than commercial utilization. If we could lower that difference by half, Medicaid and Medicaid health plans could save millions. The development of an appropriate observation stay policy in lieu of hospital admission is another cost saving effort. There are many more that will be identified over the coming months provided the legislature and administration create a receptive environment to not just receive but act on such recommendations.

• This agenda is doable, but will require action to:

- Amend state Medicaid waivers,
- Develop new waiver/state plan amendments,
- Develop enabling state legislation in such areas as TPL, and various mental health, public health and insurance code, and
- Re-deploy state employees into a consolidated administrative structure to administer and conduct appropriate oversight of the new contract mechanism.

## Medicaid White Paper References

In addition to the references listed below, MAHP has depended on the following websites for ongoing information on various issues on federal reform, emerging health care issues, and published findings of best practices. We also encourage readers to visit the MAHP Website for news and findings: [www.mahp.org](http://www.mahp.org)

Frequently Used Medicaid Related Website Links:

- Kaiser Health News: <http://www.kaiserhealthnews.org/Topics/Medicaid.aspx>
  - Commonwealth Fund Publications: <http://www.commonwealthfund.org/Publications.aspx>
  - Americas Health Insurance Plans, AHIP, Research Center: <http://www.ahipresearch.org/>
  - National Association of State Medicaid Directors: [http://hsd.aphsa.org/Home/home\\_news.asp](http://hsd.aphsa.org/Home/home_news.asp)
  - Centers For Medicare and Medicaid: <http://www.cms.gov/home/medicaid.asp>
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  3. January 2010, “Regional Health Plans and Reform: The 2010 Agenda, Managed Care Executive Group, HTMS, Health Dialog Research Team Report.
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***(Note: Much of the data used for the Charts contained in the White Paper are based on the publicly available reports to MDCH and OFIR. Additionally, MAHP has collaborated with Sanofi-Aventis to produce a publication, “Managed Care Digest Series/Michigan HMO Data Summary. These have been produced since 2003 and are distributed as part of the annual Summer Conference of MAHP. Interested parties may contact MAHP to obtain the most recent copies of this publication.)***

**ATTACHMENT 1 — STRATEGIES FOR ADDITIONAL PROGRAM FLEXIBILITY**

The strategies listed in this attachment are an attempt to provide legislators and policy makers with additional options for program improvements in Medicaid overall, and ways of providing more cost effective services that will benefit the state budget. Some of these options will require federal waivers—and have been suggested by other state and national organization. Other options would simply require state administrative or legislative approval.

Potential Savings Suggestion	Comments	Operational Feasibility of Implementation <b>(High, Medium or Low)</b>
<b>BENEFIT/COVERAGE ADMINISTRATION AND MODIFICATION IN MEDICAID</b>		
<p>1. Establish a <b>default formulary in Medicaid of generic Rx</b> with exceptions for psychotropic pharmaceuticals without generic replacements.</p>	<p>The current State Medicaid formulary is open ended and is based on selections that provide the most attractive rebates to the state and not necessarily the most effective products for beneficiaries.</p> <p>Considerable savings have taken place through the emphasis on generic drugs and the State’s Medicaid Formulary should establish the principle of generics as primary tool.</p> <p>Most health plans are now paying for more than 80% generics of all prescriptions.</p>	<p align="center">Medium</p>
<p>2. <b>Limited Benefit Arrangement.</b> Federal policy (Deficit Reduction Act, DRA) permits states to have a differing benefit plan for certain optional populations. Michigan should look at the feasibility of such a plan</p>	<p>This option will permit the state also to established incentives to access preventive health services and practices.</p>	<p align="center">High</p>

<p>3. Provide enabling rules or statute to provide Medicaid access to tools that enable more effective and timely care to be provided to Medicaid beneficiaries. This would include <b>access to the MAPS Program, MCIR</b>, and full access to data on 3<sup>rd</sup> party liability.</p>	<p>In particular, Health Plans should be provided with access to the Michigan Automated Pharmacy System, MAPS, to track heavy utilizers of pharmaceutical products and access to data on MCIR (Immunization Registry) to enable health plans to more efficiently manage preventive services.</p>	<p>HIGH</p>
<p><b>ADMINISTRATIVE SERVICES &amp; EFFICIENCIES</b></p>		
<p>4. Either develop statewide contract for <b>durable medical equipment</b>, (may include injectibles, and infusion products) or update the Medicaid fee structure for these products that would result in capturing the savings from the cost structure now present in this area</p>	<p>If a single contract were pursued for the Medicaid Fee for Service Program, it would require a statewide bid and contract to take place and followed by Medicaid policy changes. Updating the Medicaid fee structure would be implemented via a Medicaid policy change. Medicaid Health Plans would seek a voluntary agreement process through MAHP.</p>	<p>High</p>
<p>5. Similarly, consider a <b>statewide contract for transportation services</b> (non-emergency) to obtain medical services. Both the fee-for-service program and managed care could benefit and there would be consistent provider arrangements for Medicaid beneficiaries</p>	<p>Similar to above, Medicaid health plans will seek a voluntary approach to secure volume through a Master Agreement approach administered by the Michigan Association of Health Plans.</p>	<p>High</p>
<p><b>PROVIDER REIMBURSEMENT</b></p>		
<p>6. The MDCH should revise their policy for <b>short stay outliers or observation stays</b> and rate established for Medicaid – Their approach is inconsistent with approach used by other carriers—based on standard criteria protocols and recent Medicare Rules.</p>	<p>Implementation of this initiative would bring Michigan Medicaid into conformance with the Medicare program and eliminate confusion regarding which policy is in place.</p>	<p>HIGH</p>

<p>7. <b>Hospital Capital Payments.</b> Hospitals are provided with separate reimbursement for their capital expenses— current policy requires HMOs (and fee-for-service) to pay this on a discharge (total DRG) basis rather than actual use basis — which would be per diem.</p>	<p>Until October 1, 2004, Medicaid policy permitted flexibility in the payment of capital. Based on the cost impact of the policy returning to the previous policy could result in savings of about \$100/admission.</p>	<p>Medium to high</p>
<p>8. Require Hospitals to sign the <b>Hospital Access Agreement (Medicaid Policy)</b> in order to receive supplemental funding from Medicaid Health Plans.</p>	<p>Currently, Medicaid Health Plans rates are inclusive of supplemental funding for Michigan Hospitals. However, not all hospitals have signed the Medicaid Policy assuring access for Medicaid Beneficiaries. Implementation of this recommendation will assure that access.</p>	<p>HIGH</p>
<p><b>LEVERAGE OF FEDERAL DOLLARS</b></p>		
<p>9. <b>Disease management</b> contracts for fee-for-service beneficiaries. Medicaid HMOs use targeted disease management and case management to address high cost beneficiaries. Medicaid fee-for-service is not able to provide medical management services and patients are left on their own to develop the best program. This proposal would suggest that the state contract with selected HMOs to provide services for the fee-for-service program.</p>	<p>This option is alternative to those in the Recommendations of our White Paper and would yield fewer saving. Would require state contracting and perhaps a bid program and arrangements could be on a risk-sharing basis.</p>	<p>Medium</p>

<b>COORDINATION WITH OTHER PARTS OF MEDICAID AND OTHER STATE HEALTH PROGRAMS</b>		
<p>10. <b>Expanding Medicaid Managed Care.</b> About ¾ of the Medicaid expenditures occur in programs not subject to the Medicaid HMO program enrollment and is the area where growth in expenditures will continue (long term care, children’s special health care program, etc.). Efforts need to begin to share best practices from managed care into these areas and review the feasibility of enrollment these Medicaid beneficiaries into a managed care product—that is accompanied by adequate pricing. The experience in Medicaid Managed Care has consistently demonstrated cost-savings, greater access, and program accountability. There is no reason to believe that cannot be achieved in these areas compared to the current fee for service arrangements.</p>	<p>This is option to those listed in the Recommendations of the White Paper. Assuming even a modest change in policy that promotes the management of care can assist in providing more cost-effective care.</p> <p>Changes would obviously involve federal waiver requirements, development of rate structure and enrollment process. However, a template for each of these is in place. Dual Eligible’s (Medicare/Medicaid) may be enrolled in Special Needs Plans that have been certified by CMS</p>	<p>Medium</p>
<b>EXPANSION OF HEALTH CARE COVERAGE</b>		
<p>11. <b>State vendors</b> — The Administration should consider a requirement that all vendors doing business with State of Michigan provide health insurance for their employees — to address uninsured issues and those who may otherwise qualify for Medicaid.</p>	<p>While this proposal would not directly impact the Medicaid program — it would assist in assuring that more persons are covered under private insurance and reduce the uninsured population in Michigan.</p>	<p>Medium</p>
<p>12. <b>Consider moving responsibility for the administration of ABW and County Health Plans to Medicaid Health Plans.</b> This could be done as preliminary to recommendation #13 below.</p>	<p>The populations served by these programs are part of the target population for Medicaid expansion. Several of the Medicaid Health Plans currently provide the administrative services for ABW and County Plans, so a logical extension would be to amend the Medicaid Health Plans Contracts to provide this benefit program.</p>	<p>Medium to High</p>

<p><b>13.</b> MAHP also recommends that <b>statutory revisions</b> be made to regulate the insurance industry in the implementation of guaranteed issue products and other basic benefit coverage options that many employers and individuals currently seek for their employees that will be provided under the State Insurance Exchange. This recommendation will be pursued by MAHP with the House and Senate Health Policy Committees.</p>	<p>This would assure that all carriers approved in Michigan would be subject to similar regulatory requirements and a new competitive environment would be established.</p>	<p>Medium to high</p>
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## ATTACHMENT 2

### MICHIGAN ASSOCIATION OF HEALTH PLANS PHILOSOPHY OF CARE

Several years ago, the Michigan Association of Health Plans adopted a policy that established an “industry” philosophy of care. Within this policy was the following statement that continues to be important in the current discussions regarding the Medicaid program:

*“We represent a philosophy of health care that emphasizes active partnerships between patients and their physicians. We believe that comprehensive health care is best provided by networks of health care professionals who are willing to be held accountable for the quality of their services and the satisfaction of their patients. We are committed to high standards of quality and professional ethics, and to the principle that patients come first.”*

The Medicaid managed care program has sought to improve outcomes through alignment of financial incentives to stimulate appropriate change in the health care delivery system to:

- hold a single organization accountable for the full range of benefits for a group of beneficiaries;
- provide greater flexibility in the delivery of services compared to fee-for-service requirements;
- improve beneficiary access to needed care;
- provide for the demonstrable improvement in the quality of care delivered; and
- achieve greater cost efficiency and predictability of costs.

The State of Michigan has contracted with HMOs to manage the required comprehensive health care benefits that Medicaid beneficiaries are entitled to receive in order to achieve objectives for “value purchasing.” These objectives are similar in their intent as the principle developed by MAHP listed above:

- establish standards for network and provider accessibility;
- create reporting and other accountability measures; and
- improve access and quality of customer services, including enrollment services.

**ATTACHMENT 3**

**TABLE OF ADMINISTRATIVE FUNCTIONS PROVIDED BY MEDICAID HMOS**

Historically, in the Medicaid fee-for-service program, the state’s major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed and state budget expenditures increased steeply from year to year and were unpredictable. To gain cost predictability and control without sacrificing medical benefits, the State engaged health plans to perform functions previously not performed for Medicaid beneficiaries. The underlying administrative infrastructure required of each HMO needs to be understood as critical to their ongoing performance.

Costs associated with these “functions” are not included in those costs labeled “medical costs” or “medical loss ratio” as those measures typically are used to identify how much of the premium dollar received by an HMO is spent on direct health care delivery services. Nevertheless, the cost for the “administrative functions” outlined in this Table are inherently necessary in order to establish and sustain the improved delivery of services for Medicaid beneficiaries consistent with the objectives prescribed by the state and to continue to provide the best value for the State of Michigan.

Notwithstanding additional administrative requirements related to the management of care for Medicaid beneficiaries, the overall average administrative costs incurred by Medicaid health plans continue to decline as a percent of the state premium from 10.3% in CY 2003 to under 8% of total premiums estimated for CY 2009.

**Administrative Functions of Medicaid Health Plans**

<b>Category</b>	<b>Feature of Medicaid Health Plans Under the State’s Medicaid Contract and State HMO Requirements</b>
Administration Cost: Beneficiary Services— Member Information	<ul style="list-style-type: none"><li>• Member Enrollment Packet (Welcome letter, ID cards, Certificate of Coverage, Provider Directory)</li><li>• Member Handbook at time of enrollment</li><li>• Member Newsletter distributed periodically (no less than 3 times per year)</li><li>• Toll-Free Member Hotline (24/7) to answer questions and resolve problems for members</li><li>• Member Advisory Committees and/or Membership as Consumer member on Governing Body</li></ul>

	<ul style="list-style-type: none"> <li>• Grievance &amp; Appeal Process including Medicaid Fair Hearing</li> <li>• OFIR external reviews</li> <li>• Enrollment services functions including special dis-enrollments</li> </ul>
Administrative Cost: Beneficiary Services— Health Education and Health Promotion	<ul style="list-style-type: none"> <li>• Member Health Education</li> <li>• Targeted Beneficiary Incentive Programs</li> <li>• Health Fairs</li> <li>• Health Assessment Programs</li> <li>• Outreach for EPSDT and for services to pregnant women</li> </ul>
Administrative Cost: Beneficiary Services— Care Coordination	<ul style="list-style-type: none"> <li>• Care Coordination, especially with mental health or substance abuse agencies and for Children with special needs</li> <li>• Case Management</li> <li>• Disease Management to help members with chronic conditions, such as diabetes or asthma</li> <li>• Maternal and Infant Support Services (MSS/ISS)</li> <li>• Primary Care Provider—Medical Home</li> <li>• Local Health Department Coordination, including WIC</li> <li>• Coordination with Community Mental Health</li> <li>• Coordination of Transportation</li> <li>• Referral Management</li> <li>• For Cause--Disenrollment</li> <li>• Discharge Planning activities for inpatient services</li> <li>• Pharmacy management</li> </ul>
Administrative Cost: Quality of Care Assurance	<ul style="list-style-type: none"> <li>• Providers who are credentialed every three years</li> <li>• External Health Plan Accreditation (e.g., NCQA, URAC)</li> <li>• Individual Site Visits/medical record reviews of Plan Providers</li> <li>• Focused Clinical Studies and Quality Improvement Plans to improve care identified as less than optimal</li> <li>• Health Care Standards and Policies, including Access Standards</li> <li>• Fraud &amp; Abuse policies and activities</li> <li>• Development and distribution of Clinical Guidelines</li> <li>• Profiling and reviewing physician practices for quality measures</li> </ul>

<p>Administrative Cost: HMO Public Accountability</p>	<ul style="list-style-type: none"> <li>• Data Reporting to the Department of Community Health <ul style="list-style-type: none"> <li>○ Utilization of Services (Encounter Reporting-Monthly)</li> <li>○ Paid Claims (Monthly)</li> <li>○ Grievance and Complaints (Semi-Annual)</li> <li>○ Data Quality Improvement Reviews (Semi-Annual)</li> <li>○ Provider Network (Monthly Updates)</li> <li>○ Physician Incentive (Annual)</li> <li>○ Litigation Reporting (Annual)</li> </ul> </li> <li>• Audited HEDIS Reports (Annual)</li> <li>• HMO Financial Reports (Quarterly and Annual—available on OFIR Web Site)</li> <li>• Customer Satisfaction Surveys (CAHPS), including adolescent CAHPS (available as tool only for Medicaid Products)</li> <li>• Provider Satisfaction Surveys</li> <li>• External Quality Reviews (performed by MDCH)</li> <li>• Administration of annual site visit by OFIR and DCH</li> <li>• External Accreditation from a National Organization</li> </ul>
<p>Administrative Cost: Provider Services</p>	<ul style="list-style-type: none"> <li>• Provider Hotline and other provider communications</li> <li>• Provider Manuals, Education, Orientation &amp; Training</li> <li>• Administration of Provider Complaint and Appeals</li> <li>• Electronic Billing Capacity</li> <li>• Serve as Third Party Administrator for Psychotropic Medications prescribed by Community Mental Health Providers</li> <li>• Coordination of Benefit Activities</li> <li>• Physician and Provider Profiling Reports</li> </ul>