



MICHIGAN ASSOCIATION
OF HEALTH PLANS | 2011

Performance, Value, Outcomes: Medicaid Managed Care

FY 2011--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 12/FY 13

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EXECUTIVE SUMMARY

A New Starting Point

Michigan has a structural deficit that the new governor and legislature must address for the FY 12/FY 13 budget development. Further, the November election outcome should be clearly interpreted as a mandate to live within existing revenue. Therefore, we should assume the structural deficit—including support for Medicaid--will be addressed through:

- Reform through administrative consolidations and efficiencies;
- Redirection of existing resources to those programs demonstrating value and outcomes; and
- Reductions and program eliminations.

The incoming Administration has emphasized that a “results” oriented budget will be in order—that is, programs must demonstrate a return of value in order to deserve continued support.

View of MAHP

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 containment that addresses 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

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.

Minimally, **\$4.5 billion in total savings** has been realized due to Medicaid Managed Care between FY 00 and FY 10 or nearly **\$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.

During this most critical year for determining the policy and funding of Medicaid, it is more fundamental than ever that Michigan's decisions are built upon facts, performance and demonstrated outcomes—these are successful building block of Medicaid managed care.

I. Next Steps and Recommendations

MAHP understands that the legislative and administrative challenge is to not only identify the “path” for cost effective care, but make the hard and difficult underlying administrative and operational decisions to make it happen. With few exceptions we cannot look to other states as most are now just moving toward the comprehensive managed care approach that Michigan has implemented for a number of years. However, in some instances other states are going beyond—that is, to implement programs for long term care and dual eligible and moving toward more integrated services.

We should all expect that the executive and legislative decisions that will now 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:

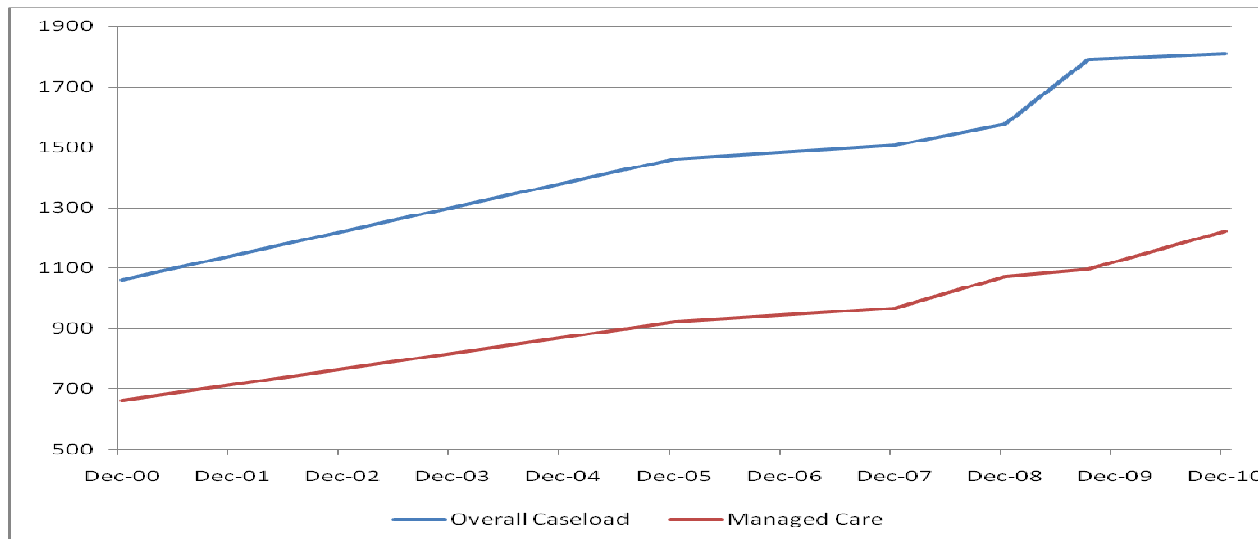
- **Nearly 3/4 of the cost of Medicaid still resides with the remaining fee for service Medicaid population not enrolled in managed care.** MAHP believes that the state can achieve significant cost savings, extend the value, (already documented by managed care), through further expansion and/or the application 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 anyone 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 agree upon 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.

Given the growth in Medicaid caseload, we believe the only reasonable choice is to focus on an overall strategy of moving remaining Medicaid population into managed care and couple that with restructuring the Medicaid benefit delivered through the contract and consolidation of the state administrative oversight. Unless all pieces are implemented, savings will not occur.

Chart on Overall Medicaid Caseload and Enrollment in Managed Care



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:

1. **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. So if we assumed a movement of all remaining population into managed care then Michigan should assume savings from this change of about \$200 Million--Gross Funding or approximately, \$70 Million (GF).
2. **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 creating a more seamless delivery of health care services. A reasonable estimate for these savings over a 2 year period would be about nearly \$100 million in gross savings or approximately \$35 million in GF savings.
3. **Savings from State Administration.** Couple 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. Assuming these principles are implemented, savings of \$20-\$ 30 million dollars gross could be realized (or about \$10 million GF).
4. **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 and recovery information. It is estimated that many Medicaid beneficiaries have other insurance coverage from spouse, family, estates, and recoveries 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 to the State as much as \$40 million in gross savings; (\$12-15 Million) could be realized with the enactment of enabling legislation or granting through administrative rule for such TPL recoveries.
5. **Savings from development and implementation of policies addressing “waste” in our health system.** There has been must research and studies regarding the 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 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. 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 admission to an inpatient stay that could otherwise be treated in the communicate with effective coordination and reimbursement policy. Later in the 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 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 staff 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. We believe the following MAHP Recommendations can begin this process:

MAHP Specific Recommendations:

1. Enroll all Medicaid Beneficiaries into Medicaid Health Plans.

1.1. New Populations and programs to be added to the Managed Care Program and as necessary specific rate structure recognizing the actuarial costs:

- Dual-Eligible Population and begin working with overall long term care options
- MI CHILD Enrollment into Medicaid Managed Care

- Children’s Special Health Care Services (mandatory enrollment)
- Complete work of the Foster care Children enrollment
- Revise and update Medicaid Eligibility policy in order to create an environment to manage the care of more beneficiaries, including medically need. Develop differing benefit programs based on Medicaid Program enrollment status. This would also permit consideration for personal responsibility initiatives.
- Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.

1.2 Reform Medicaid eligibility by:

- Study the option to delink Medicaid application from other human services program applications
- Develop Eligibility Access Points:
 - Outstationed Workers.
 - Application Assistance.
 - Automation.
- Remove the requirement that individuals verify their income when they apply for assistance and when eligibility is redetermined.
- Eliminate the asset test for low-income parents. Remove the requirement that assets be verified for all Medicaid applicants (or at least for low-income parents).
- Consider Express Lane Eligibility (ELE) for children.
- Evaluate the status of use of “pre-populated” redetermination forms and/or a simplified redetermination form for those subject to the “long form”.
- Pre-populated redetermination forms. Simplified redetermination.
- Start planning now for a faster, cheaper and more user-friendly system for determining Medicaid eligibility to go into effect in 2014.

2. Consolidation Medicaid Benefits into a Comprehensive Contract and Streamline Administration and Oversight of Medicaid Health Plans.

- 2.1. Consolidate the delivery of Medicaid benefits through a comprehensive Medicaid Contract that will focus on coordination of an integrated benefit, (physical, mental health, substance abuse, dental, and other currently contracted services), require patient centered medical home support, establish performance standards documented by audited data, and that is supported by actuarial sound rates.
- 2.2. Consolidate the current multi-agency state responsibility for oversight of Medicaid Contract into a central office and focus on health outcomes using common metrics and objective and audited performance requirements.
- 2.3. 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, and changing the perspective to a “regulation by exception”—that is focus on contractors who are not meeting standards established in the contract.

3. Maximize all levels of non-state General Fund support (Federal, special use, and local revenue)

- 3.1. Increase amount of Federal Funds to protect Michigan’s Safety Net. This would continue efforts for:
 - 3.1.1. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries
 - 3.1.2. Options to additional federal support into Medicaid, including FQHC, patient centered medical homes, grants and programs to bring wellness and prevention as a key component of Medicaid.
 - 3.1.3. Consideration of the cost-effectiveness of early expansion of Medicaid eligibility as part of the economic recovery for Michigan

- 3.2. Increase third party collections for Medicaid Program
 - 3.2.1. Coordination of benefits including provision of access by Medicaid Health Plans to other carrier (including auto) information;
 - 3.2.2. Improved fraud and abuse coordination through the Medicaid Inspector General Office to and
 - 3.2.3. Focus collaboration efforts on reducing “waste” in our health system that will benefit all payers, including Medicaid.

- 3.3. Continue use of provider based taxes where it is permitted and supported by the affected provider community and assure that such support is dedicated to Medicaid.

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

I. Creating Value For The State of Michigan

Expectation of Performance

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 models of care and guidelines. It is these guidelines and protocols that improve quality and access and, importantly 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 MQIC¹. 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>

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

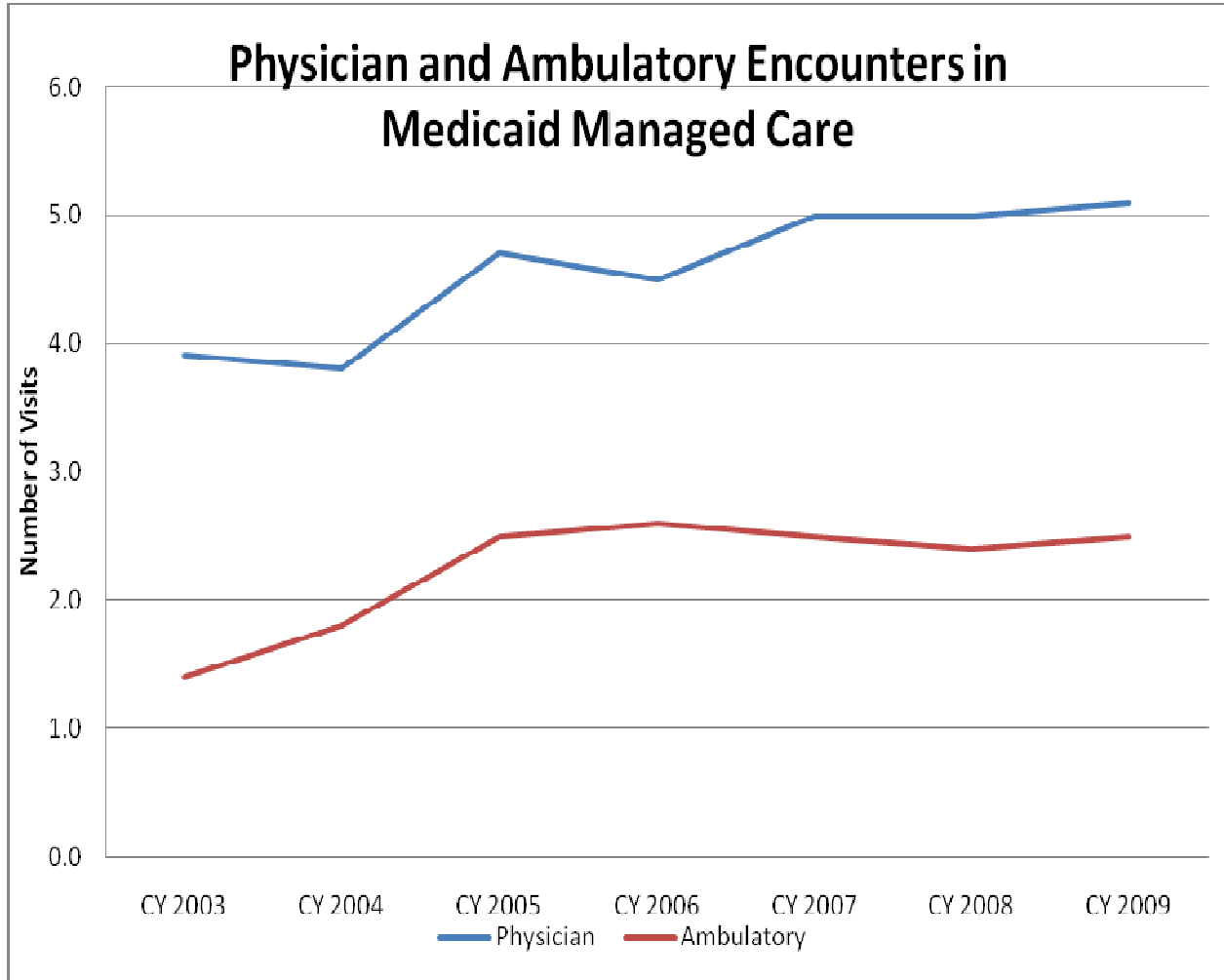
- A focus on preventive health care;
- Coordinated disease management;
- Effective management of utilization;
- Key indicators for improved health status of beneficiaries;
- Assurances that access to care for members is available;
- Quality monitoring of performance;
- Preferred pricing arrangements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

Reducing Hospital Utilization

¹ The MQIC website is located at: <http://www.mqic.org/guid.htm>

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 Health². 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

² See MDCH Web site Report for Preventable Hospitalizations at: <http://www.mdch.state.mi.us/pha/osr/CHI/HOSP/PHT7TT.ASP>

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.

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 or condition.

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

Preventable Hospitalization Diagnoses (Primary Diagnosis only)	Number of Preventable Hospitalizations (2008)	Percent
All Preventable Hospitalizations	269,383	100.0
Congestive Heart Failure	38,275	14.2
Bacterial Pneumonia	32,061	11.9
Chronic Obstructive Pulmonary	26,605	9.9
Asthma	16,440	6.1
Kidney/Urinary Infections	16,390	6.1
Cellulites	15,412	5.7
Diabetes	12,607	4.7
Dehydration	8,193	3.0
Grand Mal/Other Epileptic Conditions	6,582	2.4
Convulsions	4,316	1.6
All other Ambulatory Care Sensitive Conditions	92,502	34.3

(Ambulatory Care Sensitive Hospitalizations are those for conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness or managing a chronic disease or condition.)

Chart 2 and 3 also illustrates a point that bears repeating—that is, the Medicaid population has generally more acute illness and admissions than commercial populations.

Chart 2

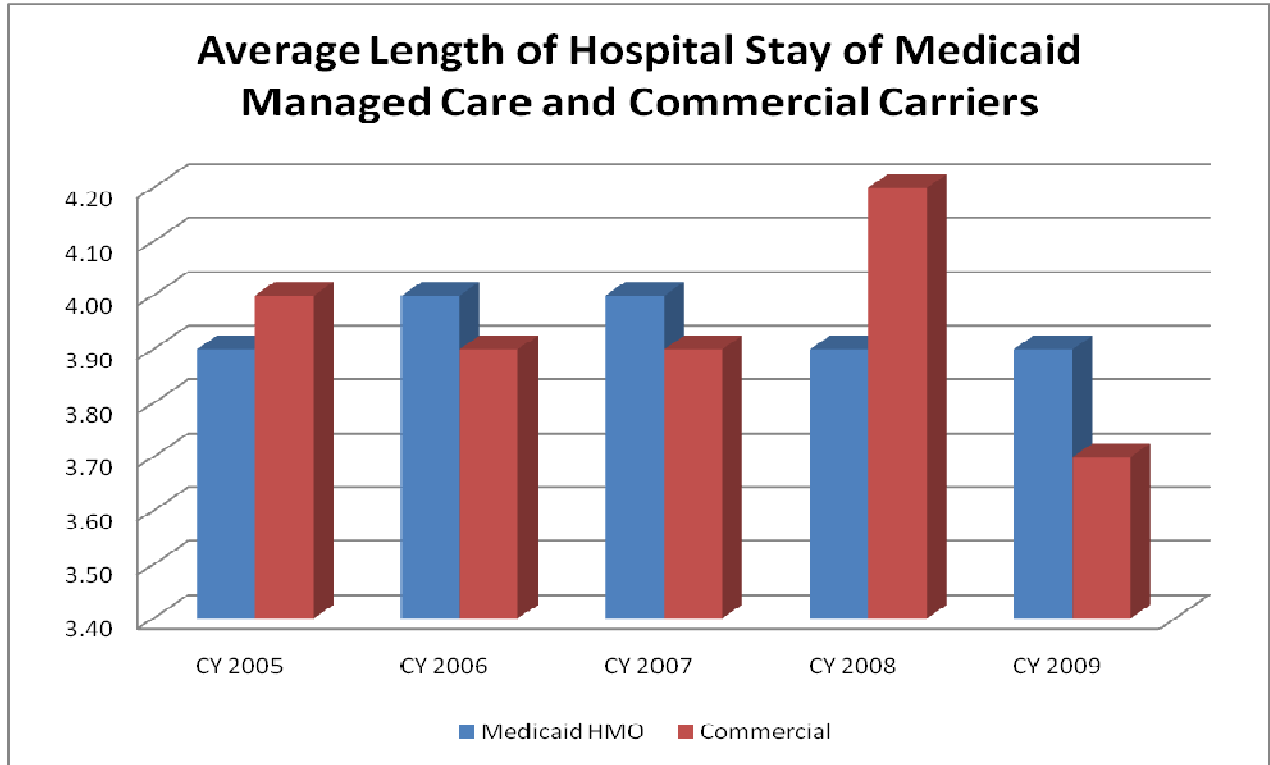
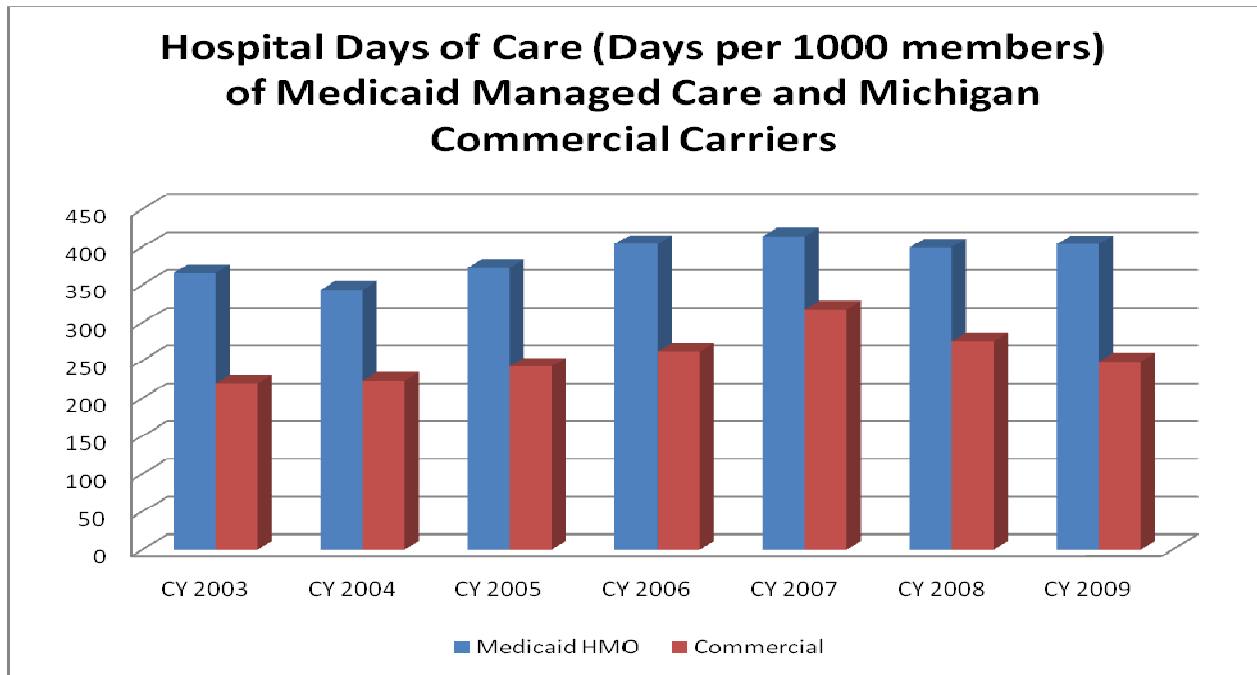


Chart 3



Therefore, access to Michigan’s hospitals for appropriate utilization of care is part of the overall management of care. Finally new data (Charts 4 and 5 below) highlights the costs to Medicaid (managed care and fee for service) and other payers for chronic disease—in this instance diabetes. Managing these chronic conditions can produce savings through prevention of hospital inpatient or emergency department encounters.

Chart 4

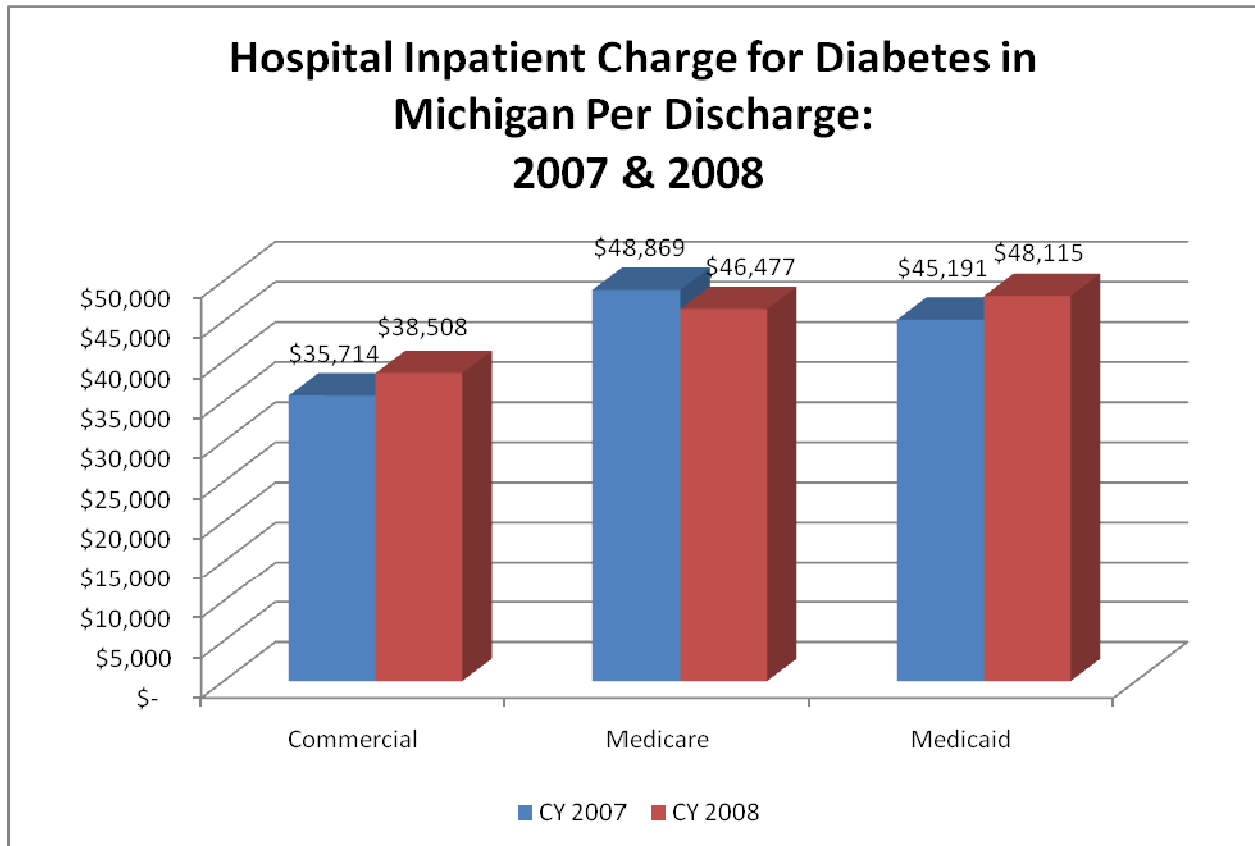
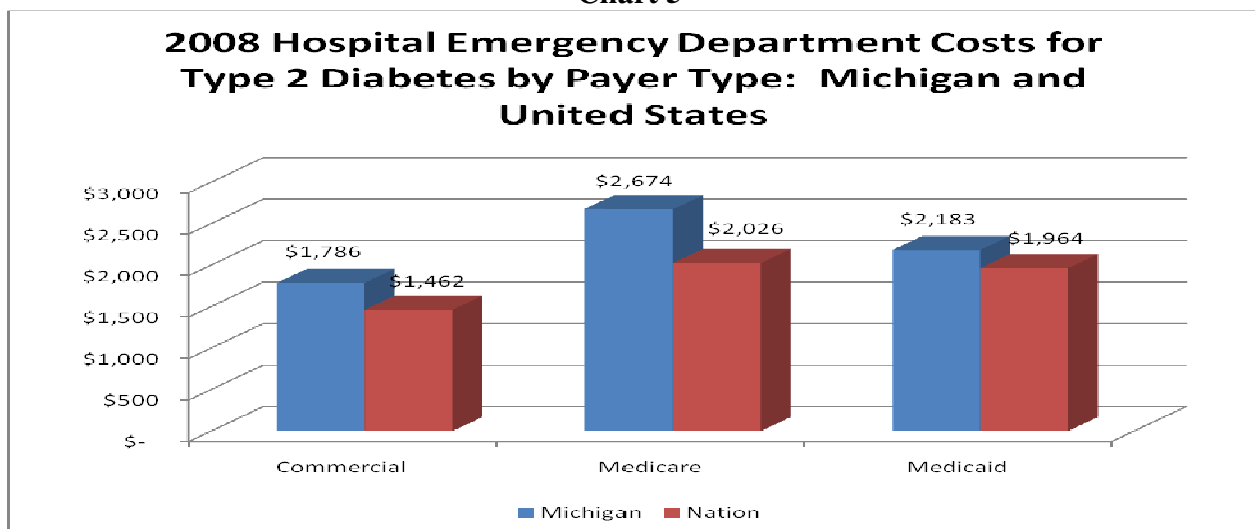


Chart 5



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 \$350-400 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 between \$350 and \$400 million by the end of FY 10 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

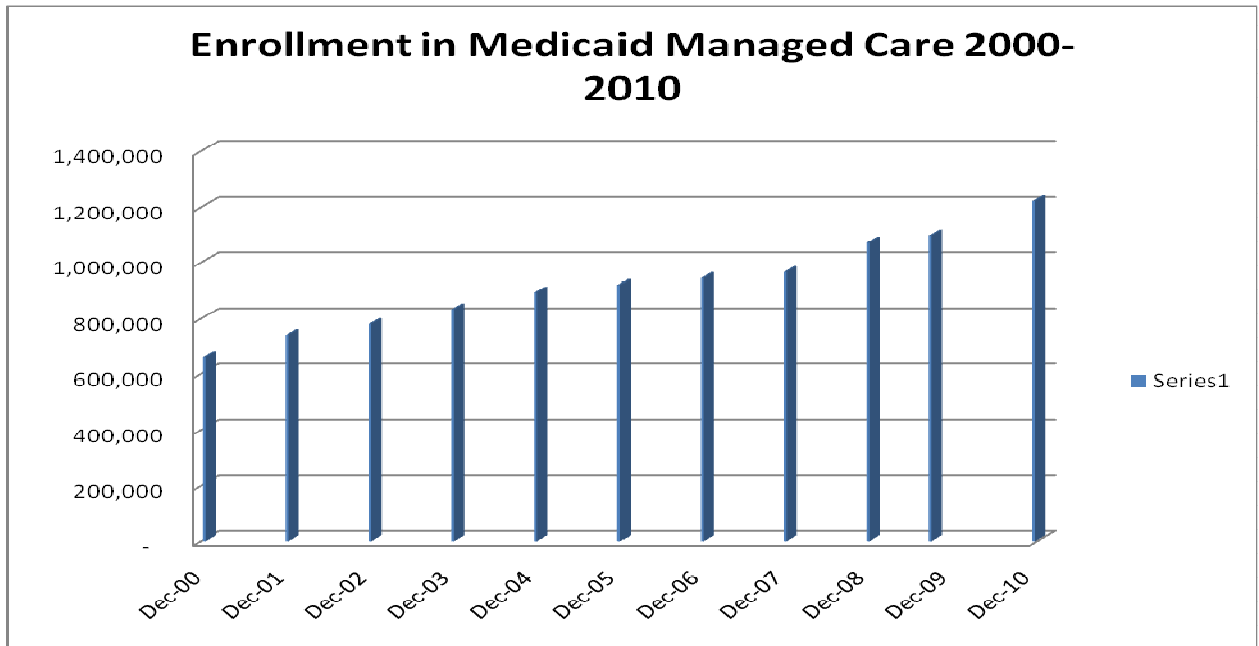
Unlike Medicaid managed care program, the state has little or no ability to control utilization, technology and other health care cost “drivers” in fee-for-service that result in increased and uncontrollable expenditures.

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 7) 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 6



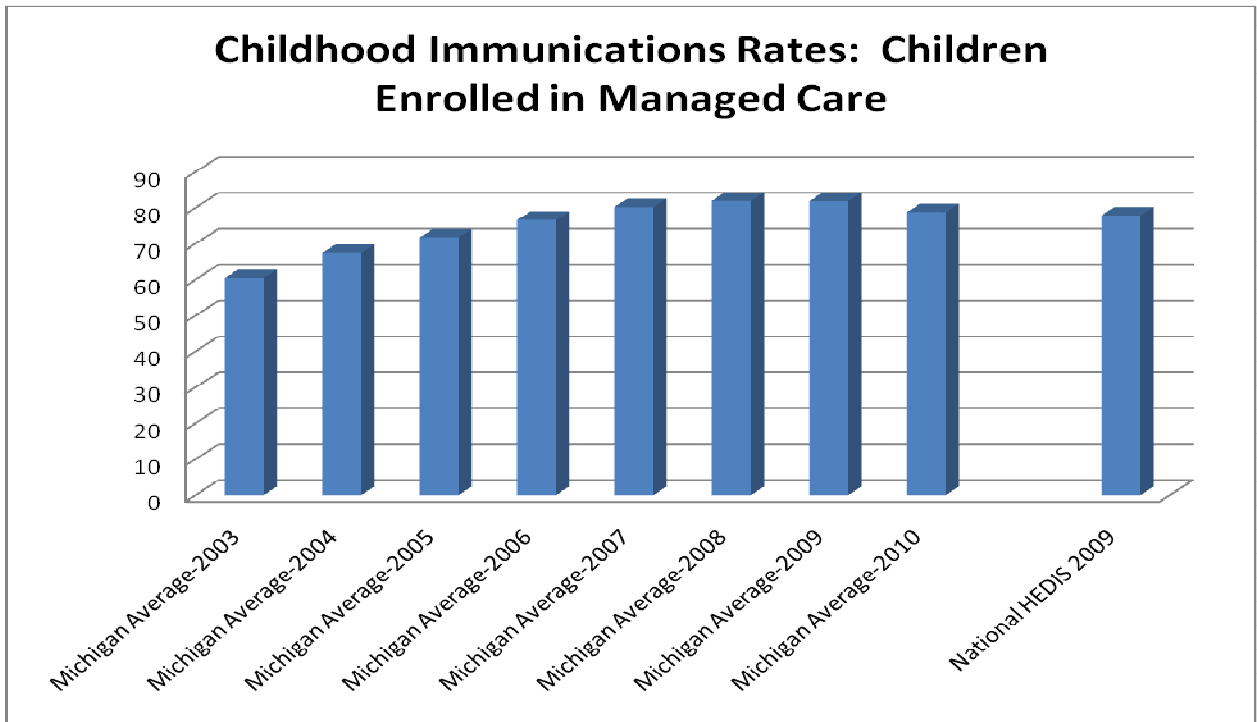
2. Services provided by Medicaid health plans are accountable under terms of both the state’s contract and the HMO requirements in the Insurance Code.

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/documents/mdch/MI2008_HEDIS-Aggregate_Report_F1_266926_7.pdf

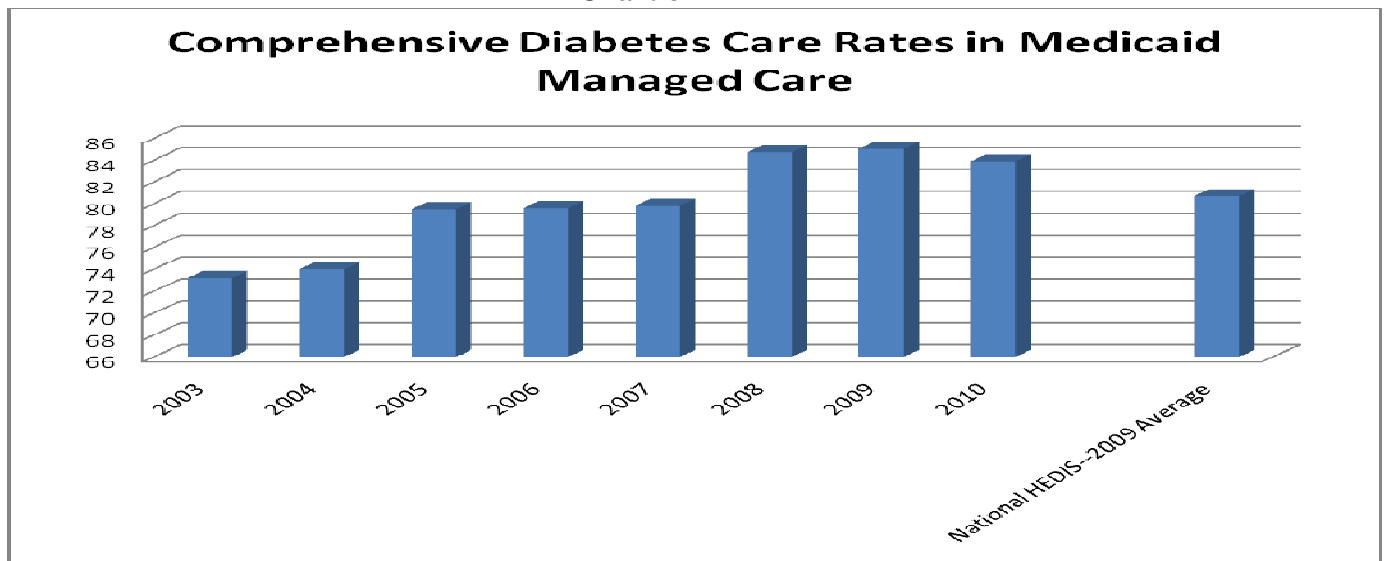
An illustration of the improved performance of Medicaid health plans has been in the area of immunizations. Under the HEDIS® analysis, key areas are reviewed each year — immunizations being one area. NCQA has now developed national Medicaid averages that states can use for comparison purposes. As displayed in Chart 8 below, the Michigan Medicaid managed care average immunization rate has increased by nearly 33% since 2003.

Chart 7



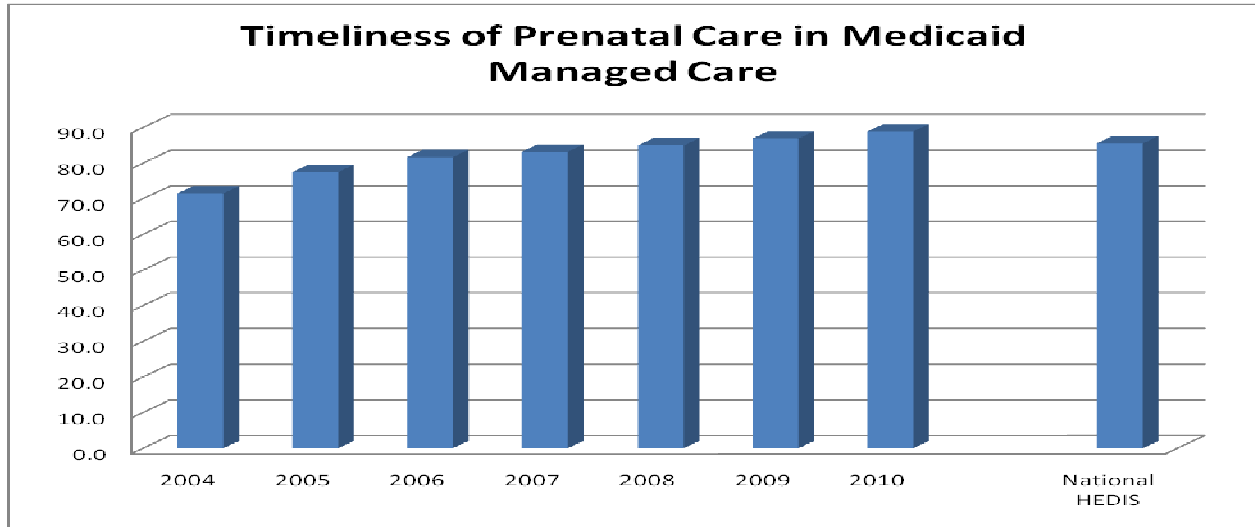
Further, the performance by Medicaid health plans enabled Michigan's overall performance in immunizations to leap forward over the past several years from nearly last in the United States to being one of the top performing states. Another example of audited data showing clinical quality outcomes is *diabetes*. As Chart 8 illustrates, the basic diabetic testing rate has increased substantially over the past several years and is above the comparable Medicaid national average.

Chart 8



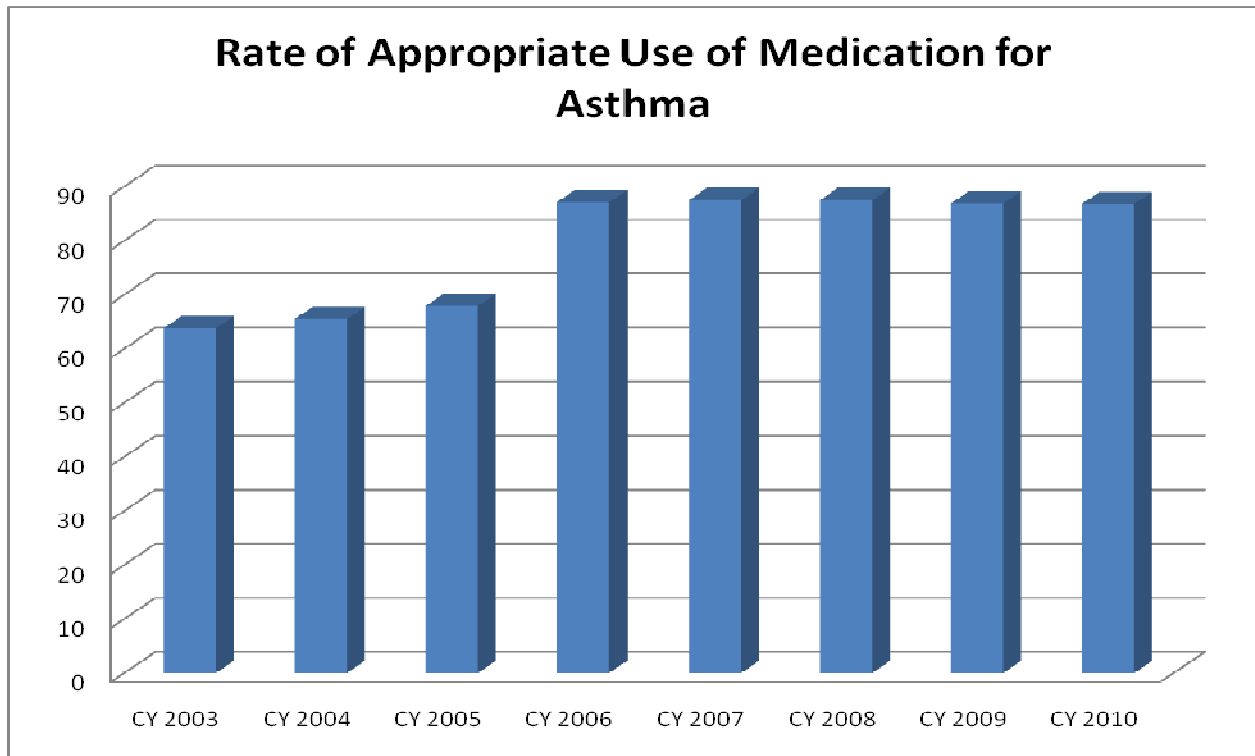
Another area is prenatal care which has always been a marker in the determination of safe and healthy deliveries and reducing infant mortality rates. Medicaid Health Plans have emphasized prenatal care, and the results are illustrated below in Chart 9.

Chart 9



Finally, an example that illustrates improvement in services for a condition that is common for Medicaid Children — asthma — is displayed below in Chart 10.

Chart 10

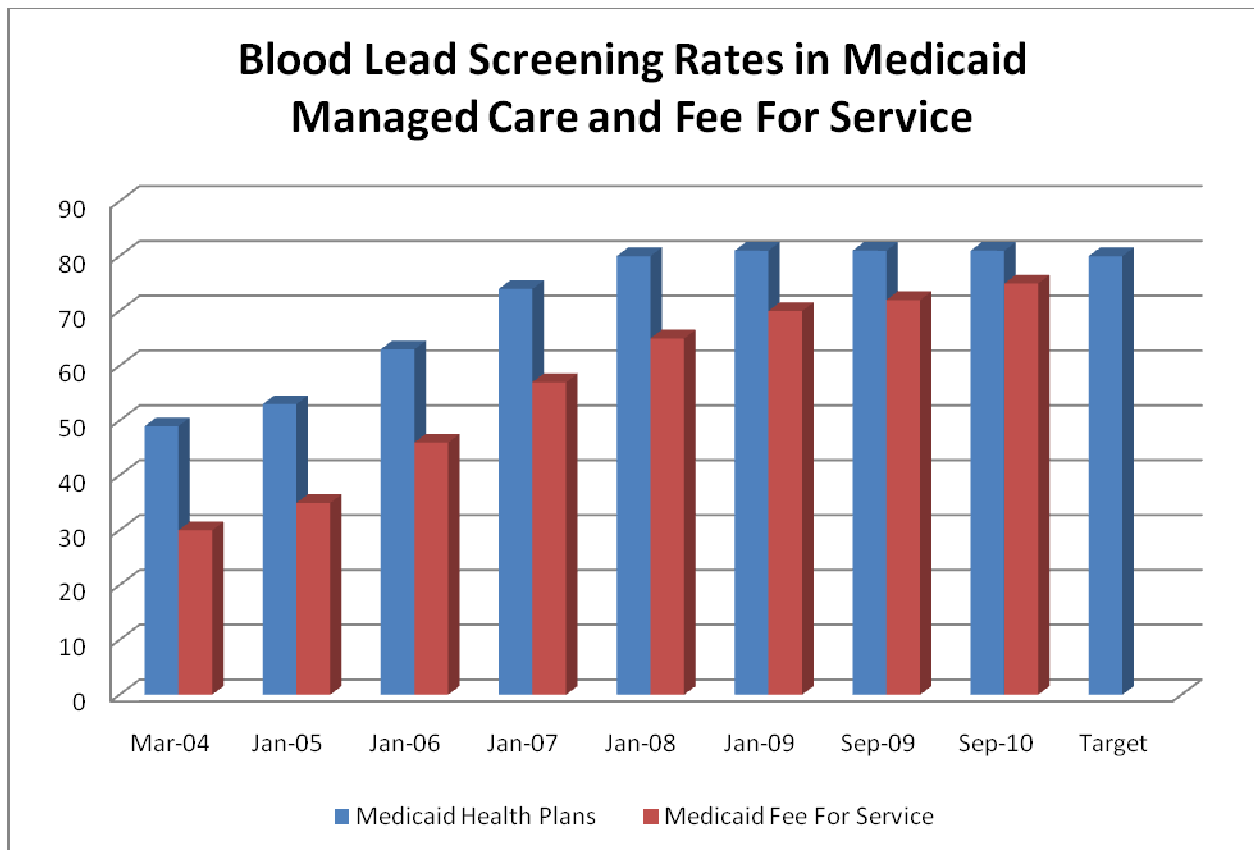


The second element is the use of external measures to determine customer satisfaction. Again, the standard used in Michigan is the customer services satisfaction survey of the NCQA. This survey is known as Consumer Assessment of Health Plan Survey, (CAHPS). This is a tool that is used for both commercial and Medicaid products; however, the adolescent 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 11, 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 11



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 2010 as having 12 of the 50 top ranked Medicaid plans in the United States based upon performance scores.

http://www.ncqa.org/portals/0/health%20plan%20rankings/2010/HPR2010_NCQA_Plan_Ranking_Summary_Medicaid.pdf

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 OFIS — 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.

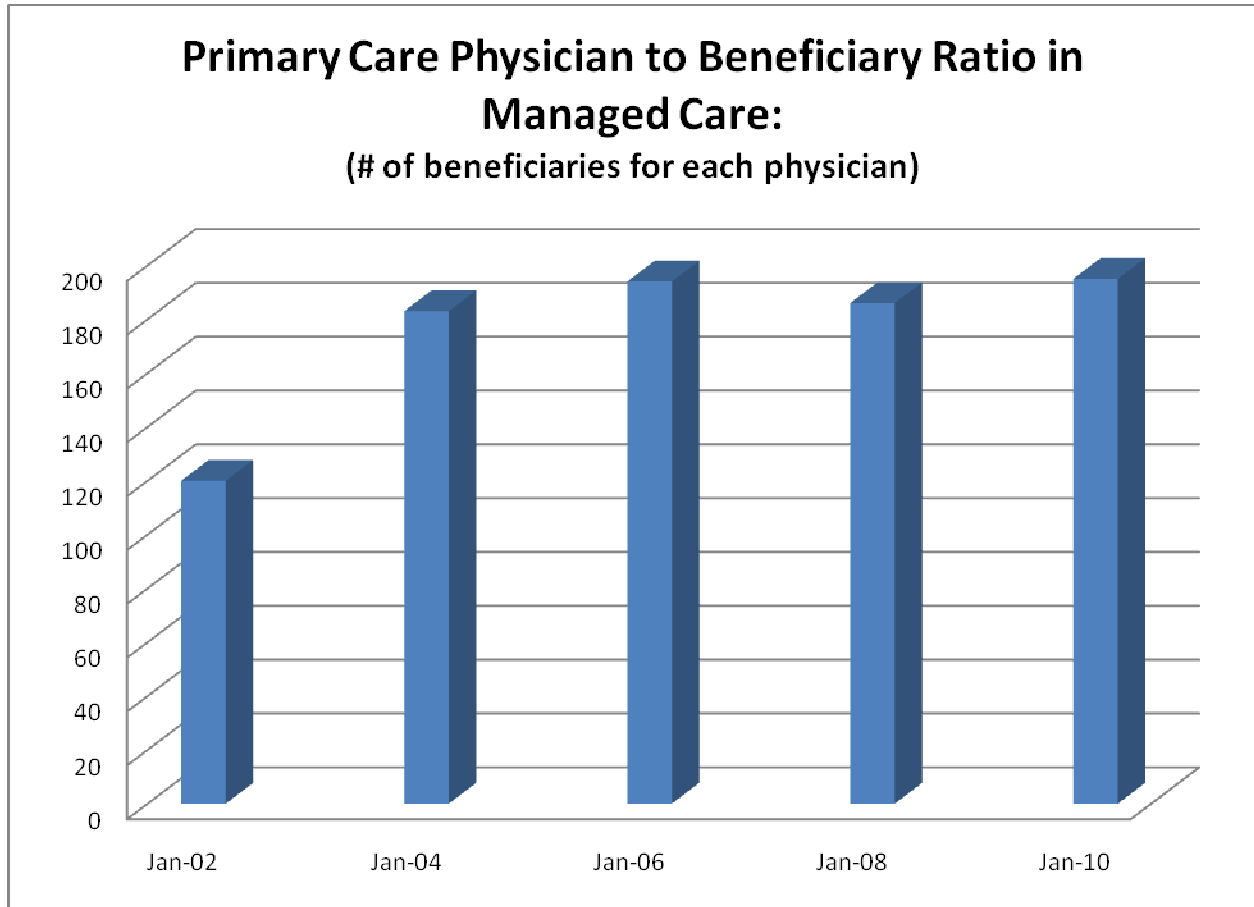
Additional accountability is provided through:

- 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.”

Chart 12



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 12 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.

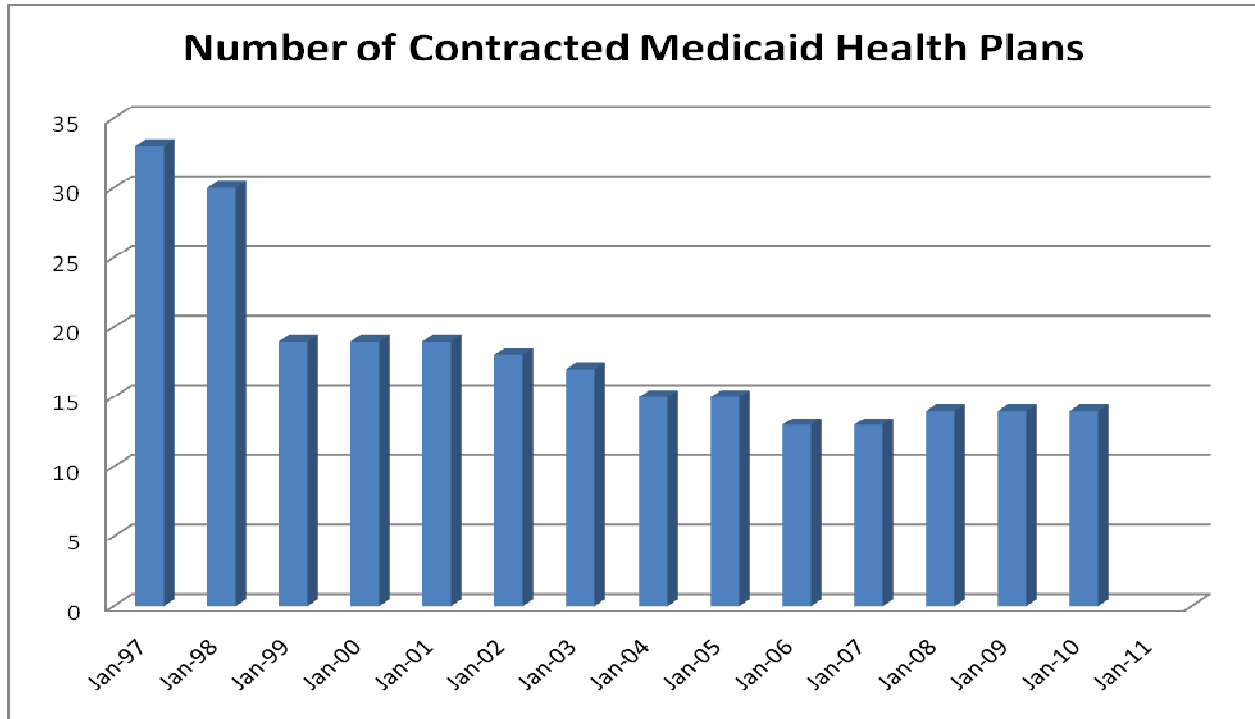
Historically, in the Medicaid fee-for-service program, the state's major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed either as to unit or utilization cost increases and as a result, state budget expenditures 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 13



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 the cost savings and 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 11 Recommendations

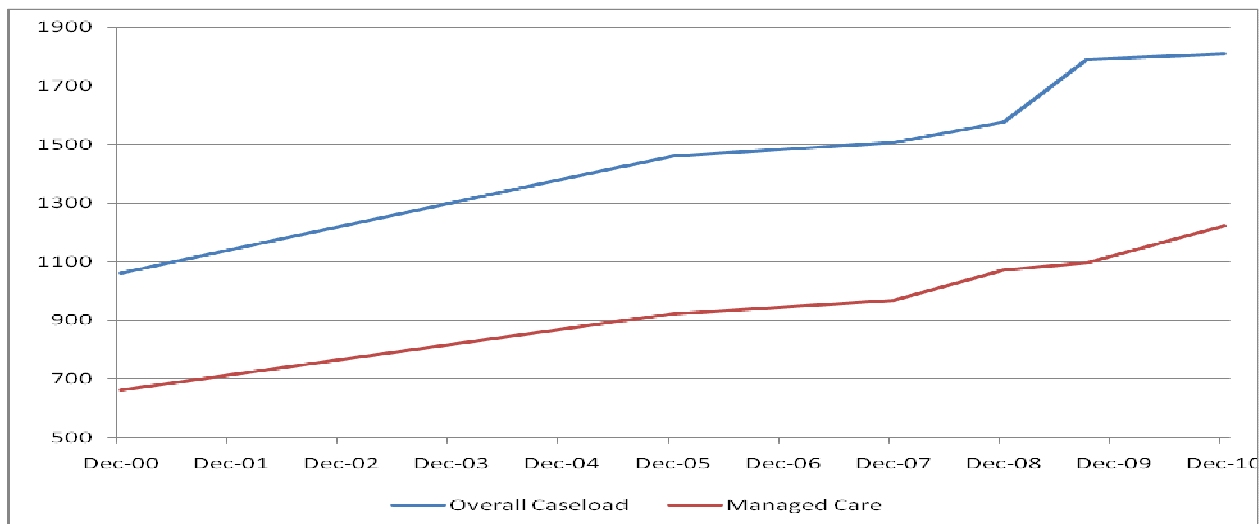
1. Enroll all Medicaid Beneficiaries into Medicaid Health Plans.

1.1 New Populations to be added to the Managed Care Program and as necessary specific rate structure recognizing the actuarial costs:

- Dual-Eligible Population and begin working with overall long term care options
- MI CHILD Enrollment into Medicaid Managed Care
- Children’s Special Health Care Services (mandatory enrollment)
- Complete work of the Foster care Children enrollment
- Revise and update Medicaid Eligibility policy in order to create an environment to manage the care of more beneficiaries, including medically need. Develop differing benefit programs based on Medicaid Program enrollment status. This would also permit consideration for personal responsibility initiatives.
- Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.

Rationale: Michigan can no longer take the “luxury” of retaining certain populations in unfettered fee for service. We cannot begin a discussion about creating savings in Medicaid without looking at a different administrative model. It no longer make sense to have nationally recognized Medicaid health plans provides services for Medicaid (now more than 1.2 million Medicaid beneficiaries) and not assume that the same advantages and cost savings would be realized by utilizing that structure for the remainder of the Medicaid beneficiaries.

Chart on Overall Medicaid Caseload and Enrollment in Managed Care



While the growth in Managed care has been impressive, it has remained relatively stable as constituting about 2/3 of the overall enrollment as displayed in the chart above. We all know that it is the remaining population in fee for service that is and will contribute to the largest cost obligations. A prime example is in realizing that over \$6 billion dollars are spent by the federal and state government on the Medicare/Medicaid Dual eligible population in Michigan—and yet this population remains in fee for service and arguably is a population that needs more management, care coordination, and access than other populations—features central to that of Medicaid Health Plans and Special Needs Plans, SNPs—those Medicaid Plans certified by CMS.

Three savings opportunities related to this population have been identified and should be pursued. One is to use coordination of care to reduce the Medicaid cost for acute care services for dual eligibles, such as hospitalization, that are components of the Medicare program. The second is for the state to get control of the Medicare funds spent on this population and retain the savings that can be achieved through care management – particularly savings in reduced inpatient hospital costs through coordinated preventive and ambulatory care. The third is to address long term care costs, both for dual eligible individuals and those covered by only Medicaid.

For decades states have been frustrated with the fragmentation and lack of care coordination between the fee-for-service Medicaid and Medicare programs which results in poorer health care at a higher cost. In the long term care arena Michigan has a relatively low level of spending on long term care services, but a much higher proportion of what Michigan does spend on long term care is spent for nursing home care rather than home and community-based services.

The Affordable Care Act includes provisions related to improved coordination for dual eligible beneficiaries. Section 2602 created a new “Federal Coordinated Health Care Office” reporting directly to the administrator of the Centers for Medicare and Medicaid Services. This new office has broad authority to approve five-year dual-eligible demonstrations. Under this authority Michigan could propose an integrated care model managed by the State that included both Medicaid and Medicare funds for both acute care and long term care services. Today efforts by Medicaid to improve the health status of dual-eligibles frequently result in savings to the federal government in reduced Medicare costs and little benefit to the state. Under an integrated waiver managed by the State there could be an agreement that Michigan would not only reap any Medicaid savings due to appropriate and efficient use of long term care services, but also share in the Medicare savings. Michigan must move aggressively to take advantage of this opportunity.

Similarly, the Children’s Special Health Care Services, CSHCS—a population dominated by beneficiaries with acute illness and diagnosis, would be better served with coordination for all services. We expect that the enrollment transitions for the Foster Care children in Michigan will be fully completed and implemented during the remainder of FY 11 and improved access and cost savings will be realized. Likewise, the integration of MI CHILD program into Medicaid can help realize both cost savings and administrative savings by merging contracts and oversight.

Finally, like all programs, there needs to be more aggressive and unique arrangements to assume care for those who cannot function within a managed care environment. These arrangements

need special attention due to high utilization of services, including ER and Pharmacy. Program expansion for this effort will save Michigan dollars and continue to provide necessary care for the affected program beneficiaries.

1.2. Reform Medicaid eligibility by:

- Study the option to delink Medicaid application from other human services program applications
- Develop Eligibility Access Points:
 - Outstationed Workers.
 - Application Assistance.
 - Automation.
- Remove the requirement that individuals verify their income when they apply for assistance and when eligibility is redetermined.
- Eliminate the asset test for low-income parents. Remove the requirement that assets be verified for all Medicaid applicants (or at least for low-income parents).
- Consider Express Lane Eligibility (ELE) for children.
- Evaluate the status of use of “pre-populated” redetermination forms and/or a simplified redetermination form for those subject to the “long form”.
- Pre-populated redetermination forms. Simplified redetermination.
- Start planning now for a faster, cheaper and more user-friendly system for determining Medicaid eligibility to go into effect in 2014.

The steps will help Michigan to change our eligibility efforts that may result in the following outcomes:

- Accelerating the enrollment into health plans at time of eligibility rather than 60-90 days after enrollment in fee for service;
- Change eligibility to annual, to create opportunity to work with spend-down population in managed environment.
- Begin the process of automating eligibility and enrollment consistent with State Insurance Exchange interoperability requirements.
- Identify and seek solutions to issues related to retroactive eligibility

Rationale:

MAHP cannot take credit for the series of eligibility recommendations, but we can endorse these proposals as reasonable attempts to bring more efficiency and automation to this process that will serve the needs of the State for its responsibility, beneficiaries for a more responsive system, and providers for facilitating enrollment of those who qualify for services.

The need to start now on automating this process is imperative. Under health care reform, as of 2014 individuals will be able to apply for assistance with health care using a one or two page web-based application without the need to complete a complex application that tests the availability of all other state-sponsored services. For the interim between 2011 and 2014 Michigan should study the option of delinking the Medicaid application from other human

services programs. This is the only way to get to a simple one or two page web-based Medicaid application. If the web-based software includes the decision rules for other human services programs such as SNAP (Food Stamps), individuals could still receive information that they MIGHT qualify for these other programs and have an opportunity to provide additional information if they want these additional services.

It has been generally recommended that a primary strategy for improving eligibility is to increase the number of “outstationed” Medicaid eligibility workers – located at hospitals, Federally Qualified Health Centers (FQHCs), nursing facilities and other community sites. Under these arrangements, providers would supply the non-federal share of the cost of these outstationed workers, thereby saving state dollars and relieving pressure on DHS. Michigan should also explore use of “application assisters” at non-profit community-based organizations who would assist individuals in either applying for Medicaid online or in completing paper Medicaid applications (for eligibility groups not eligible for online application). These individuals could improve the quality of the applications received by DHS and thereby reduce the time that it takes to process applications. Application assistance will be especially effective if the parties doing the assistance take advantage of available technology that uses the Michigan eligibility rules to pre-screen applicants. If this option is adopted, it should be developed carefully with reputable partner organizations that are already providing services in their communities.

There are many opportunities within the existing Medicaid eligibility rules to streamline Medicaid eligibility and enrollment procedures, thereby making the process more efficient. The Department of Human Services (DHS) staff is already overburdened and many eligibility workers have retired creating even higher “caseloads”. In light of the current environment, Michigan should consider the following steps to improve eligibility: Already in Wayne County the Detroit Wayne County Health Authority is using HelpEngen which is a web-based service that includes the complex eligibility rules for Medicaid, SNAP (Food Stamps), Temporary Assistance for Needy Families (TANF) and other human services. To the extent that community-based organizations find financial support to purchase this type of tool, the workload for state eligibility workers can be significantly reduced. HelpEngen and other similar programs determine what programs are available to an individual or family and assist them in completing an application and identifying any additional documentation that is required.

Michigan should study methods in place in Louisiana and other states that use data from other sources, such as Treasury, to verify income online. (Note that identity and citizenship are already being verified through automated data exchanges with the Social Security Administration and vital records. Automated matches with vital records can also be used for verification of marriage, divorce and death.) The Affordable Care Act already requires that the asset test for parents be eliminated by January 1, 2014. Early implementation would significantly reduce the time required to open new Medicaid cases. If removal of the asset test is unacceptable, the requirement for verification of assets could be eliminated without any significant impact on the accuracy of the eligibility process.

States are allowed to use data from other sources, such as the school lunch program to determine initial eligibility or to extend Medicaid eligibility. Several states have implemented or are

implementing ELE. Again the Medicaid eligibility workgroup should study the experience of other states. Currently the eligibility of Medicaid enrollees must be redetermined at least annually. Historically the redetermination process collected most of the data collected in the initial eligibility process. Frequently individuals were disenrolled for not providing information that hasn't changed. The BRIDGES system was intended to simplify this process, but providers, including nursing home owners, report challenges with redeterminations. The process should be especially simple for special groups such as nursing home residents where it is highly unlikely that circumstances or income will change to create an impact on eligibility. The re-enrollment process for these individuals causes more work for state employees. Several states send automated pre-populated forms to Medicaid enrollees at redetermination. If circumstances have not changed, the enrollees simply attest to that fact, thereby simplifying the process for both enrollees and eligibility staff. For at least the elderly on Medicaid, a one-page simplified re-determination application process to verify income status would not only be as accurate as the current system, but it would lessen the burden on the enrollees and their families, at the same time freeing state workers to spend their time on more important issues. These individuals are the least likely to have experienced a change of circumstances.

Finally, eligibility for many individuals will occur through the new Health Insurance Exchange beginning in late 2013. Work needs to begin now to re-engineer the Medicaid eligibility process that will be needed by October 2013. **On November 8th the Centers for Medicare and Medicaid Services (CMS) published a proposed federal regulation that provides for 90% federal funding for the development of new eligibility systems that are designed to interface with the Exchanges. In addition, this proposed rule provides for 75% federal funding for operation of such systems.** Michigan should take advantage of this opportunity. Michigan should also start now working with CMS to assure that there is not a need for a complex, two track eligibility process to be in place starting in 2014. The state should advocate for an audit or sampling process to obviate the need for concurrent eligibility systems for low income individuals seeking health care.

2. Consolidation Medicaid Benefits into a Comprehensive Contract and Streamline Administration and Oversight of Medicaid Health Plans.

- 2.1 Consolidate the delivery of Medicaid benefits through a comprehensive Medicaid Contract that will focus on coordination of an integrated benefit, (physical, mental health, substance abuse, dental, and other currently contracted services), require patient centered medical home support, establish performance standards documented by audited data, and that is supported by actuarial sound rates.
- 2.2 Consolidate the current multi-agency state responsibility for oversight of Medicaid Contract into a central office and focus on health outcomes using common metrics and objective and audited performance requirements.
- 2.3 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, and changing the perspective to a “regulation by exception”—that is focus on contractors who are not meeting standards established in the contract.

Implementing these recommendations may be perhaps the most difficult as it require the state to focus on outcomes for beneficiaries through a broad comprehensive contract management approach—rather than directly managing care or using single benefit contracts. For a current Medicaid beneficiary, there is a maze of service delivery access points, each with their different requirements and each having separate state oversight. Where there is shared responsibility, too often it is the beneficiary who is disadvantaged while providers and contractors argue over where responsibility resides. Further, extensive contract resources and time is spent to “articulate” policy that only results in more administrative costs and reporting.

The combined recommendations argue that it is time for Michigan to take a common sense approach to contracting for Medicaid services. This approach would:

- Use a comprehensive contract that creates clear ultimate responsibility and is performance based. These contracts must be risk-based in order for incentives to be aligned and uses regulated carriers to protect the public’s interest.
- Unifies the multiple points of state oversight into a single state administrative oversight office within MDCH/Medicaid. In doing so, this will eliminate the need to replace many of the vacancies caused by the recent early retirement program (cost avoidance for the state), and can modernize the contract function to rely on electronic and information technology rather than paper reports. The state can take the opportunity to promote best practices through this office, highlight performance areas, and regulate by “exception” when contractor are not performing at expected levels. By using regulated carriers, many of the actions will be already addressed through the Insurance Commissioner’s office.
- Finally, the state should take advantage of the national accreditation requirements and standards and use those qualifications as “deemed” compliance for related contract areas.

The savings stipulated in this White Paper are largely dependent on these recommendations. We believe there is a willingness to move in this direction as long as the outcomes are clear and that the intent is to serve the needs of Michigan’s vulnerable population. Clearly, this will be a multi-year task.

3 Maximize all levels of non-state General Fund support (Federal, special use, and local revenue)

3.1 Increase amount of Federal Funds to protect Michigan’s Safety Net. This would continue efforts for:

- Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries

- Options to additional federal support into Medicaid, including FQHC, patient centered medical homes, grants and programs to bring wellness and prevention as a key component of Medicaid.
- Consideration of the cost-effectiveness of early expansion of Medicaid eligibility as part of the economic recovery for Michigan

3.2 Increase third party collections for Medicaid Program

- Coordination of benefits including provision of access by Medicaid Health Plans to other carrier (including auto) information;
- Improved fraud and abuse coordination through the Medicaid Inspector General Office to and
- Focus collaboration efforts on reducing “waste” in our health system that will benefit all payers, including Medicaid.

3.3 Continue use of provider based taxes where it is permitted and supported by the affected provider community and assure that such support is dedicated to Medicaid.

All of these recommendations are common sense, but bear the need to continue to remind ourselves that all avenues of support for Medicaid should be pursued. For each dollar raised by local or special use funds, a dollar of general fund is saved and the matching support from the federal government can be secured. For managed care, the various support for the program is ultimately built into the assumptions used for actuarial soundness in accordance with federal rules and guidance. Each year, Medicaid Health Plan rates must be approved by the federal government.

If assumptions for Third Party Liability are included in the actuarial assumptions, then Michigan must create the underlying enabling rules and statute for health plans to access such data. If the underlying assumptions assume savings related to reducing “waste” in the health care system—then Michigan must create the enabling statutes and policies that will permit health plans to achieve these objectives. MAHP will be developing supporting proposed legislation and policy for these areas to help generate further savings.

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

We know that eligibility for many individuals will occur through the new Health Insurance Exchange beginning in late 2013. To prepare for this, work needs to begin now to re-engineer the Medicaid eligibility process that will be needed by October 2013. As indicated earlier under the eligibility recommendations, additional federal funds are available to help in this preparation and Michigan should take advantage of this opportunity. Michigan should also start now working with CMS to assure that there is not a need for a complex, two track eligibility processes to be in place starting in 2014. The state should advocate for an audit or sampling process to obviate the need for concurrent eligibility systems for low income individuals seeking health care.

This activity and the size and role of Medicaid should give the Administration pause to consider the feasibility of its location in state government. We need to group Medicaid eligibility and determination together and modernize the process consistent with the anticipated new eligibility requirements. Further, in the event that Michigan chooses to seek early adoption of the expanded eligibility, then the most important factor will be how the eligibility program can quickly adapt to such changes.

Medicaid is more than anything else, the “insurer of last resort” and all the changes in federal reform for Medicaid were directed as reducing the uninsured population with coverage through Medicaid. Further, it is the firm expectation that Medicaid eligibility and enrollment will be facilitated via the same mechanism that all individuals seeking insurance coverage will use—the State Insurance Exchange. Planning for this “interoperability” must begin now. In the context of insurance coverage—if there is relocation of Medicaid, it should be coupled with eligibility and policy and as a separate entity linked to the Insurance Exchange. While coordinate must continue with all welfare and social services programs, the most efficient arrangement is to combine into a single agency.

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

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
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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 (High, Medium or Low)
BENEFIT/COVERAGE ADMINISTRATION AND MODIFICATION IN MEDICAID		
1. Establish a default formulary in Medicaid of generic Rx with exceptions for psychotropic pharmaceuticals without generic replacements.	<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 70% generics of all prescriptions.</p>	Medium
2. Limited Benefit Arrangement. 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	This option will permit the state also to established incentives to access preventive health services and practices.	High

<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 access to the MAPS Program, MCIR, and full access to data on 3rd 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 managed preventive services.</p>	<p>HIGH</p>
<p>ADMINISTRATIVE SERVICES & EFFICIENCIES</p>		
<p>4. Either develop statewide contract for durable medical equipment, (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 statewide contract for transportation services (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>PROVIDER REIMBURSEMENT</p>		
<p>6. The MDCH should revise their policy for short stay outliers or observation stays 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. Hospital Capital Payments. 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 Hospital Access Agreement (Medicaid Policy) 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>LEVERAGE OF FEDERAL DOLLARS</p>		
<p>9. Disease management 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>

COORDINATION WITH OTHER PARTS OF MEDICAID AND OTHER STATE HEALTH PROGRAMS		
<p>10. Expanding Medicaid Managed Care. 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>
EXPANSION OF HEALTH CARE COVERAGE		
<p>11. State vendors — 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. Consider moving responsibility for the administration of ABW and County Health Plans to Medicaid Health Plans. 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>13. Phase In Early Expansion of Medicaid Eligibility. Implementation of this option could begin to provide coverage to Michigan residents without insurance coverage. Further, this will place Michigan in good position to move to full implementation by 2014 and take full advantage of the 100% federal funding available at that time.</p>	<p>MAHP is prepared to work with the Administration and legislature on this proposal and to help identify funding strategies for implementation of the phase in component. We believe the investment in this initiative will more than be returned in savings from care now provided in the Emergency Departments.</p> <p>Under Federal reform, this change can be accomplished via a state Medicaid plan amendment and not lengthy waiver proposal. Savings would accrue to other payers, including the state of Michigan due to limiting uncompensated costs.</p>	<p>Medium to high</p>
<p>14. MAHP also recommends that statutory revisions 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>

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

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

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

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