



**Performance, Value, Outcomes:
Sustaining Medicaid Managed Care:
Part of the Solution For Improving
The Medicaid Program**

FY 2009 – 2010

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.

Executive Summary

Medicaid White Paper: FY 10

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MAHP Medicaid White Paper for FY 10-Executive Summary

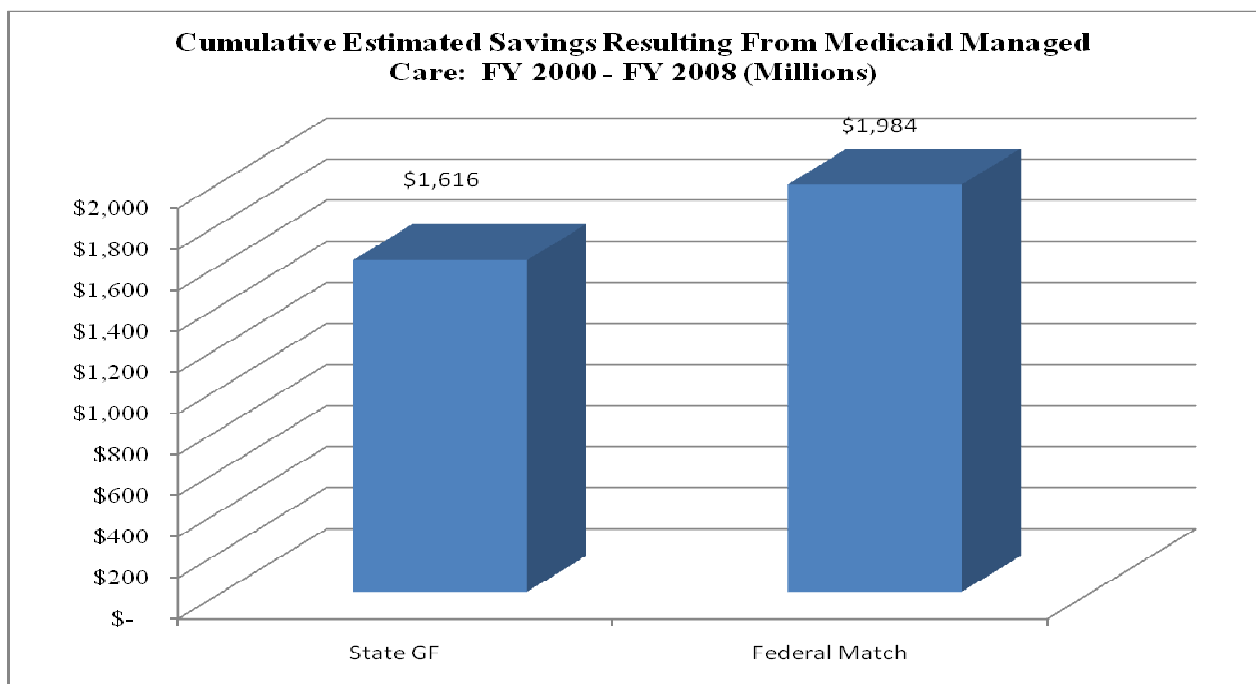
EXECUTIVE SUMMARY

Over the past several years, the Michigan Association of Health Plans has issued an annual Medicaid White Paper that highlights the performance of Medicaid health plans and includes recommendations for sustaining and improving Michigan Medicaid. The key points that are emphasized — then and now — continue to be cost effective health care, high quality health care, and improved access to health care. Recently the *Commonwealth Fund* issued a paper describing a framework for a high-performance health system in the United States. Their suggested framework is one that Michigan should model — not just for Medicaid, which is the focus of this paper — but for all health care delivered in this state.

The definition of “high performance” used by the Commonwealth Fund can be summarized as follows:

- Commitment to a clear strategy;
- Delivery of care through models that emphasize coordination and integration; and
- Establish and track outcomes in such areas as: quality of care, access to care, and population-based disparities, and efficiencies.

Medicaid Managed Care can be described as a building block for such a system of health care. The demonstrated and audited outcomes of the Medicaid managed care program are its strongest features. Policy makers, administrators and the public can expect value from the 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.

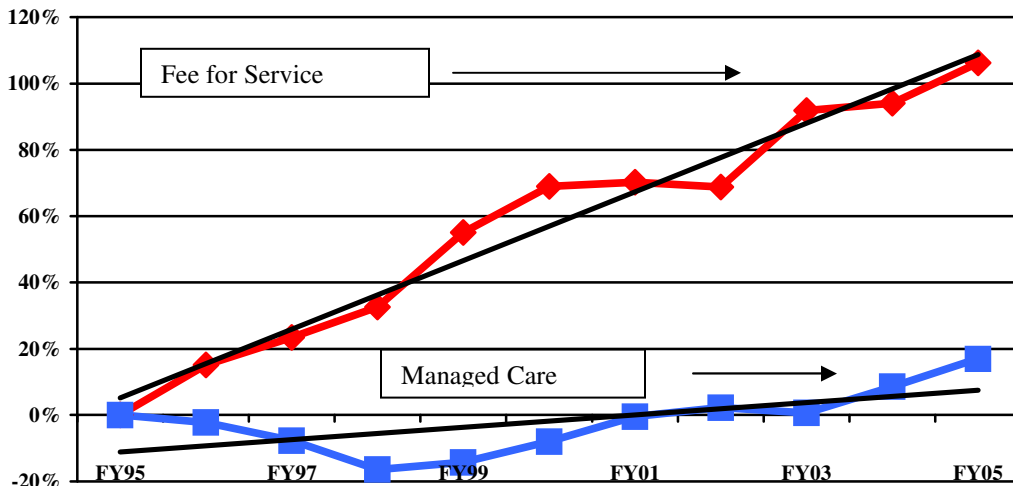


MAHP Medicaid White Paper for FY 10-Executive Summary

Translated into real terms, this has resulted in **\$3.6 billion in total savings** compared to Medicaid alternatives between FY 00 and FY 08 or between **\$350 and \$400 million each year** and is displayed in the above graph. 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. As noted elsewhere in this White Paper, these cost savings are accompanied by increasing improvements in health status measures for children and adults that are determined by audited record review, and greater access to needed health care services documented by provider file contract information retained by the state. *Continuing to invest in Medicaid managed care will continue to provide these results for Michigan.*

Without a managed care program, Michigan would be relying on a fee-for-service base of operations with inherent inefficiencies and inability to manage the health care needs of the population. The line-chart below illustrates the relative payment to the Medicaid managed care program (payments to health plans) compared to the same costs that would otherwise take place in the regular fee-for-service program (at 100%) for the same population — this illustrates far better than any other description the value that Medicaid managed care has provided and can continue to offer for the State of Michigan.

**Managed Care Reduces State and Federal Costs
Per-Person Cost Growth Fee-for-Service and Health Plans**



FY 95 – FY 05

(Source: MDCH Presentation to House Health Policy Committee, February 2007)

The savings (compared to fee-for-service) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care. Our intent in producing the MAHP White Paper is to provide illustrations of accountability,

MAHP Medicaid White Paper for FY 10-Executive Summary

access, and cost effectiveness in order to demonstrate the value that Medicaid managed care has provided to the State of Michigan. Our recommendations for sustaining and building on this performance are summarized below and provided in greater detail in the body of the White Paper.

Conclusion

In past years, the Administration, Legislature and MAHP had focused on issues related to how the future Medicaid program will be shaped and the role of a performance based managed care program. Many would argue we are still at that crossroad in the determination of FY 10 recommendations. But we can all agree on the following:

- Both the Legislature and Administration continue to rely on Medicaid managed care to deliver services to over 1,000,000 Michigan citizens. Most other states are now just moving toward the comprehensive managed care approach that Michigan has implemented for a number of years. To retreat from this position would not only cost the state hundreds of millions to cover health care obligations in a fee-for-service environment — but would lose accountability, care coordination and preventive health services currently being provided to Michigan’s most vulnerable population. The real question may be why we are not doing more managed care in Medicaid.
- While 2/3 of the eligible Medicaid population is enrolled in managed care, **3/4 of the cost of Medicaid still resides with the remaining Medicaid population not enrolled in managed care.** MAHP believes that the state can 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 programs administered by MDCH.
- Medicaid is the building block for **overall health care reform.** The new initiatives that are expected to be developed at both the federal and state levels will be based on where Medicaid ends. Therefore, to promote health care reform, a strong and sustained Medicaid program is essential.

To continue to achieve the performance and outcomes described in this White Paper, the Medicaid health plans have invested millions of dollars in order to meet the increasing standards, systems requirements, and beneficiary services required under the state’s contract.

A partnership with the state similarly requires the investment by the State of Michigan in the form of adequate rates in order to sustain and build upon the successes of the managed care program that have been achieved to date. The Executive Budget for FY 10 recognized the need to support increased rates associated with cost and utilization changes and other actuarial soundness criteria that will help the State of Michigan support Medicaid managed care at the level required by federal rules. In return, the Medicaid managed care program will continue to provide the best possible value and return of investment for the State of Michigan.

MAHP Recommendations For FY 10 MDCH Budget

1. Recommendations for Actuarial Soundness and Supplemental Support for Providers

- The Michigan Association of Health Plans supports the Executive Budget Recommendations for FY 10 as recognition of the need to assure sound financing for the Medicaid Managed Care Program and recommends legislative support.
- The Michigan Association of Health Plans supports the continued initiative for funding of supplemental access payments to hospitals, adolescent programs and public entities as part of the approved rates paid to Medicaid Health Plans.

2. Recommendations for Rebid of the Michigan Medicaid Managed Care Program

The MAHP recommends that the development of the new contract for Medicaid Health Plans to be established under the re-bid for FY 10 specifically identify the requirements that will be used in conducting oversight. This includes:

- Process for enrollment & disenrollment of beneficiaries
- Conduct of formal site visits
- Use of continuous enrollment criteria in measuring performance
- Clarification that permits the conduct of health education and health promotion session in individual health plan provider network offices—and such sessions will not be consider “marketing”.
- Administration of Performance Bonus Withhold to be maintained at current level and inclusion of performance bonus template along with provisions that measurement will permit Medicaid Health Plans with time to implement changes.

3. Recommendations for Health Care Reform for Michigan

The MAHP recommends that the Legislature and Administration support a plan to support universal access for Michigan’s uninsured population and take full advantage of the options available to Michigan under the federal stimulus package and flexibility under the 2006 Federal Deficit Reduction Act. In developing this initiative, the legislature and Administration must hold Medicaid as the core building block for overall health care reform.

MAHP Medicaid White Paper for FY 10-Executive Summary

MAHP and members have adopted the following principles and recommended steps for health care reform in Michigan. Medicaid is a key feature of this initiative. Other features of a broad reform package include the following:

- **Access to affordable choices.**
 - Standard minimum benefits package offered by all carriers
 - Consideration of subsidies and guaranteed issue if coupled with individual mandate
 - Potential short-term options to cover the newly uninsured
 - Catastrophic risk pools and pre-existing conditions requirements
- **Protection of the safety net (Medicaid and MICHild)**
 - As described in the White Paper Recommendations
- **Quality.** Support public and private sector payment innovations to link payment with quality performance and outcomes. Address overuse, underuse, and misuse of health care resources.
- **Transparency in pricing and provider rates.**
 - Access for citizens of price and access information on providers
 - Protection against balance billing of members
 - Provider Discount Parity
- **Personal accountability and wellness as part of a “value based benefit design” model**
- **Efficiency**
 - Potential inclusion of Connector/exchange
 - **Use of Health Information Technology**
- **Other reforms elements**
 - Market innovation to improve management of chronic conditions and deployment of appropriate technology (electronic health record)
 - Insurance Code /PA 350—Chapters 34, 35, and 37—focusing on bringing products to market quickly while preserving appropriate regulatory oversight
 - Public Health Code (CON reform, particularly on technology; licensure of health professionals; liability reform; prevention; technology advances)
 - Mental Health Code (implementation of parity)

4. Recommendations for Expansion of Coverage into Managed Care

In order to expand the population served by Michigan’s high performing Medicaid Health Plans and create further cost-effective services, MAHP recommends the following additional populations currently in regular Medicaid Fee for Service be enrolled in or served by managed care programs:

- Foster Care Children (required under current year budget boilerplate)

MAHP Medicaid White Paper for FY 10-Executive Summary

- Children with Special Health Care Needs (under a risk sharing model with MDCH and on voluntary enrollment basis)
- Dual Eligible Beneficiaries (Medicare/Medicaid) on voluntary basis for Michigan's Special Needs Plans already certified by CMS) and other Long Term Care Services

The MAHP recommends that the enrollment for MI CHILD program be moved to the Medicaid managed care program OR the default enrollment is provided for Medicaid Health Plans in order to:

- Improve and document performance consistent with the proven record of Michigan's Medicaid Health Plans
- Provide continuity of care for children and adolescents and their families
- Capitalize on Medicaid outreach efforts to reach those children eligible but yet enrolled in MI CHILD
- Eliminate redundancies of administrative expenses and member materials associated with Medicaid Health Plans who participate in both programs
- Eliminate MDCH costs associated with cost settlement agreement with BCBSM and eliminate costs otherwise absorbed by BCBSM
- Provide funding to support targeted increase in Medicaid physician reimbursement for level 1 through 5 of the E/M codes.

5. Recommendations for Medicaid Policy—Operational, System and Technology Issues

- The MAHP recommends that the Legislature continue the boilerplate adopted for FY 09 (Section 1770) that would limit the effective implementation date of Medicaid policy to October 1st, January 1st, April 1st and July 1st of each fiscal year in order to minimize system changes and related costs for health plans, providers and advocates.
- The MAHP recommends that the Legislature should enact policy to assure that any costs increases due to Medicaid policy adopted after Medicaid health plan rates are certified by CMS are included in subsequent rate adjustments enacted within 90 days of the effective date of the new policy.
- The MAHP recommends full implementation of electronic billing and communication in the Medicaid program for all payers and providers. MAHP also supports incentives and other efforts to expand e-prescribing, electronic medical records and other advances in health care technology.

MAHP Medicaid White Paper for FY 10-Executive Summary

6. Recommendations for Administrative and other Cost Savings

- The MAHP recommends that collaboration on efforts to reduce Medicaid emergency department utilization for non-emergent services continue with the overall objective to develop and implement incentives for services to be provided in alternative settings. Efforts should also recognize policy for ambulance services.
- The MAHP recommends that Medicaid and Medicaid Health Plans follow the precedent established by the Medicare program relative to reimbursement policy for “Never Events and adjust the Medicaid DRG program to recognize low day outliers for 1 day admissions that are less than 24 hours.
- The MAHP recommends that boilerplate be established to require the use of Medicaid Health Plan encounter data in the development and revisions of Hospital DRG pricing. Further, MAHP recommends that a routine process be used to assure that opportunities are made available to correct health plan data in order to be used in this process.
- The MAHP recommends the implementation of cost savings opportunities through such principles as expanding the use of managed care principles for managing the Beneficiary Monitoring Program, revision of contract administrative and or regulatory requirements that will continue to emphasize outcomes or performance, and in changes in DCH operations in such areas of recognizing “deeming” that would accept external accreditation as compliance with certain state requirements.
- The MAHP recommends the development of the new contracts for Medicaid Health Plans to be established under the re-bid initiative specifically identify the requirements that will be used in conducting oversight. This includes the process for enrollment and disenrollment of beneficiaries, conduct of formal site visits, and use of continuous enrollment criteria in measuring performance of health plans.
- The MAHP recommends that representative(s) of Medicaid Health Plans be part of the decision process in determining the selection of psychotropic products on Michigan’s Preferred Drug List.
- Allow Medicaid Health Plans to assist beneficiaries with redetermination process through outreach activities, (phone and in-person) to ensure continuation of Medicaid eligibility and enrollment in managed care. Redetermination efforts would be limited to individual health plan beneficiaries.