Performance, Value, Outcomes: Medicaid Managed Care: Part of the Solution For Health Care Reform

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.

Medicaid White Paper: FY 10

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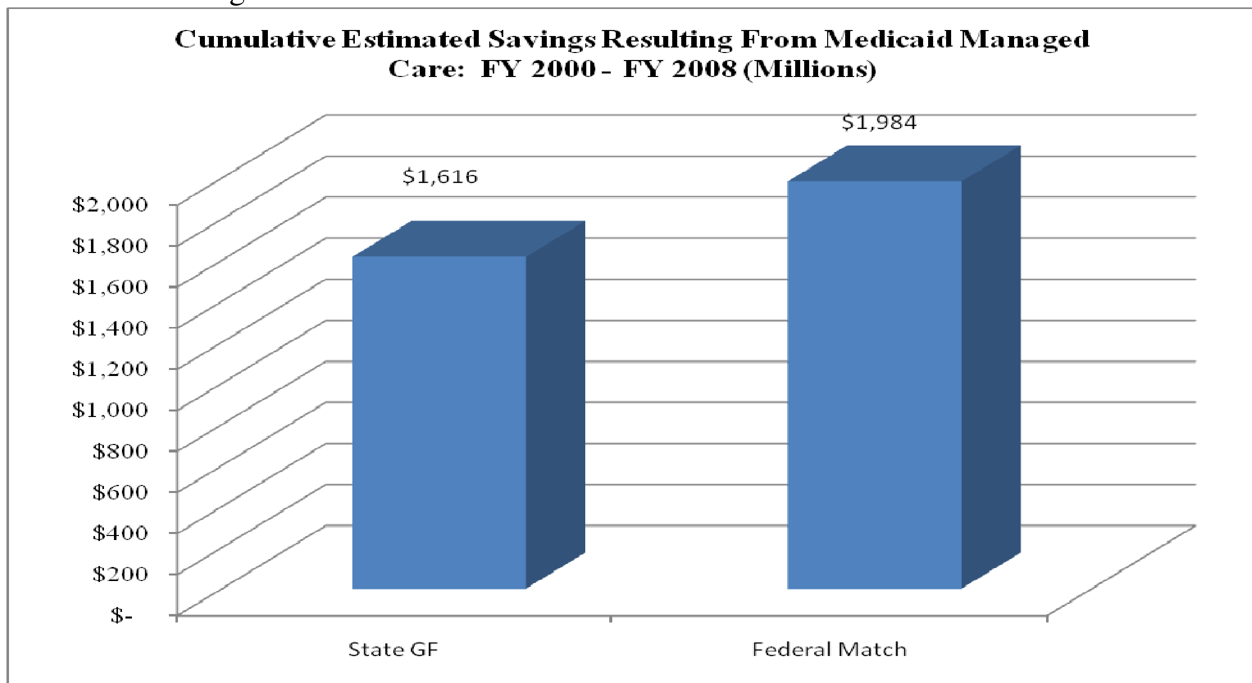
EXECUTIVE SUMMARY

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.

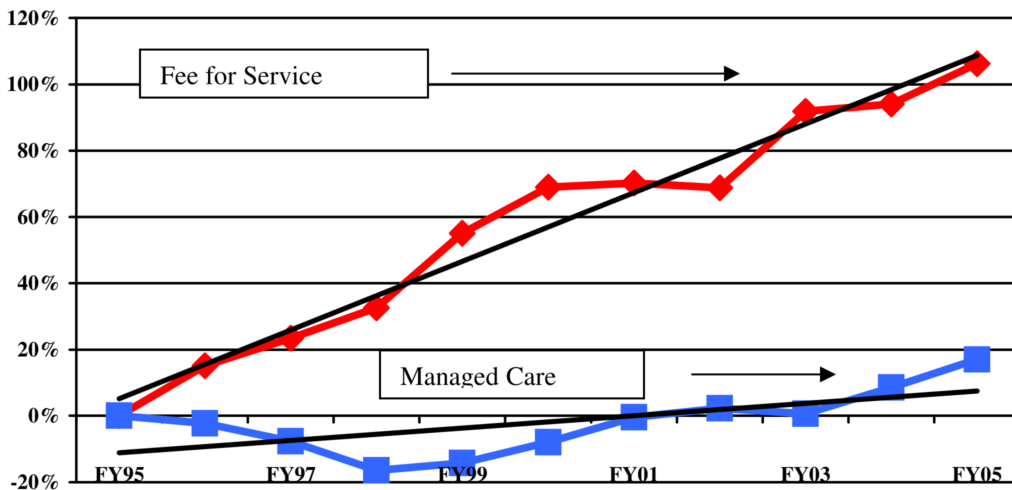


Translated into real terms, this has resulted in **$3.6 billion in total savings** compared to Medicaid alternatives between FY 00 and FY 08 or between **$350 and $400 million each year**

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, 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 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)
- 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 or Medicaid
- 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 3 of the E/M codes.

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.

5. 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 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.

Other Considerations

MAHP has also proposed other areas for considering reform and savings in Attachment 1 of the White Paper. These proposals address such issues as:

- Benefit/coverage modifications similar to other product lines and other state programs;
- Administrative, contract and policy changes that can reduce the underlying administrative requirements for managed care;
- Reimbursement policy changes that can affect both the Medicaid fee-for-service program and managed care;
- Leveraging additional federal dollars for the state by incorporating additional features to the managed care program and benefiting the state through the HMO assessment used to underwrite Medicaid services; and
- Extending managed care concepts of competition, best practices, evidence-based medicine, and outcome-based services elsewhere in health care services supported in different program areas of the state budget

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 in the Medicaid program, Medicaid managed care operates in a performance-based environment. 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 MQIC[1]. 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:

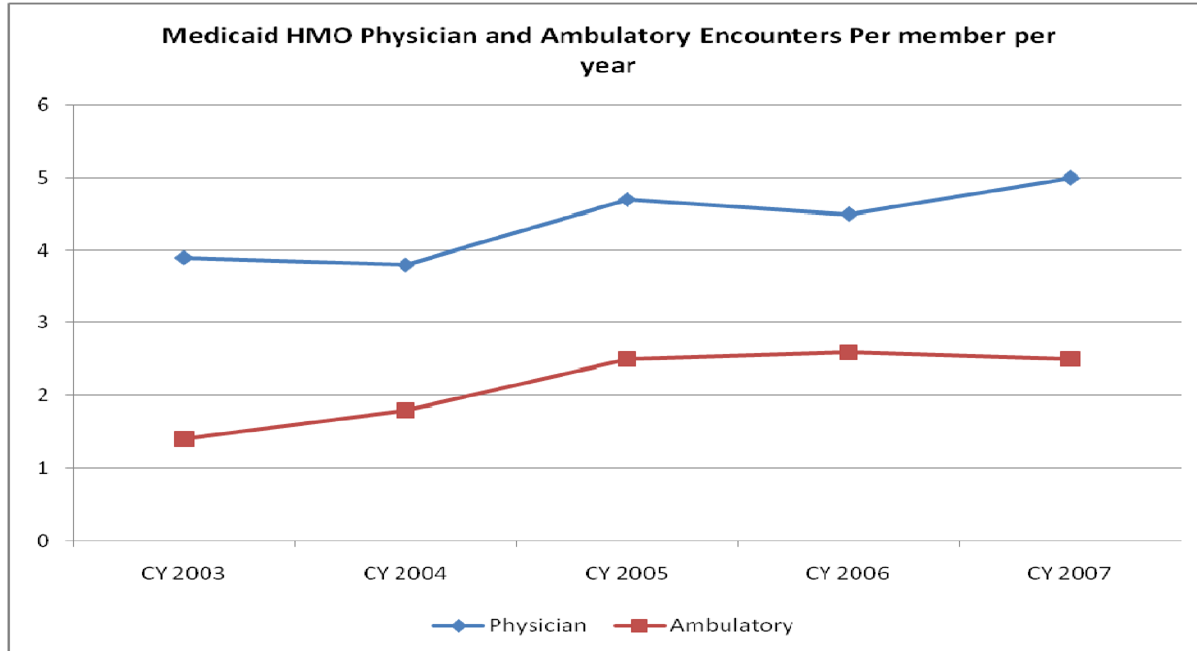
- A focus on preventive health care;
- Coordinated disease management;
- Effective management of utilization;
- Key indicators for improved health status of beneficiaries;
- Assurances that access to care for members is available;
- Quality monitoring of performance;
- Preferred pricing arrangements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

Reducing Hospital Utilization

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.

[1] The MQIC website is located at: http://www.mqic.org/guid.htm)

Chart 1



The potential for moving further in this direction is highlighted by data produced by the Michigan Department of Community Health[2]. This data has documented the extent of preventable hospitalizations in Michigan by condition, age and gender. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care.

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 2006, it is not difficult to picture the targeted areas for

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

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 (2006)	Percent
All Preventable Hospitalization	264,605	100.0
Congestive Heart Failure	41,090	15.9
Bacterial Pneumonia	36,369	13.7
Chronic Obstructive Pulmonary	21,683	8.2
Asthma	16,067	6.1
Kidney/Urinary/Infection	15,748	6.0
Cellulitis	14,886	5.6
Diabetes	11,890	4.5
Dehydration	8,601	3.3
Convulsions	7,389	2.8
Gastroenteritis	4,620	1.8
All other Ambulatory Care Sensitive Conditions	85,262	32.2

(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. Therefore, access to Michigan's hospitals for appropriate utilization of care is part of the overall management of care.

Chart 2

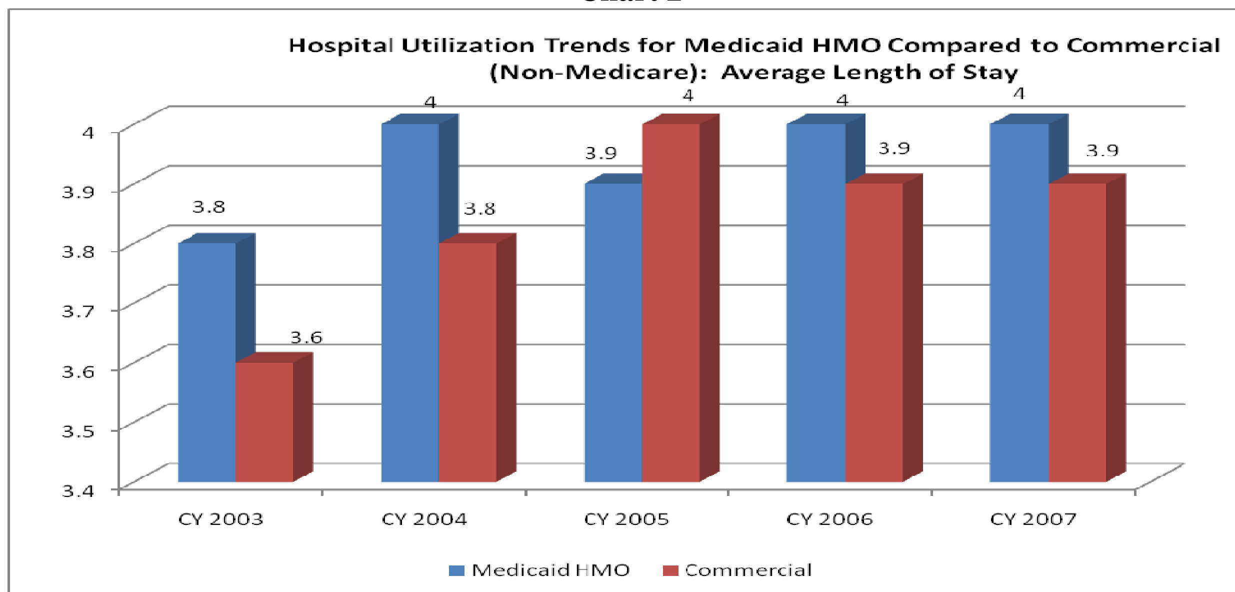
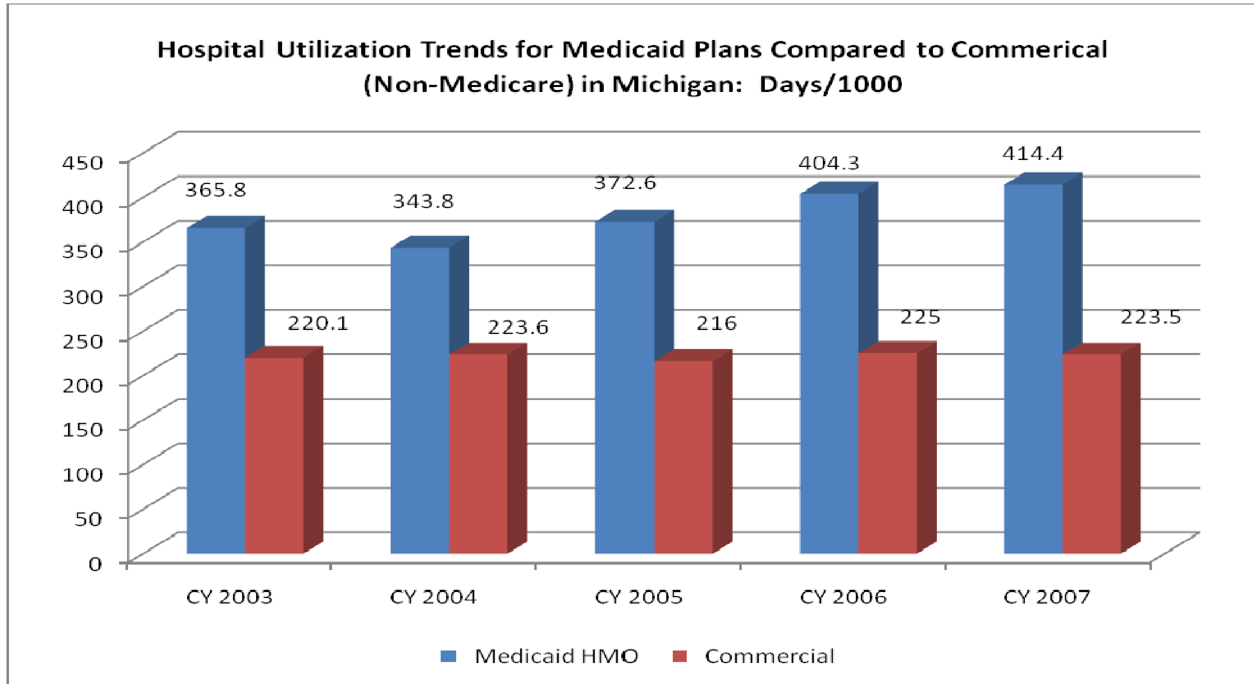


Chart 3



II. Building the Infrastructure for Medicaid Managed Care

Cost-effective health care, high quality health care and improved access to health care: these are terms that continue to describe the demonstrated and audited outcomes of the Michigan managed care program. Translated into monetary terms, this means $350-400 million in annual savings for Michigan tax payer, improved health status measures for adolescents and adults, and greater access to needed health care services.

Recent History

Through competitive bidding that has taken place from 1997 onward (in 1997 in SE Michigan; in 1998 for the remainder of state; 2000 and 2004 statewide), and will be undertaken again this year for FY 10 contracts, the Medicaid managed care program has provided the following results:

1. Medicaid managed care expenditures are managed and predictable for the beneficiaries enrolled in an HMO. 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 08 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, the savings to the state compared to the previous program (fee-for-service) have grown as illustrated in Chart 4 below. This chart indicates the relative cost per member per month for the

same services provided in fee-for-service versus Medicaid health plans. As the gap grows between fee-for-service and Medicaid health plans, the overall savings have grown.

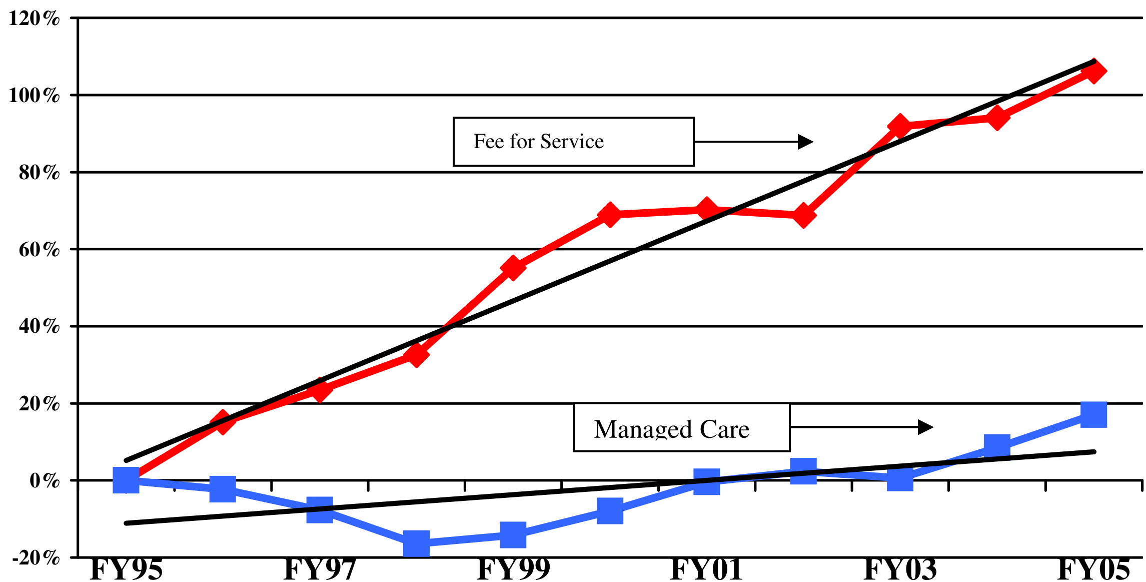
Per Member Per Month Increases: Managed Care vs. Fee-for-Service

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, as noted in the chart below, without the cost-effectiveness of Medicaid managed care, the expenditures in fee-for-service would have increased substantially over the amount currently allocated to Medicaid health plans — and without the improved health status, access and accountability.

Chart 4

Managed Care Reduces State and Federal Costs
Per-Person Cost Growth Fee-for-Service and Health Plans (FY 95- FY 05)

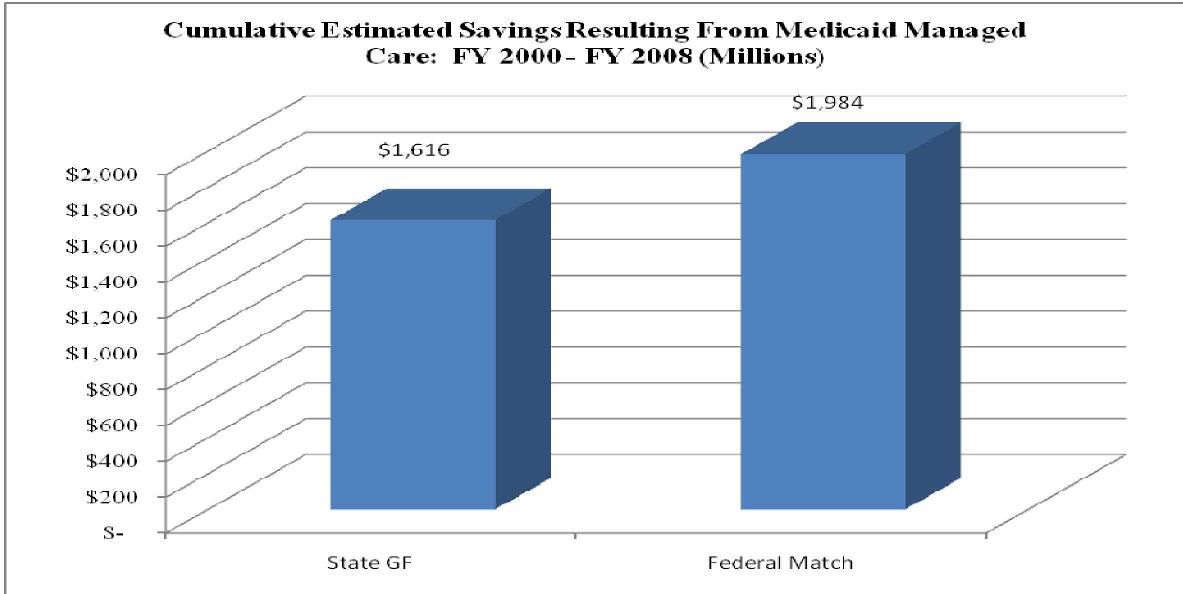


(Source: MDCH Presentation to House Health Policy Committee, February 2007)

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 6) 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

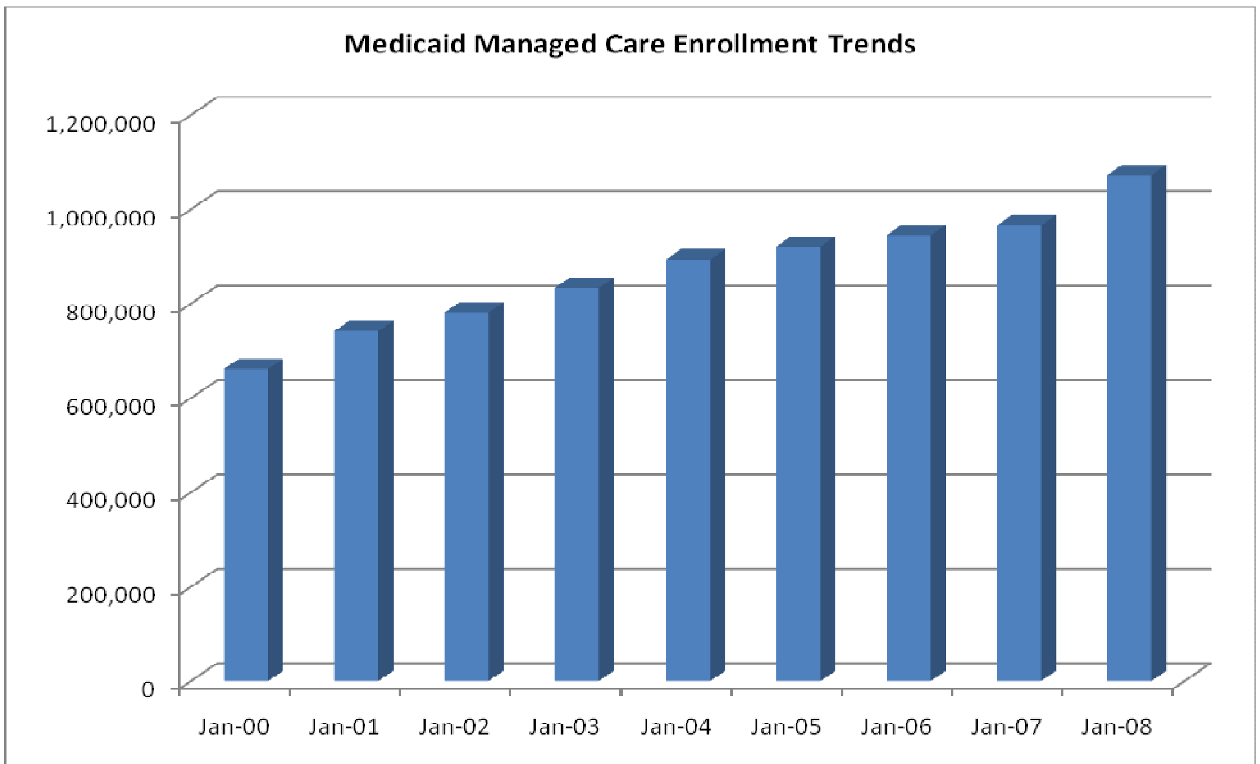
additional cost control and savings comparable to those implemented by managed care for the State of Michigan.

Chart 5



As noted above, the past nine years has resulted in total savings of $3.6 billion—shared between the State and Federal Government.

Chart 6



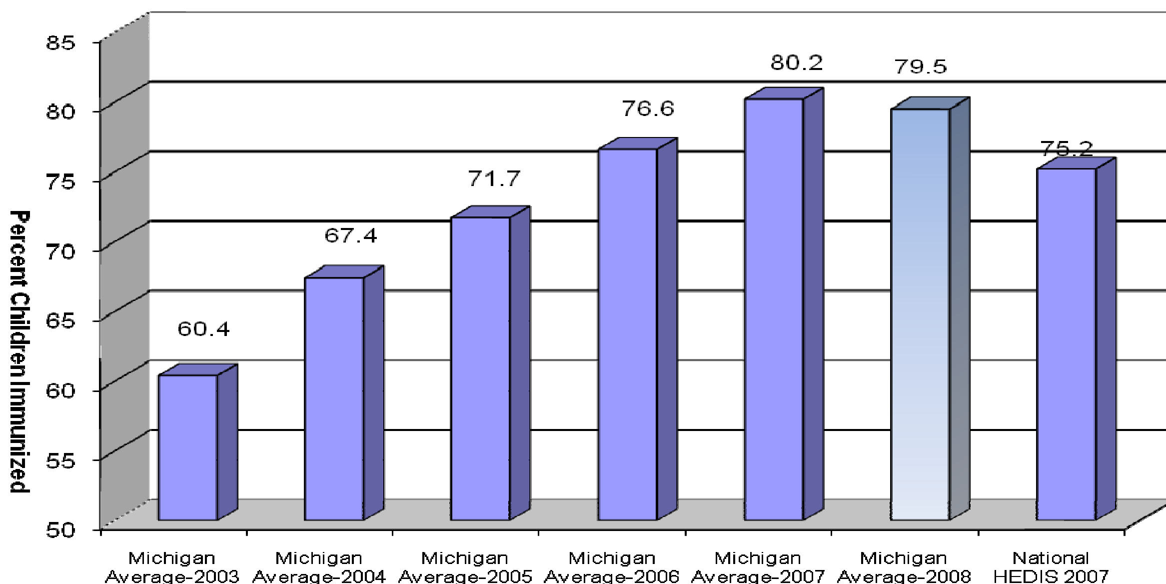
2. Services provided by Medicaid health plans are accountable under terms of both the state's contract and the HMO requirements in the Insurance Code.

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

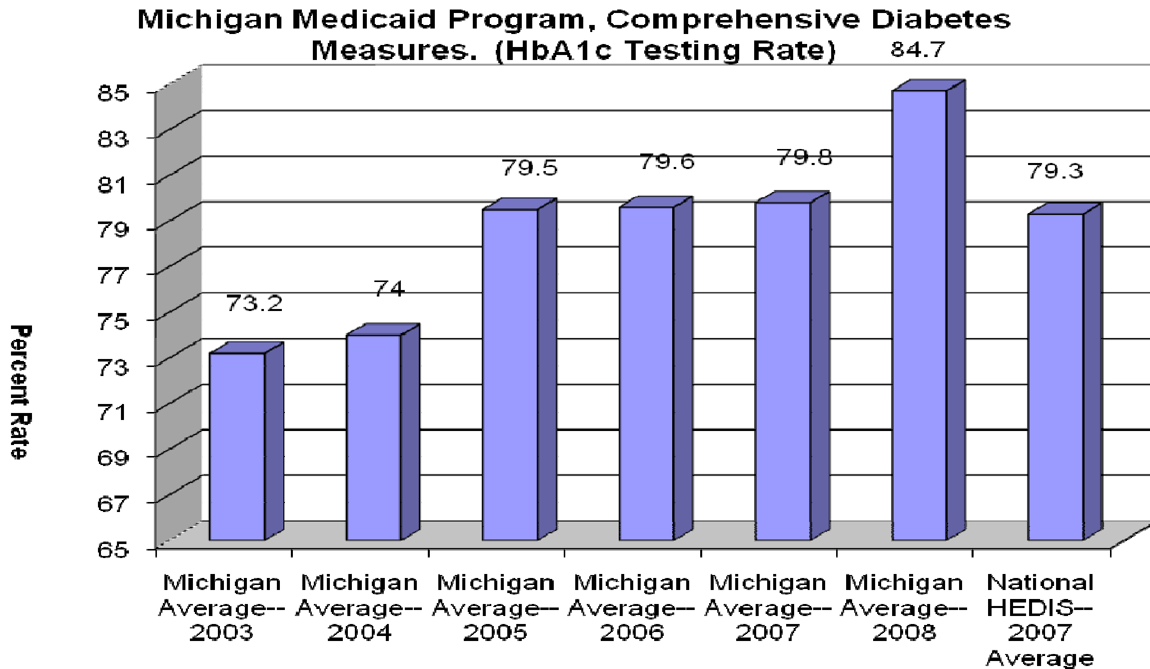
An illustration of the improved performance of Medicaid health plans has been in the area of immunizations. Under the HEDIS® analysis, key areas are reviewed each year — immunizations being one area. NCQA has now developed national Medicaid averages that states can use for comparison purposes. As displayed in Chart 7 below, the Michigan Medicaid managed care average immunization rate has increased by nearly 33% since 2003 and in 2008 is 4.3 points above the national Medicaid average as recorded by the NCQA for the prior year.

Chart 7



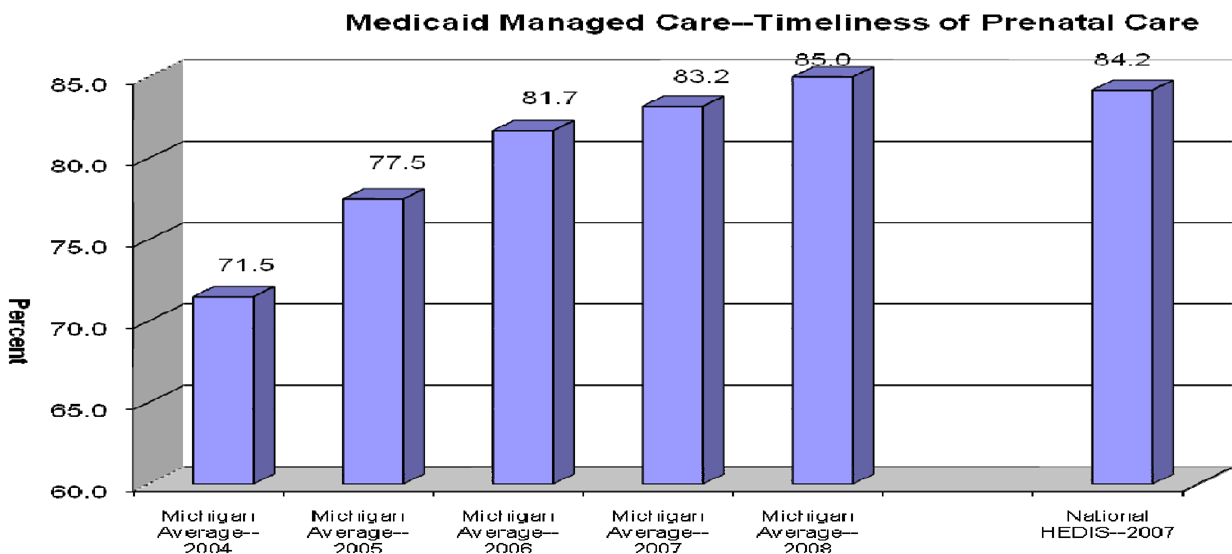
Further, the performance by Medicaid health plans enabled Michigan's overall performance in immunizations to leap forward over the past several years from nearly last in the United States to being one of the top performing states. Another example of audited data showing clinical quality outcomes is *diabetes*. 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



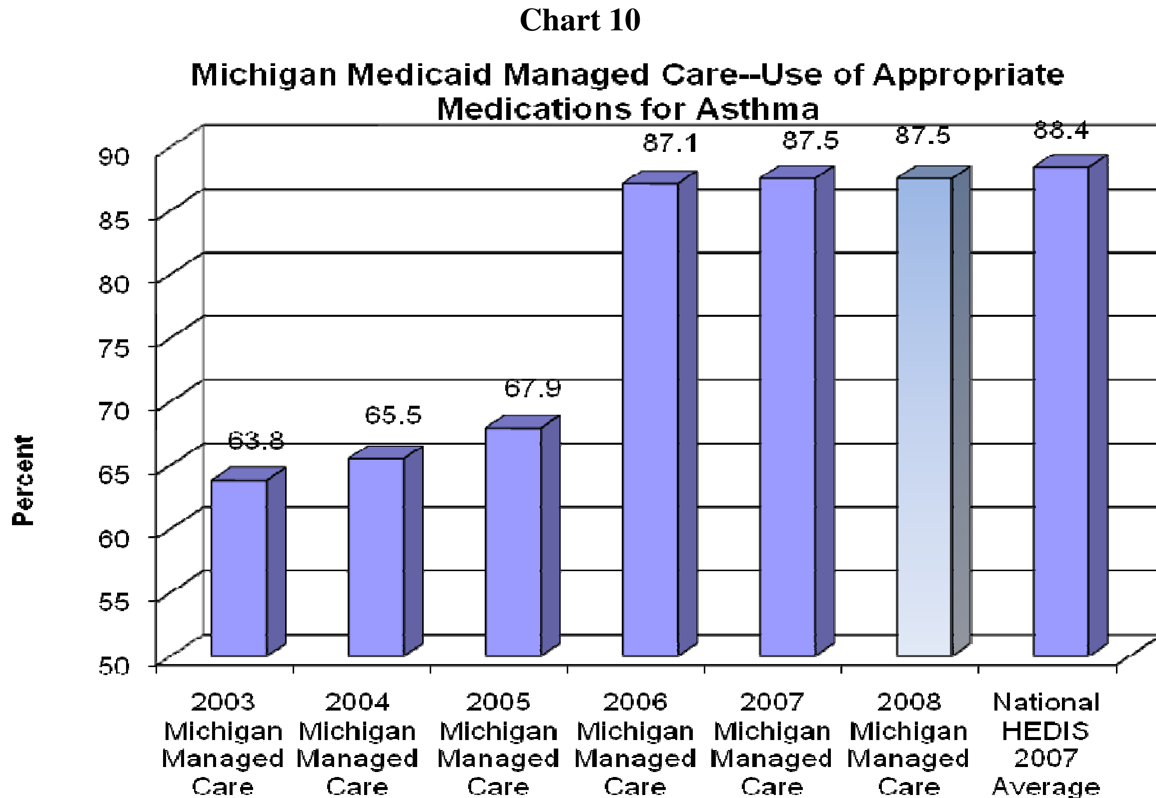
Another area is prenatal care which has always been a marker in the determination of safe and healthy deliveries and reducing infant mortality rates. Medicaid Health Plans have emphasized prenatal care, and the results are illustrated below in Chart 9.

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



<u>The second element is the use of external measures to determine customer satisfaction</u>. 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. Chart 11 contains the most recent composite information from the CAHPS survey results taken in 2007.

Chart 11

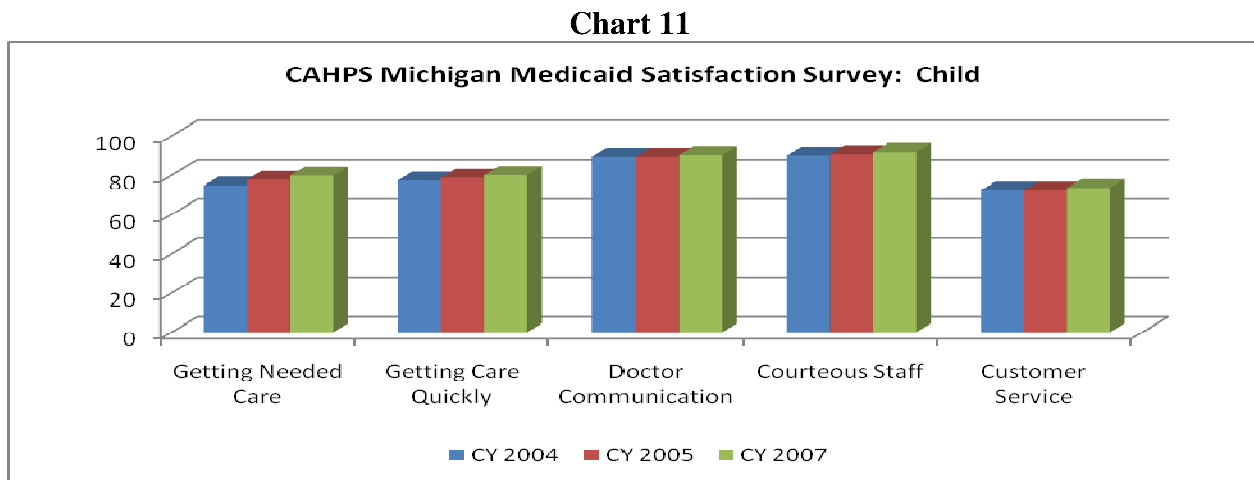
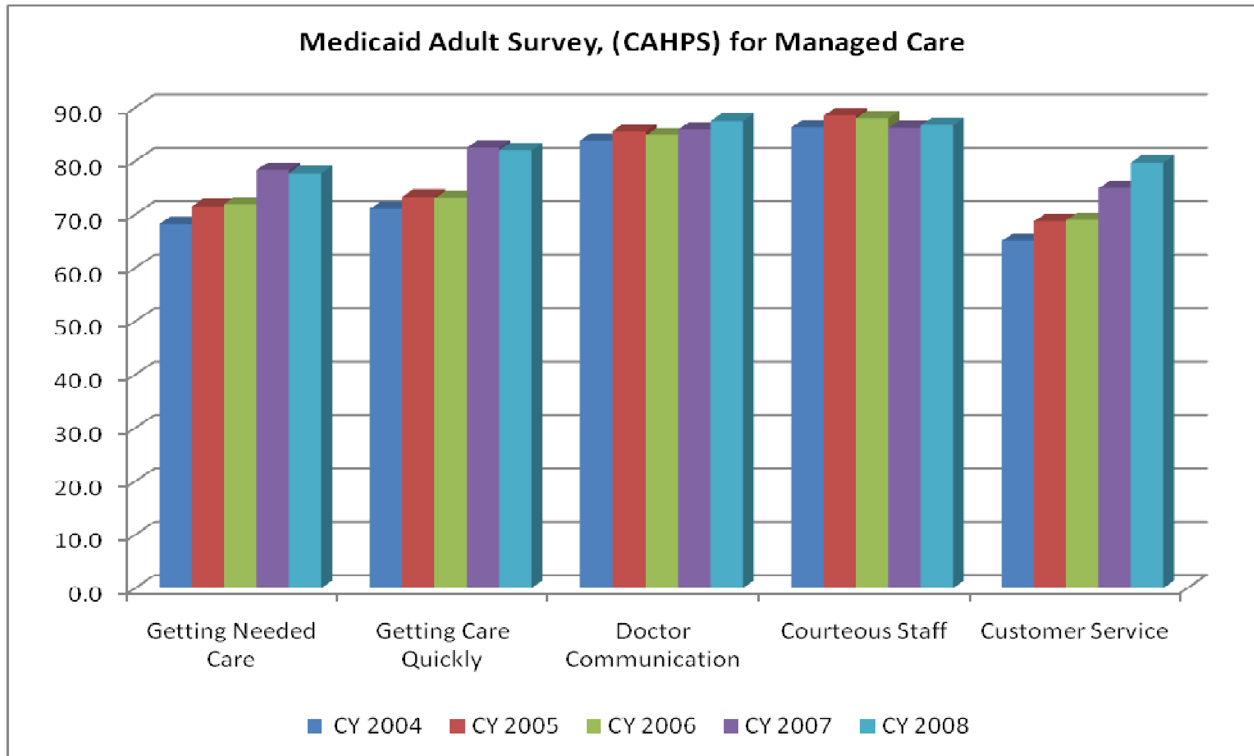


Chart 12 displays the most recent adult consumer responses and their degree of satisfaction in the delivery of health care within the managed care program and includes the same measures as illustrated in the Child CAHPS survey. MDCH summarizes all of this information into a Consumer Guide provided to new beneficiaries in Medicaid who are then presented with choices for health plan selection.

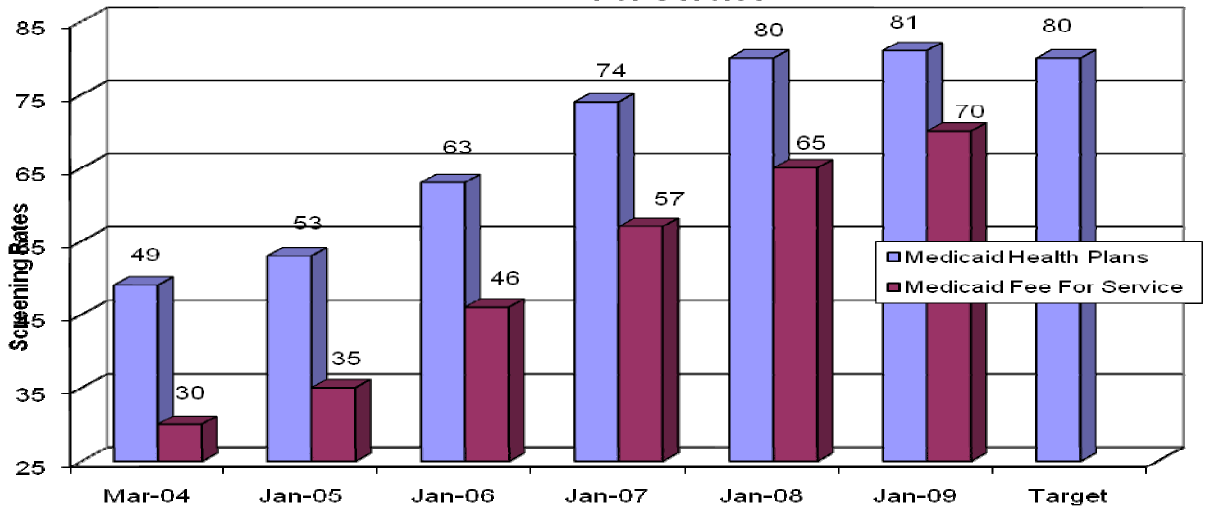
Chart 12



<u>The third element for accountability is the use of performance standards</u>. These standards are specific to Michigan and are reviewed and revised each year by the DCH 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 13, Medicaid health plans have recorded over a 60% increase in the screening rate objective established under legislation **and met the targeted 80% screening rate during fiscal year 2007**.

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.

Chart 13



This accountability has also been recognized nationally as Michigan's Medicaid health plans were recognized by the NCQA in October of 2008 as among the top ranked Medicaid plans in the United States based upon performance scores -- 11 of Michigan's Medicaid health plans were ranked in the top 50 nationwide. (***U.S. News and World Report: America's Best Health Plans***). http://www.usnews.com/directories/health-plans/index_html/plan_cat+medicaid/type_id+/plan_name+/accreditation+/region_id+/state_id+/sort+rank/detail+more/page_number+1/page_size+10

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 OFIS relative to denied claims, and Third Party Liability Reports);
- financial reporting (quarterly and annual filings with OFIS — available on the OFIS 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.

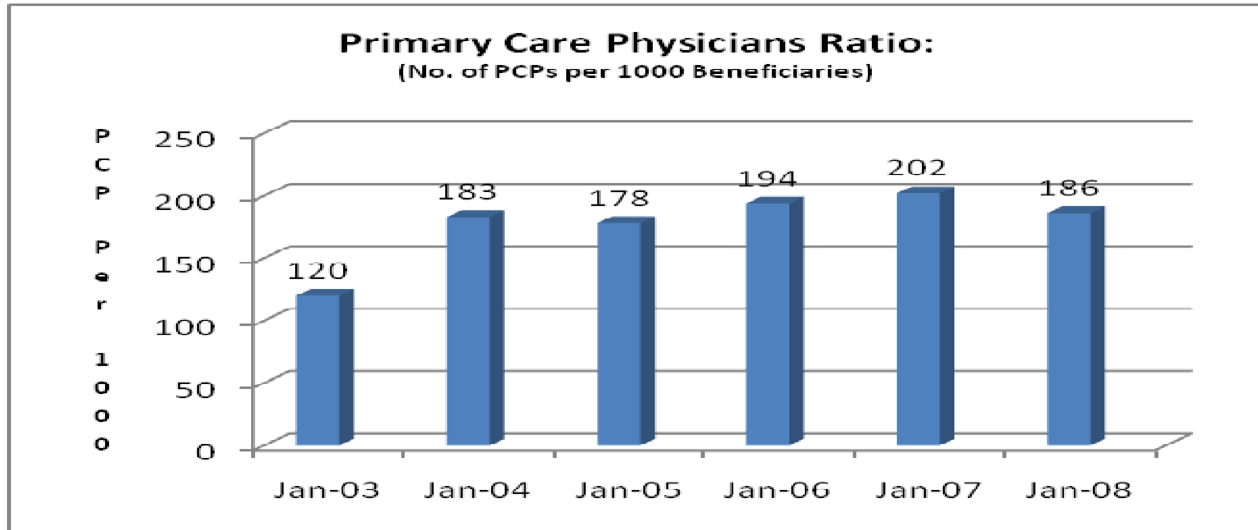
Additional accountability is provided through:

- 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 OFIS;
- 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 14



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.

The Chart 14 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.

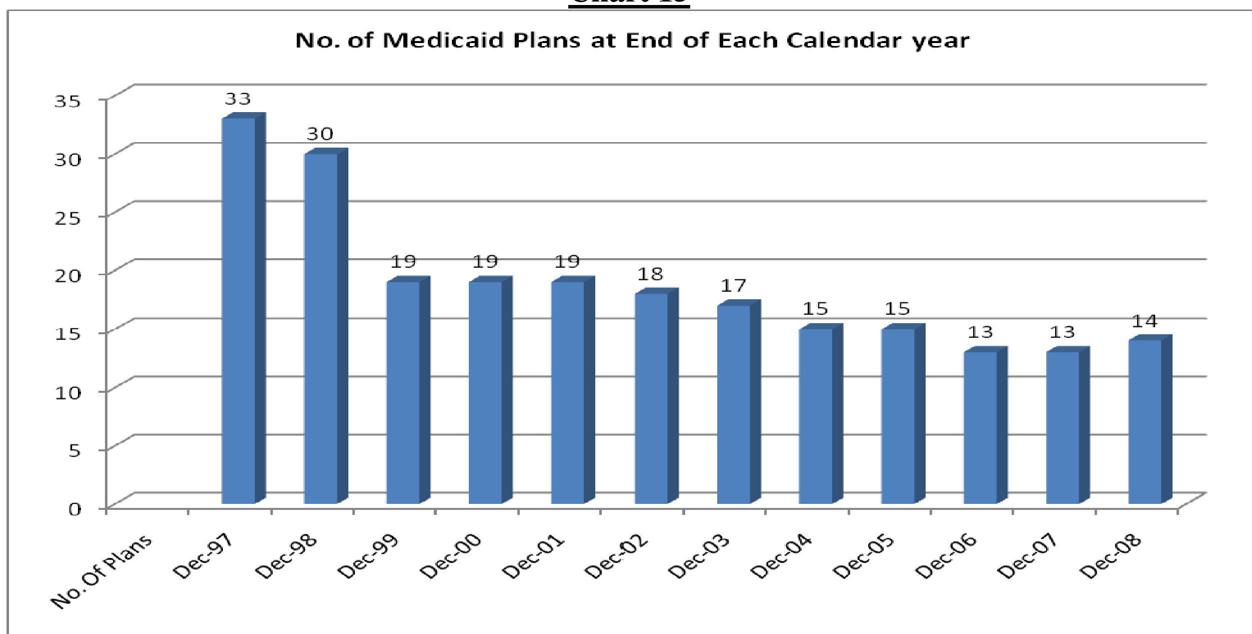
4. Administrative functions are built into state contract.

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.

Chart 15



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**." It 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 a number of alternatives that can permit this program to be continued funded under the federal requirements. Our recommendations on the following pages are developed in this context.

III. Recommendations for Sustaining Medicaid Managed Care and Improving the Medicaid Program: Part of the Solution for Health Care Reform

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.

The MAHP is pleased that the Administration has recommended an increase for FY 10 to recognize the expected cost trends for the next year and cost and utilization expenses absorbed over the past years by Medicaid health plans. ***Legislative support for the Executive Budget recommendation will be a key step in assuring the sustainability of the program.***

MAHP and its Medicaid Health Plan members were the first health care industry to develop and support a provider assessment that enabled the state of Michigan to increase support for Medicaid. This provider assessment now covers the capitated arrangements for Michigan's Public Mental Health System and ***provides annually about $430 million dollars*** that otherwise would be provided by general fund or reductions in the program. When matched by federal funds, the overall impact of the HMO provider assessment is nearly $800 million in gross funding. Because the State enabling legislation for this assessment eliminated this assessment for September 30, 2009, MAHP supported the adoption of an alternative mechanism that was adopted at the end of the last legislative session, PA 440 of 2008. The alternative mechanism, an amendment to the State's use tax law, also provided an increased assessment, thereby generating additional revenue for the state's Medicaid program. ***MAHP will be seeking assurances from the legislature and administration that the new assessment will be implemented similar to the HMO QAAP.***

Beginning in the FY 07 budget MAHP and members work collaboratively on a process to provide supplemental funding to Michigan's Hospitals to provide greater access for beneficiaries. This supplemental funding appears in the Medicaid Health Plan line item and is funded directly to health plans. Through a series of voluntary agreements and in cooperation with the Michigan Health and Hospital Association and its members, funding

is now flowing as designed in this project and we look forward to continuing this initiative into FY 10.

Similarly, several years ago, the School-Health Alliance of Michigan and the Michigan Association of Health Plans, working with the MDCH, proposed and then implemented a program that now provides—through health plans—funding to support Michigan's child and adolescent programs. These programs in turn provide Medicaid outreach services for health plans. It is important that the underlying state match dollars continue for that program in order to secure the federal match and sustain overall support for this vulnerable population. MAHP Medicaid health plans are also taking on an initiative to support the public medical schools (public entities) through a similar concept that began in FY 08 and is supported again for the FY 10 budget. All of these supplemental access payments help to support the underlying costs of Medicaid and assures greater access for Michigan's Medicaid beneficiaries.

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

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.

Federal policy requires that the Medicaid managed care program be periodically rebid to offer opportunity for new contractors and to re-assess the overall program. The State of Michigan will be conducting this rebid during the current fiscal year in order to secure contracts with Medicaid health plans for the contract year beginning October 1, 2010. This process also is inherent in the development of the administrative contract between Medicaid Health Plans and the State of Michigan. Our recommendations are made in that context to support appropriate contract changes to continue to make this program more cost effective.

3. Recommendations for Health Care Reform in 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 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**. Beneficiaries and subscribers must feel that "access," "affordable," and "choices" are all essential aspects of any reform package. Without these considerations the objective for addressing the deep concerns of insured and underinsured (whose premiums and out-of-pocket costs are growing) as well as the uninsured and newly uninsured will not be me. The question is then, "Choice for what?". MAHP recommends that health care reform be based on providing choice to:
    - 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.** Citizens and other purchasers of health care services need easy-to-use information to make choices and take better charge of their health care.
    - 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)

MAHP is including these issues in the Medicaid White Paper and other documents to keep the issue of overall health care reform in front of decision makers and to establish the point that Medicaid is the building block for reform.

4. <u>**Recommendations for Expansion of Coverage into Managed Care**</u>

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)
- 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 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 physician reimbursement for level 1 through 5 of the E/M codes.

MAHP believes that the Michigan 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. The need to apply cost-effective measures becomes more important each year. As about ¾ of the Medicaid costs occur in for populations not enrolled in managed care, continued opportunity presents itself to continue to serve the same populations with same or similar benefits. If we don't take such measures, other actions may be necessary, including reducing benefits or eligibility.

Similarly, by more closely integrating MI-CHILD with Medicaid Health plans not only can Michigan provide greater performance and accountability but also the change would create opportunity to generate additional funding that MAHP believes should be targeted for Medicaid physician reimbursement relief. This will help in providing greater access for all Medicaid beneficiaries while bringing a performance based program into play for MI-CHILD.

5. Medicaid Policy—Operational and 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.

By virtue of state Medicaid policy, Medicaid health plans are required to use the Medicaid fee-for-service pricing as the base mode for reimbursement to out-of-network providers. Medicaid policy also dictates the manner and format for Medicaid billing. Unfortunately, the implementation of new Medicaid policy, implemented after Medicaid health plan rates are established, too often has additional cost-implication for Medicaid health plans that are neither recognized in the policy development nor provided by subsequent rate adjustments. These additional cost increases place Medicaid health plans at additional financial risk. By limited the effective date of policy these costs can be minimized and efficiencies achieved—without affecting the intent of the policy itself.

The MAHP believes the implementation of Medicaid policy must include financial impact analysis and compensation for Medicaid health plans when such policy is implemented after the health plan rates are approved as being actuarially sound by the federal government.

Through expansion of electronic billing and communication, Medicaid health plans see a great opportunity to achieve financial savings for all parties and also create greater efficiency and effectiveness in our health care programs. The MAHP recommends that authorization to require all providers to submit bills electronically begin as soon as possible and be phased in over a reasonable period of time. Electronic billing is not only more cost effective for health plan management costs but also enables the plans to pay providers more promptly. Electronic billing also fosters on-line claim adjudication, which helps health plans and providers resolve issues more quickly for claims that are not initially approved for payment. Implementation of these recommendation along with the requirements developed under the Health Insurance Portability and Accountability Act (HIPAA) would result in nearly a virtual single claim payment system — as all payers

(each health plan, Medicaid fee-for-service, etc.) would be using the same electronic format and uniform coding requirements.

MAHP and its members support these efforts and pilot programs to demonstrate different aspects of technology in such areas as e-prescribing and overall health information technology platforms for MAHP members.

6. <u>Recommendations for Administrative and other Cost Savings</u>

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 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.

The **MAHP recommends that MDCH 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**.**

Health care costs increase, quality of care is affected, and coordination of services is lost whenever non-emergency services are provided in the hospital emergency department rather than the "medical home" established for Medicaid beneficiaries. Unlike commercial products, Medicaid health plans cannot depend on individual incentives or responsibility that encourages beneficiaries to seek services in the most appropriate

setting. Therefore, the need for policy is critical. A high volume of non-emergent services is provided in the hospital emergency department creating upward pressure on costs.

A different opportunity for administrative savings is present through state administrative action to reduce or eliminate unnecessary regulatory requirements. Savings can then be directed to sustain services for beneficiaries. In this effort of "re-engineering," the opportunity to provide a continuous improvement in the delivery of essential health care services will remain the prime objective.

While much has been done in this area over the past several years, there are more opportunities. One example is to expand the use of "deeming" from national accreditation (e.g. NCQA, JCAHO or URAC); that is, for state agencies to accept national accreditation as meeting the same or similar state requirement. Such action would also save resources of state agencies. Since Medicaid health plans are reviewed by multiple state agencies (Michigan Department of Community Health and Office of Financial and Regulatory Services), opportunities exist to coordinate both the timing and routine regulatory reviews that take place each year. MAHP will be proposing legislation and boilerplate to address these opportunities.

MAHP has also proposed other areas for considering reform and savings in Attachment 1 of the White Paper. These proposals address such issues as:

- Benefit/coverage modifications;
- Administrative, contract and policy changes that can reduce the underlying administrative requirements for managed care;
- Reimbursement policy changes;
- Leveraging additional federal dollars; and
- Extending managed care concepts of competition, best practices, evidence-based medicine, and outcome-based services elsewhere in health care services supported in different program areas of the state budget

Conclusion

Michigan's Medicaid health plans are making concerted efforts to streamline their operations and reduce administrative costs. These initiatives include business process improvement efforts, streamlined administrative procedures, alliance and group purchasing initiatives, and provider contracting initiatives, including preferential contracting with high quality, lower cost providers.

Moreover, the Medicaid health plans have invested millions of dollars in order to meet the increasing standards required under the state's contract. ***A partnership with the state similarly requires the investment and support by the State of Michigan in order to sustain and build upon the successes of the managed care program that have been achieved to date.*** Michigan's Medicaid health plans look forward to this continued partnership with the State of Michigan to provide access to high quality medical services for Michigan Medicaid enrollees.

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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 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 options to not only support the Medicaid managed care program but to suggest areas that may be pursued in order to secure additional program flexibility while still maintaining the overall objective of providing medically necessary services for Michigan's most vulnerable population. 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. Implementation of all nearly all of the strategies will benefit the Medicaid fee-for-service program or the overall state budget.

Potential Savings Suggestion	Comments	Operational Feasibility of Implementation (High, Medium or Low)
BENEFIT/COVERAGE ADMINISTRATION AND MODIFICATION IN MEDICAID		
1. Consider feasibility of limiting the benefit package for targeted (non disabled or elderly) optional Medicaid beneficiaries **consistent with the package of benefits developed for Michigan First** Insurance Program. This option would be far preferable than eliminating eligibility categories.	This option would be permissible under the Federal Deficit Reduction Act of 2006 but would require federal involvement in approving managed care contract changes, rate changes, and waiver changes.	Medium
2. Additional option may be in reviewing coverage for **state employees** and assessing the feasibility of using that as basic coverage template for Medicaid optional populations.	(See Attachment 4 of MAHP Medicaid White Paper for comparison of Medicaid benefits to state employee benefits.)	Low to Medium
3. Establish or designate **Centers for Transplant Excellence**. Establish a standard Medicaid policy and fee that managed care and fee-for-service program use — unless individual plans contract for other arrangements. Currently, there are no such designations and in many instances, there is no specific reimbursement under the DRG program, and payment is based on charges.	In order to be consistent with Administration's directive on bidding of services — May require state DMB to develop a bid—and Medicaid contract and policy change in Medicaid to assure adherence. Outcomes should be improved access, cost-effectiveness and quality of care for beneficiaries	Medium

4. Development of additional **co-payments** that are permitted under federal rules (42 CFR 447.50 – 447.60) and now under the Federal Deficit Reduction Act. Examples would include various outpatient services, non-emergency visits in the hospital emergency department (highest cost setting). This is a common feature of other insurance carriers and could address current utilization, (about 30-35% of all emergency department visits are for non-emergency (primary care) services that could be provided in "medical home"). Also note that co-payment is not permitted for pregnant women or those under 18.	Legislative language has been adopted, and federal approval has now been secured for certain copays. However, Medicaid health plans continue to believe the most effective "personal responsibility" payment would be for non-emergency use in the hospital emergency department. Further federal approval would be necessary for this change but federal flexibility is available under conditions of the Federal Deficit Reduction Act of 2006.	Medium to High
5. **Pharmacy Management**. Continue to focus on **generic Rx** as main part of Medicaid Pharmacy—require authorization for name brand.	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. Most health plans are now paying for nearly 70% generics of all prescriptions.	High
6. Consider permitting health plans to manage products under the **Preferred Drug List** similar to other pharmacy products	Medicaid health plans remain financially responsible for a portion of mental health drugs but are unable to manage the benefit as long as they are required to be consistent with the State's Preferred Drug List policy. Savings for both managed care and fee-for-service could take place if management by the plans were implemented. If that is not possible, the state should remove health plans from the financial exposure of these products—similar to the policy for anti-psychotic products.	High

ADMINISTRATIVE SERVICES & EFFICIENCIES		
7. **Medicare and other Carriers as Primary**. Under Federal rules, Medicaid is payer of last resort—and Medicaid health plans—as Medicaid contractor is also payer of last resort. Incentives to determine eligibility for other carriers, and further efforts on coordination of benefits.	State policy and statute needs to be revised to assure all opportunity for coordination of benefit is realized, including COB with auto and other casualty payers. Benefits are to the state and managed care plans, and providers who would receive more than Medicaid rates from other carriers.	Medium to high
8. 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	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.	High
9. 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	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.	High
10. Continue to review and revise **Medicaid contract** requirements on distribution of member materials, provider directories, etc., and coordinate state site visits to save both state and HMO time/resources	Over the past year important changes have been implemented in this area, however, there are additional considerations that can be made regarding the timeliness and consistency in the review of materials used of incentives and other customer services and coordination of review between MDCH and OFIR.	High

11. **Reinsurance potential**—Medicaid HMOs are required to have reinsurance to cover high-cost care. However, under fee-for-service there is no such coverage. Since the residual Medicaid FFS population is more acute, a similar program should be considered for special high cost population groups.	The MAHP is attempting to develop additional information in this area as part of the overall initiative for health care reform in Michigan. Implementation of this program through Medicaid could use federal matching dollars to establish a overall reinsurance pool.	High
PROVIDER REIMBURSEMENT		
12. 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.	MAHP will monitor the changes/ impact on this program	Low to Medium
13. **DRG Rebasing and HMO data**. Change the nature of DRG rebasing. Currently, every two years the DRG is rebased based on the fee-for-service cost — however, this sets the base for HMO pricing and HMO data is not used in setting the DRG pricing. Current policy is to use Medicaid Health Plan encounter data for January 2010 update.	Policy change on rebasing should take place to reflect the total Medicaid market and not just fee-for-service. Medicaid Health Plan Data should be included in the analysis and development of revised DRGs	Medium to high
14. **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.	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.	Medium to high

15. Sustaining/Increasing Provider Rates. Without a doubt, reduction in Medicaid reimbursement will have fundamental, if not permanent impact on provider participation in the Medicaid Program. Medicaid Health Plans are dependent on a viable provider network to provide the necessary medical services for the enrolled population. Any opportunity to increase provider rates should be supported as another investment in health care—otherwise critical access will be impaired and hospital emergency departments will be the location of services—more expensive, and potentially affecting their ability to provide emergent services for all citizens. MAHP and members will identify all possible options for supporting providers during this difficult budget environment.	Targeted increases for primary care physicians should be supported. MAHP has recommended the redirection of MI CHILD to Medicaid Health Plans with costs savings and increased HMO QAAP to be used to provide provider rate increase.	High
LEVERAGE OF FEDERAL DOLLARS		
16. **Integration of services in Managed Care**. An overall approach to be considered by the Administration and Legislature is to review various health care programs and their source of financing to determine if the integration of services under the Medicaid managed care contract with the state can take place. The advantage is both cost savings—general fund or other state restricted dollars could match federal dollars—and accountability as the implementation of these programs would then come under the performance requirements and accountability of managed care. The Medicaid Health Plan provider tax levies a 6.0 % tax on medical services provided under the Medicaid contract — if additional services (or other programs) are added to the Medicaid HMO program, an additional 6.0 % is raised to substitute for state GF that is currently used to match federal dollars. This is in additional to matching previously unmatched state dollars.	The best example is the conduct of Medicaid outreach services provided for Medicaid Health Plans by Michigan's children and adolescent center programs—which were previous 100% state funded. For purposes of leveraging additional federal dollars and improved coordination, such change would be seamless to beneficiary. Programs that relate to services required under the State's contract with Medicaid HMOs would be potential candidates for integration. Last year, the Legislature enacted language to capitalize on this concept for Hospital GME support and other Hospital Supplemental payment services and began program with Public Entities providing specialty Medicaid services.	Medium to High

17. Consider incentives to provide more **MI-CHILD** Program enrollment with Medicaid HMOs. This would bring additional premium revenue subject to the HMO provider tax as well as being provided in a more accountable system. As part of this consideration, the State should implement an auto assignment algorithm to assign new members as default to participating Medicaid plans.	Would require a policy change by the state Medicaid Program. (See Recommendation # 15)	Medium to high
18. **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.	Would require state contracting and perhaps a bid program and arrangements could be on a risk-sharing basis. Based on HMO experience that may be potential of about 1000 cases that could be handled in fee-for-service — and assume 10% savings from the costs incurred compared to current utilization. Would also likely show as additional income by the HMO subject to the provider tax — saving more GF.	Medium
COORDINATION WITH OTHER PARTS OF MEDICAID AND OTHER STATE HEALTH PROGRAMS		
19. **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.	Assuming even a modest change in policy that promotes the management of care can assist in providing more cost-effective care. 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 Eligibles (Medicare/Medicaid) may be enrolled in Special Needs Plans that have been certified by CMS	Medium

EXPANSION OF HEALTH CARE COVERAGE		
20. **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.	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.	Medium
21. **Health Care Reform/Universal Access**. Implementation of this program (with considerations identified by MAHP) in this White Paper) will enable Michigan's uninsured to receive coverage and reduce the state's uncompensated cost.	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.	Medium to high
22. MAHP also recommends that **statutory revisions** be made to enable the managed care industry full participate in the implementation universal access and other basic benefit coverage options that many employers and individuals currently seek for their employees.	Similar to above, this proposal would not directly impact Medicaid—but would create more affordable health care options for Michigan's employers and purchasers.	Medium to high

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 7.6 % of total premiums estimated for CY 2007.

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	• 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

	• Grievance & Appeal Process including Medicaid Fair Hearing • OFIS external reviews • Enrollment services functions including special dis-enrollments
Administrative Cost: Beneficiary Services—Health Education and Health Promotion	• 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	• 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	• Providers who are credentialed every three years • External Health Plan Accreditation (e.g., NCQA, JCAHO, 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

<table>
<tr><td>Administrative Cost:
HMO Public
Accountability</td><td>

Data Reporting to the Department of Community Health

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 OFIS 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 OFIS and DCH
External Accreditation from a National Organization
</td></tr>
<tr><td>Administrative Cost:
Provider Services</td><td>

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
</td></tr>
</table>

ATTACHMENT 4—COMPARISON ON MEDICAID BENEFITS TO STATE EMPLOYEE COVERAGE

The following table illustrates the benefits paid by the State of Michigan for coverage for Medicaid beneficiaries and state employees. As suggested in Attachment 1 (Recommendation 1) of this White Paper, using state employee coverage as a template could be explored for potential cost savings of the benefits for optional Medicaid population groups.

The major differences between state employee and Medicaid HMO coverage are:

- State employee premium contributions by state employees (possible under Medicaid with waiver and state policy);
- State employee deductibles (not possible for Medicaid);
- State employee copays (possible under Medicaid with federal waiver and state policy);
- Benefit limits of coverages (possible under Medicaid with federal waiver and state policy); and
- Additional benefits for Medicaid that is not available for state employees (OTC prescription coverage and transportation for non-emergency covered benefits).

	MEDICAID HMO	STATE EMPLOYEE PPO	STATE EMPLOYEE HMO
Doctor Visits/Preventive Services	Covered	Covered $10 co-pay	Covered $10.co-pay
Prescription Drugs	Covered: Some plans have $1 and $3 co-pay	Covered: three tier co-pay $7, $15, $30	Covered: $5 and $10 co-pay
Over the Counter Medicine	Covered	Not Covered	Not Covered
Immunization	Covered	Covered	Covered
Inpatient Hospital	Covered 100%	Covered 100% after deductible	Covered 100%
Outpatient Hospital	Covered	Covered 100% after deductible	Covered
Emergency Services	Covered	Covered 100%	Covered $50 co-pay if not admitted
Chiropractic	Covered - some have $1 copay	Covered 90% after deductible	Covered - copay varies by HMO
Transplants	Covered	Covered 100% after deductible	Covered

DME	Covered	Covered 90% after deductible	Covered
Prosthetics & Orthotics	Covered	Covered 90% after deductible	Covered
Hospice	Covered	Covered 100%	Covered
Emergency Transportation	Covered	Covered 100% after deductible	Covered
Non-emergency Transportation	Covered	Not Covered	Not Covered
Maternity Care	Covered	Covered 100% after deductible	Covered
Hearing Aid	Covered	Covered 100% after deductible	Covered
Speech Therapy	Covered	Covered 100% after deductible	Covered - $10 copay
Physical/Occupational Therapy	Covered	Covered 100% after deductible	Covered - $10 copay
Medical Tests, Lab X-ray, & Other Imaging Services	Covered	Covered 100% after deductible	Covered
Home Health Care	Covered	Covered 100% after deductible	Covered
Mental Health	20 outpatient visits - other services covered by mental health program	Covered - co-pays vary by service	Covered - co-pays vary by service
Substance Abuse	Covered by substance abuse coordinating agencies	Covered - co-pays vary by service	Covered - co-pays vary by service