mahp
Michigan Association of Health Plans

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

MEDICAID STRATEGIC PAPER: FY 21

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EXECUTIVE SUMMARY

The mission of the Michigan Association of Health Plans (MAHP) is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan. To implement this vision and promote the growth and sustainability for our managed care system, critical objectives are necessary at the beginning and through the program's duration. These objectives align with those of the State to achieve value and continue to raise the performance bar for improved outcomes from Medicaid Health Plans.

Policy makers, administrators and the public rightfully expect (and we believe receive) value from Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination, disease management, social determinants of health (SDoH) and a single point of accountability.

Transition to Managed Care

Medicaid is the largest health care program in the country, covering about 1 in 5 Americans with two-thirds enrolled in a managed care program. States have increasingly turned to Medicaid managed care programs to provide a variety of services historically performed by the state. Managed care plans assume full financial risk for services provided and day to day operations performed by states with traditional fee-for-service Medicaid programs.

When states shift administrative functions to managed care they do not lose control as they have oversight responsibility and must hold plans accountable for care delivery and cost effectiveness. Medicaid managed care plans cover five major service categories:

- Enrollee Engagement and Service
- Provider Access and Availability
- Care Management
- Financial Management and Reporting
- Quality

There are currently ten Medicaid managed care plans in Michigan serving just over 2 million Michiganders. Medicaid managed care plans assume responsibility of physical health care for diverse populations, ranging from children and pregnant women to Medicare-Medicaid dual eligible and people with physical or intellectual disabilities. Health plans provide diverse benefits and programs, such as acute and preventative medical services, services for children in foster care, dental care, transportation, and prescription drugs.

FFY 2018 Medicaid Spending	Capitation	Fee-For-Service	Supplemental, DSH and GME Payments
$16,519,398,146	*60%*	*30.2%*	*9.8%*

Figure 1: Michigan's breakdown in Medicaid spending for FY 2018.

Value in Managed Care

Medicaid managed care plans contract with the state to provide a comprehensive package of physical health and mild to moderate mental health services to enrollees in exchange for a prospective monthly capitation payment that remains the same regardless of the type or amount of services actually delivered. Because the managed care plans are at risk for the cost of services delivered, they have a strong incentive to manage enrollees' utilization of services. Risk contracting creates a financial incentive for managed care plans to manage enrollees' care efficiently and in a cost-effective manner, this is especially important given that managed care plans do not cost settle as other State programs do. Capitated payments represented 60% of all Medicaid spending in 2018. Figure 1 shows Michigan's breakdown of total Medicaid spending for FY 2018.

A Fee-for-Service (FFS) program on the other hand is non-managed care. Providers have individual contracts with the state Medicaid program under which they directly bill the state as services are delivered. Simply stated providers are paid based on the quantity of services provided, with no management over medical necessity, clinical appropriateness, or quality. The state's budget is less predictable, because the actual expenditures are determined by the volume and composition of services that are delivered. Moreover, providers do not have an incentive to control costs.

Without dispute, there continues to be an estimated savings each year due to the Medicaid managed care program compared to offering the service through a fee-for-service program. This savings has yielded over $2 billion in savings to state taxpayers between FY 16 and FY 20, over $400 million each year. Continued savings reflect the cumulative impact of competitive bidding, performance contracting, and more efficient and accountable management of health care in a partnership with the state in exchange for actuarially sound funding.

Actuarial soundness is important to assure financial viability by development of sound capitation rates that are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. A key indicator of actuarial soundness is the industry average margin for Medicaid managed care. A strong and viable system yields margins minimally between 2 percent and 3 percent each year, this small margin is in part due to health insurance being much more regulated than other industries. Profits that insurers can generate are limited by capping total administrative costs (including profit) as a percentage of revenue.

Plans are incentivized to meet or exceed quality standards while reducing unnecessary utilization and costs. The incentive rewards the plan for efficient management and then the State/taxpayers see savings in subsequent years as the capitation rate adjusts for decreased utilization.

This return on investment enables both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas while preserving access to quality health care services for the vulnerable populations served by the Medicaid program. Of even more value is the high quality that is the hallmark of managed care. The continued national high performance rating of Michigan's private Medicaid health plans is a testament of the dedicated efforts of each of the health care partners in this arrangement; state administrators who set the standards, providers who deliver the care as part of the provider networks, and contracting health plans who put it all together.

Michigan Landscape

Michigan's work in developing and nurturing a Medicaid managed care program has been both revolutionary and evolutionary. We should take pride that Michigan's managed care program:

- Is statewide;
- Includes disabled population as mandatory enrollment;
- Includes foster care children—then Children's special Health Care Program enrollees— and now MI CHILD;
- Includes pregnant women as targeted population;
- Includes low-income adults as an expansion population.

In partnership with MDHHS, the Medicaid health plans have been very active in working through operational details and enrolling special populations into managed care to improve access, coordinate care and provide more cost effective and accountable care for Michigan's most vulnerable citizens. These special efforts include the following, (most notably the Initiative for persons with Dual which will be further described below):

- Completed the transition of enrollment of Children's Special Health Care Services, CSHCS. This began October 1, 2012 and continued well into 2013. While there were bumps along the way, the transition was quite unremarkable due to the tremendous amount of work by the health plans in partnership with MDHHS.
- Implemented a reimbursement increase for primary care providers. This program was fully funded by the federal government for calendar years 2013 and 2014. In 2015 the Michigan legislature included funding to continue an increase that remains in effective today.
- Implementation of enhanced beneficiary monitoring program to effectively control beneficiaries with high utilization of services while maintaining access to needed care. This program is an integral part of the Medicaid contract that is monitored by MDHHS monthly.
- Implementation of Integrated Care for Persons with Dual Eligibility. This project has been very complicated, taking an enormous amount of finesse and guidance from both MDHHS and the federal government. Implementation began during the first quarter of calendar year 2015 with a phase-in through all four demonstration regions. Enrollment, education, awareness and technology continue to be outstanding issues that MDHHS and plans continue to work through. Most recently MDHHS submitted a one-year extension of the program to CMS, while they conduct stakeholder interviews to build upon findings from the CHRT and RTI reports. It is expected that MDHHS will take the information from the reports and stakeholder interviews to optimize the program and request an additional five-year extension early in 2021.

- Implementation of the Healthy Michigan Act—enacting the provisions of Public Act 107. This was a complicated implementation because of the many reforms from the base Medicaid Program and the administrative requirements necessary to meet legislative intent and related federal waiver requirements. The intention of the second waiver approval was to focus on outcomes, incentives and appropriate program revisions. While MDHHS continues to evaluate outcomes of the program, there have been barriers along the way in the form of the work requirements lawsuit and most notably COVID-19. While the future of work requirements remains in limbo, Michigan has seen continued growth in Healthy Michigan Plan (HMP), a result of the current pandemic.

The Department should be commended for continuing to meet with Medicaid health plans on a regular basis to jointly discuss how the program can be improved. In addition to those conversations, the following areas should receive more attention over the next year:

- Continue the identification of areas that can be considered "deemed compliant" as a result of national accreditation and change the focus of contract oversight to raising the performance of those contractors that are under the state average.
- Coordinate efforts for identifying and managing beneficiaries who have high utilization of care, particularly in emergency departments and in pharmacy.
- High level interactions with health plan operational staff and Department staff and consultants responsible for assuring encounter data validity and utility.
- Continue to work with the health plans and Milliman on developing actuarial sound rates based on accurate encounter data.
- Continue discussions to correct systems issues and lessen access to care barriers for health plan members.
- Continue to work with the health plans on SDoH and health disparities.
- Work with health plans on transitioning the remaining LTSS population into managed care.
- Continue work to find a path towards financial, clinical and system integration of behavioral and physical health care.
- Work with health plans on full integration of the adult dental benefit into managed care.

Finally, as it is now the policy of the state that most of Medicaid beneficiaries are or will be enrolled in managed care, it is time for Medicaid policy to be developed through the lens of managed care and not based on fee for service. Under the Medicaid Contract, once a Medicaid policy is adopted, Medicaid Health Plans must comply. Often, this requires modifications of systems, adjustments of internal protocols and policies—all of which add administrative costs. Further, these policies are often developed after the annual rates for Medicaid Plans are approved by the Centers for Medicare and Medicaid Services—therefore; costs must be absorbed within the existing rates—although these costs were never part of the rate development assumptions.

The continued success of Michigan Medicaid has been largely related to the ability to identify and implement programs that establish non-general fund support. As a result, the overall state general fund support for Medicaid has stayed largely static over the past years—while overall enrollment has increased significantly. It is vitally important that this effort continues as long as possible and be enhanced where possible.

Summary

The key points that MAHP will emphasize in various advocacy messages are as the following:

- Enrollment of population groups into managed care improves care and saves dollars. In addition to the cost savings that the management of this population will realize, the actual care and treatment in a managed environment lends to better and more efficient health care as documented by external auditors and performance contract requirements by the State of Michigan. This point has been well documented by MDHHS and various federal and state audits.
- Enrollment of population groups into managed care creates administrative efficiencies. We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools for contract management, a realization of savings to the contractors and thus a savings in the state administrative cost of the contracts would be accomplished.

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 Contract with Medicaid health plans, many have not linked the essential fact that the costs and expenditure savings to the State are the product of "administrative costs."

In other words, the state's return on investment — the improved health status and access to care as documented in this MAHP Medicaid Strategic Paper and the hundreds of millions of dollars in annual savings compared to Medicaid fee-for-service — would not be possible without the investment in the Medicaid managed care infrastructure supported by administrative costs. It is critical that this benchmark remain viable in its partnership with the State of Michigan and that viability is measured through actuarial soundness of rates paid to Medicaid Health Plans.

CREATING VALUE FOR THE STATE OF MICHIGAN

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

Unlike other service providers or contracts in the Medicaid program, Medicaid managed care operates in a performance-based environment under a full risk model. Medicaid health plans rely on data from their encounter and claims systems to identify high-cost conditions and cases and then target these conditions through programs and interventions designed to ensure quality care while at the same time reducing costs. 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 managed care plans cover the bulk of Medicaid prescriptions nationwide. **More than 70% of all Medicaid prescriptions nationwide were covered by Medicaid managed care plans in 2018, compared to only 28% in 2011.**

Medicaid managed care plans net costs per prescription were approximately 27% below net costs per prescription paid in Medicaid fee-for-services programs. **This differential yielded $6.5 billion in net savings for states and taxpayers during FFY 2018.**

Medicaid managed care plans consistently control costs more effectively than FFS programs. **Over the five-year period 2013 to 2018, net costs per prescription increased 13% more in FFS programs than in managed care plans.**

Prescription Drugs

Medicaid provides individuals access to free or low-cost prescription drugs. Prescription drugs are often effective tools for managing chronic conditions and acute illnesses. While there are protections for individuals with Medicaid from the high costs of prescription drugs, the cost of covering drug benefits has increased exponentially in recent years, largely due to the rising cost of specialty and generic drugs.

Rising drug costs have a large impact on Medicaid enrollees, state Medicaid programs, and those who support the programs through state and federal taxes. The growth in prescription drug spending is of concern to Medicaid managed care plans, state Medicaid programs and the federal government. Prescription drug pricing starts with pricing decisions made by drug companies when a drug is introduced and develops over time as the manufacturer decides to increase prices.

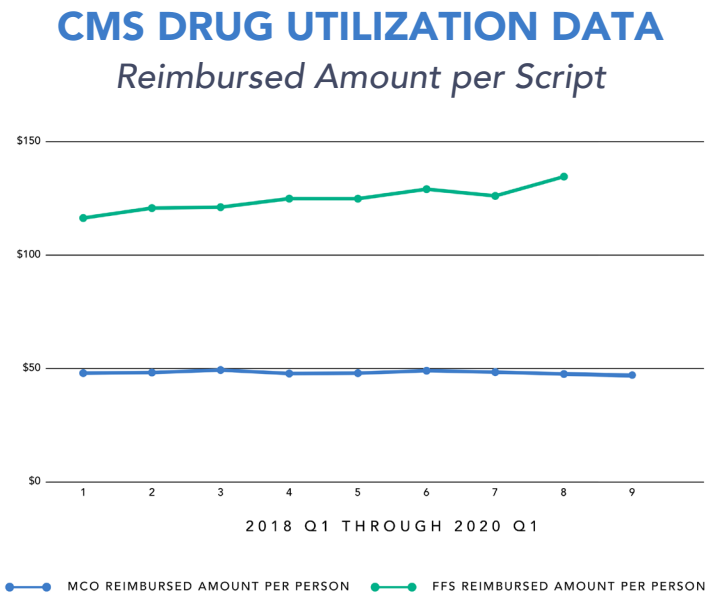


Figure 2: Average managed care organization reimbursement per person versus average fee-for-service reimbursement.

Overall spending on pharmacy is increasing nationally at a potentially unsustainable pace. As illustrated in Figure 2, because of the management activities of Medicaid Health Plans in Michigan, the average amount per script has remained relatively stable over the past 9 calendar quarters. However, fee-for-service reimbursement amounts continue to grow over the same period.

The increased cost of prescription drugs, explains one of the important cost drivers for the Medicaid program. Figure 3, illustrates examples of potentially unsustainable growth of prescription drugs which were the most expensive in Medicaid nationally.

States continue to recognize the value of Medicaid managed care plans in delivering cost effective health care and savings. Medicaid managed care plans are responsible stewards of taxpayer dollars, providing affordable, high quality health care.

MEDICAID DRUGS

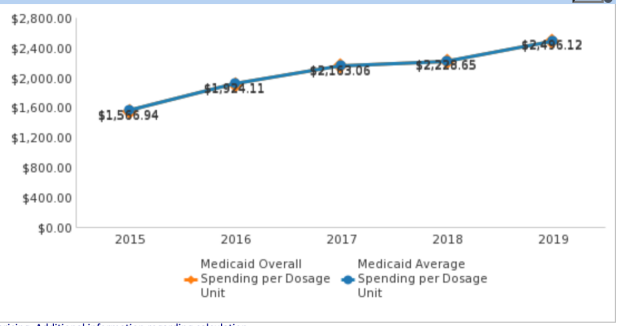
i | Medicaid Drugs | Information

Brand Name	Generic Name	Number of Manufacturers	Average Spending per Dosage Unit 2018	Average Spending per Dosage Unit 2019	Change in Average Spending per Dosage Unit (2018 - 2019)	Annual Growth Rate in Average Spending per Dosage Unit (2015 - 2019)	Total Spending 2019
3-Day Vaginal Cream^	Clotrimazole	1	$0.26	$0.43	65.2%	2.3%	$159
5x Probiotic^	L.Acid/B.Animalis,Bifi,Inf,Lon	1		$0.50			$469
8hr Arthritis Pain^	Acetaminophen	1		$0.06			$871
A & D^	Vitamins A And D	1	$0.01	$0.01	119.8%	-26.7%	$763
A And D^	Vits A And D/White Pet/Lanolin	1	$0.10	$0.08	-18.3%	4.0%	$92
A And D Diaper Rash^	Dimethic/Zinc Ox/Vits A,D/Aloe	1		$0.07		10.4%	$91
A-Hydrocort^	Hydrocortisone Sod Succinate	1	$301.45	$55.86	-81.5%	-42.1%	$2,123
A-Methapred^	Methylprednisolone Sod Succ	1	$582.43	$2,359.62	305.1%	539.1%	$436,217
Abacavir	Abacavir Sulfate	7	$2.30	$2.31	0.3%	-19.8%	$2,389,707
Abacavir-Lamivudine	Abacavir Sulfate/Lamivudine	6	$7.24	$6.54	-9.7%	-42.1%	$4,563,398
Abacavir-Lamivudine-Zidovudine^	Abacavir/Lamivudine/Zidovudine	1	$18.17	$21.32	17.4%	-1.1%	$1,265,884
Abdek Multivitamin^	Multivitamin No.58/Vit D3/K	1	$0.44	$0.52	17.8%	17.8%	$2,277
Abelcet	Amphotericin B Lipid Complex	1	$6.97	$4.62	-33.7%	-12.3%	$220,539

Manufacturer Information - Humira Pen

Manufacturer Name	Average Spending per Dosage Unit 2018	Average Spending per Dosage Unit 2019	Change in Average Spending per Dosage Unit (2018 - 2019)	Annual Growth Rate in Average Spending per Dosage Unit (2015 - 2019)	Total Spending 2019
Abbvie US LLC	$2,228.65	$2,496.12	12.0%	12.3%	$861,637,787

Manufacturer Trend in Spending Per Unit - Abbvie US LLC



*Average spending per dosage unit reflects multiple routes of administration of the drug (e.g., intravenous, subcutaneous) which individually may have different unit pricing. Additional information regarding calculation of spending per unit can be found in the methodology document.
^Drug identified as outlier; use measures based on Average Spending per Dosage Unit with caution. See methodology document for additional details.

CMS *Produced by the CMS/Office of Enterprise Data & Analytics (OEDA), December 2020*

Figure 3: Potentially unsustainable growth of prescription drugs which were the most expensive in Medicaid nationally.

Innovation

Medicaid managed care plans in Michigan are working with the State to improve care delivery and benefits through innovative cutting-edge programs. This public private partnership continues work to meet the needs of the individuals that are served by the Medicaid program to ensure quality and value.

Telehealth

The Comprehensive Health Plan Contract requires the health plans meet the health care needs of enrollees by a number of standards including the availability of telemedicine or telehealth, e-visits, triage lines or screening systems or other technology used to enhance access to care.

Population Health and Social Determinants of Health

Population Health management is built on a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors which impact health outcomes among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age), and the distribution of health conditions, health related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age). Population Health requirements are fairly new and were added to the Michigan Comprehensive Health Plan Contract in 2016.

Medicaid managed care plans utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by Utilization Management (UM) data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations. Population Health management interventions are designed to address the SDoH, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity.

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. SDoH are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. The State of Michigan added SDoH requirements to the 2016 contract. Managed care plans have developed a vast array of innovative programs aimed at addressing these social barriers to health.

The Comprehensive Health Plan Contract requires health plans to analyze data, including SDoH, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees.

The COVID-19 pandemic has triggered a state of emergency in Michigan to mobilize resources and decrease the spread of the virus. The COVID-19 public health emergency has strained the State's economy resulting in an increased demand on Medicaid and community resources.

With the fluctuating climate, Medicaid managed care plans have seen a rise in member's need for assistance navigating SDOH. The onset of the COVID-19 pandemic has heightened the awareness of racial disparities in healthcare as well as enhanced the need for SDOHs like housing, behavioral health, food security, and employment. The Michigan Medicaid program and health plans have been working together for several years to address the

behavioral health and social needs of their beneficiaries through various interventions. In an effort to address the economic impact of COVID-19 and continue to meet the growing needs of enrollees in Michigan, MDHHS has requested plans expand their focus on SDoH by including a needs assessment, referral process, community partnerships, and data collection for the FY21 contract year.

Value-Based Purchasing (VBP)/Alternative Payment Methodology (APM)

There are a number of approaches Medicaid managed care plans may use to transition the provider community to more value-based arrangements such as quality incentives, bundled payments and shared risk arrangements.

Michigan has adopted the LAN Framework as a guide to align core APM design components.[1] The goal of APMs is to ensure meaningful improvements in quality of care and reductions in transitions of care. While payment transformation is part of the strategic plan for the State here has been provider reluctance to participate in APMs and to accept risk.

To date, most MHPs have focused their APM strategies on their primary care providers (PCPs) through a combination of LAN Category 2 models, including:

- Patient Centered Medical Home (PCMH - Category 2A),
- Care management payments for specific codes (Category 2A),
- Pay for Reporting (Category 2B),
- Pay for Performance (Category 2C).
- MHPs have also entered into Category 3A shared savings or total cost of care (TCOC) models with some large PCPs and groups within their network.
- There has been little movement to shared risk (Category 3B) or primary care capitation (Category 4) models.
- Some MHPs have APM contracts with non-PCPs, including hospitals and specialists

The State is currently working with Medicaid managed care health plans on a multi-year strategic planning initiative for increased use of APMs, specifically in category 3 and 4 payments. The contract requires that a minimum of 30% of health care service reimbursement is under value-based contracts, and that a minimum of 1.5% of health care services reimbursement are made based on a provider incentive under a value-based contract for the fiscal year 2022 reporting period.

Community Health Workers

Community Health Workers (CHW) are frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Medicaid managed care plans must provide or arrange for the provision of CHWs in accordance with CHW requirements of the Comprehensive Health Care Contract or Peer-Support Specialist Services to enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or Peer-Support Specialist Services.

[1] *http://hcp-lan.org/workproducts/apm-framework-onepager.pdf*

Quality

Medicaid managed care plans meet and exceed the high standards set by state and federal regulators and deliver real results for the people they serve. Fee-for-service programs pay providers for the quantity of services they provide to patients, instead of quality. The Health Plan Quality Check-Up produced by MDHHS that rates health plan performance in five categories can be found here: https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf

A 5-year analysis of key HEDIS and CAHPs quality measures indicate that Medicaid managed care plan performance is improving on the vast majority of measures. National data show that Medicaid managed care plans reporting a given measure's score in each of the 5 years demonstrated improvement in 87% of the 30 measures. In 2019, most of the Michigan Medicaid Weighted Averages (MWA), about 64 percent, ranked at or above the 50th percentile, indicating high performance statewide compared to national standards.

The National Committee for Quality Assurance (NQCA) uses its HEDIS and CHAPs data in annual ratings of health plans. These published ratings help Medicaid managed care plans prioritize investments, resources, and improvements in quality programs. Michigan's private Medicaid managed care plans are among four in the top 40. These numbers clearly demonstrate the quality care provided to our Medicaid population.

Michigan requires Medicaid managed care programs to obtain accreditation through an organization such as NCQA. In order to receive accreditation health plans must demonstrate they have evidence-based programs for quality improvement and measurement.

Medicaid managed care plans invest in quality measurement and improvement through personnel and information technology resources. These resources are used to identify potential quality gaps and guide efforts to address them.

COVID-19 Response

As of May 2020, more than 27 million Americans have lost their health insurance coverage following a job loss during the COVID-19 crisis. It is possible that Medicaid enrollment could increase by 5 to 18 million individuals by the end of the year, according to estimates by Health Management Associates. In Michigan we have seen an enrollment increase of 14% from January to October 2020. This crisis has demonstrated the importance of the public and private sector working together to lower costs, improve efficiencies, and provide high-quality health care.

Medicaid managed care plans provide quality care and control costs, which is especially important for the State budget sees strain from COVID-19. Michigan Medicaid managed care plans have taken action to protect patients and health care workers during the pandemic such as: covering the costs of all COVID-19 related treatments, expanding telehealth services, and waiving prior authorizations.

Medicaid managed care plans have taken steps to support communities through grants and donations to clinics and non-profit organizations supporting COVID-19 efforts. Additionally they have secured and distributed personal protection equipment to local hospitals and health care providers, and partnered with public and county health systems to administer COVID -19 tests.

The pandemic requires a collaborative and coordinated response, one that Medicaid managed care plans are committed to by working with state, federal and local officials.

Policy Recommendations

Behavioral Health Integration

Michigan has built a robust, high quality Medicaid system for its 1.8 million enrolled citizens. For many Medicaid recipients, however, the system remains fragmented and does not address their holistic needs. As the State explores its approach to ensuring a sustainable program and expanding upon its commitments to invest in value and improve outcomes, overcoming the historic fragmentation will be key.

Moving from a historically fragmented system to one that is fully integrated requires thoughtful consideration of program design, financing, stakeholder engagement and regulatory alignment. The State's experience in integrated services for its dually eligible population as well as recent efforts to improve coordination of physical and behavioral health services has laid the groundwork to move to a fully integrated managed care program. By marrying the financing, administration, and care coordination across the benefit structure and State programs through Managed Health Plans (MHPs), Michigan can:

- Support a holistic person-centered approach to care for all individuals;
- Improve individual and systemic outcomes;
- Reduce provider and consumer confusion;
- Reduce provider administrative burdens;
- Reinforce the State's focus on value and goals through aligned incentives and payments;
- Promote more efficient State management and oversight; and
- Transfer risk to the private sector, reducing costs and creating enhanced budget predictability.

Managed Long Term Services and Supports (LTSS)

LTSS in Michigan are delivered through multiple programs with varying eligibility requirements, with the majority of LTSS provided through FFS. The state's low ranking on percentage of LTSS dollars spent on home and community based services (HCBS) versus institutional care, along with the recent Center for Health and Research Transformation (CHRT) report commissioned by the Michigan Department of Health and Human Services (MDHHS) to evaluate LTSS in Michigan, together suggest that Michigan's LTSS system is ripe for rebalancing and reducing the institutional bias that results in higher costs and lower beneficiary satisfaction and quality of life. Additionally, a significant majority of those receiving LTSS in Michigan are dually eligible for Medicare and Medicaid, for whom close integration of services provided through both funding streams is very important for ensuring quality of life and positive outcomes.

Integrated Oral Health

Currently adult dental is a carved out benefit with exception of pregnant woman and Healthy Michigan Plan. Adults seeking dental services covered through FFS often experience significant access issues. When the dental benefit is managed by the Medicaid managed care plan they are contractually required to provide sufficient access based on time and distance standards. Michigan has a history of managed oral health care starting with Healthy Kids Dental that began in 2000 and was expanded statewide in 2016. The Healthy Michigan Plan included an integrated dental benefit at its inception and the most recent population, pregnant women began to receive an integrated dental benefit in 2018.

Conclusion

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

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

MAHP believes that decisions regarding healthcare are being made during a time of dramatic change and extraordinary innovation in health policymaking. Much of our work may be affected by actions taken at the federal level over the next few years.

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.

mahp
Michigan Association of Health Plans

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