Performance, Value, Outcomes: Medicaid Managed Care

FY 2016-2017

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 Strategic Paper: FY 17

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<u>RECOMMENDATIONS FOR FY 17 AND BEYOND</u>

I. <u>Finance/Revenue Recommendations</u>

1. The Department of Health and Human Services should administer and the Legislature should **appropriate adequate funding to <u>assure actuarially sound rates</u>** in support of all aspects of Medicaid Managed Care, (CSHCS, MI CHILD, Duals (including the model for Integration), Regular Medicaid, and Healthy Michigan Program). **<u>MAHP supports the Executive Budget recommendation for actuarial soundness increases for traditional Medicaid and Healthy Michigan</u>**.

    - Consistent with federal and state requirements for actuarial soundness, costs related to the health insurance premium tax imposed by the Affordable Care Act, and health insurance claims assessment is considered part of actuarial soundness and should be noted in the certification of the health plan rates and included in the contracts with Medicaid plans; and

    - All Medicaid Policy bulletins issued by the Department after federal approval of actuarial soundness should include economic analysis to demonstrate that the existing and approved rates are not compromised by the proposed changes in Medicaid Policy.

2. The Michigan Legislature should **repurpose all of the revenue generated by the use tax** paid by Medicaid Health Plans to explicitly cover non-Medicaid services and coupled this change with continued support of HICA at an effective rate of no higher than 1% (if no use tax is collected and no higher than 0.75% if use tax revenue continues to be collected.

3. The State of Michigan should continue efforts to **<u>maximize all levels of non-GF Revenue</u>** (federal, special use, local revenue, and cost avoidance) to protect Michigan's safety net. This focus would continue and expand efforts for:

    - Medicaid Health Plan "Special Needs Access Fund, SNAF and Supplemental Hospital reimbursement, HRA, Programs" to assure outreach and coverage for Medicaid beneficiaries;

    - Securing additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid;

    - Increasing third party collections for Medicaid managed care plans by providing access to other carrier data, including auto insurance and designating Medicaid Health Plans as "agents of department" for purposes of this function.

    - Improving fraud and abuse coordination through the Medicaid Inspector General Office and working with a variety of organizations regarding the development of more community based care to reduce current high cost utilization of care.

- Continue and expand efforts to support health homes and other forms of diversion from emergency department inappropriate use.

4. MDHHS should **enhance and improve the Encounter Data Quality Initiative** to assure that encounter data will be accurately used in health plan rate development, hospital DRG rebasing, and special financing initiatives and be available for studies on quality development, special analysis and potentially as proxy for all payer data base.

II. Access/Capacity/Choice for Beneficiaries Recommendations

5. As recommended in the Executive Budget for FY17, the MDHHS should engage stakeholders in a process to arrive at **a plan for integrating Medicaid services** that will improve overall access, provide choice, reduce administrative complexity, provide a single point of accountability and be implemented in the most cost-effective manner possible. Savings from this initiative should be redirected to provide additional services.

6. Consistent with Healthy Michigan Act, the State of Michigan should implement an **Integrated Long Term Care Initiative** in regions outside of the demonstration initiative for integrated care for those with dual eligibility.

7. The State of Michigan should **continue to improve and reform Medicaid eligibility** by**:**

   a. Operationally, creating a default eligibility and enrollment for newborns to be assigned to the same Medicaid health plan as the mother at the time of birth (consistent with the terms of the Medicaid contract).
   b. Delink Medicaid application from other human services program applications in order to accelerate Medicaid eligibility and enrollment.
   c. Reform the redetermination process, particularly for those in long term care facilities and other institutional settings to assure no loss of eligibility and continuity of care.
   d. Begin a process to reform the criteria use and address the "spend-down" category of eligibility which an end objective to improve coordination of services, continuity of care and reduce uncompensated services while saving general fund dollars.

III. Operational/Administrative Efficiency (Cost Avoidance) Recommendations

8. The State of Michigan should continue its efforts in **streamlining and coordinating the administration and oversight** of Medicaid Health Plans and related contracted entities. This may include such options as:
   a. Reduce and/or eliminate paper requirements in lieu of electronic documents and web-based information sites and begin using "deemed compliance" by virtue of national accreditation such as NCQA or URAC;
   b. Consolidating the internal program administration and coordination of the Integrated Services Plan for the Dual Eligible, MI CHILD, Healthy Michigan Act

and traditional Medicaid managed care program under a single administrative program.

c. Changing the regulatory perspective to a "regulation by exception"—that is a focus on those who are performing below standards established in the contract.

9. Implementation of the Healthy Michigan Act should be **consistent with the legislative intent and principles of managed care** that focus on innovations and flexibility.

10. To help reduce future enrollment and eligibility "churning", **Michigan should consider the economic feasibility of implementing either a bridge plan or basic health plan** in conjunction with the Insurance Exchange.

EXECUTIVE SUMMARY DISCUSSION

The Michigan Association of Health Plan's Board Adopted Vision for 2020 is to have improved coverage, access, value and choice for the State's population to be achieved through improved competition within the industry, and demonstrated continuous quality improvement in key health status areas for Michigan residents. To implement this vision and promote the growth and sustainability of 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 the Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management and single point of accountability. However, the most obvious value is cost savings.

Value in Managed Care

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 now yielded over $**6 billion in total savings to state taxpayers** between FY 00 and FY 16 or over $400 million each year. The 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**.

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 Medicaid program.

Of even more value is the **high quality that is the hallmark of managed care**. The continued national high performance ranking of Michigan's 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.

Once again, the **Michigan Medicaid Health Plans are cited as among the best in the nation** by Consumer Report/NCQA America's Best Health Plans. Their 2014 ranking cited Michigan Health Plans for excellence in all three categories: commercial, Medicare, and Medicaid. Specifically, Michigan Medicaid Health Plans are among eight in top 30, nine in top 50 and ten in top 60. These numbers clearly demonstrate the quality care provided to our Medicaid population.

<u>What's next?</u>

Michigan's work in developing and nurturing a Medicaid managed care program has been both revolutionary and evolutionary. The "revolutionary" aspect is the leadership and tough decisions made to incorporate different population groups and regions early in the process. We should take pride that Michigan's managed care program:

- Was statewide not regional;
- Included disabled population as mandatory enrollment—not voluntary;
- Included foster care children—then Children's special Health Care Program enrollees—and now MI CHILD;
- Included pregnant women as targeted population.

These are mentioned as illustrations as many states that are now considered "cutting edge", such as Colorado, New Mexico, Oregon, and others tout advances such as the above as examples of their development—whereas Michigan addressed these issues more than a decade ago.

Clearly, there is still much more work to be done. Following the leadership of MDHHS and 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 Eligibility and implementing the Healthy Michigan Act 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.

- Implementing a reimbursement increase for primary care providers. This program was fully funded by the federal government for calendar years 2013 and 2014. The Michigan legislature has included funding to continue an increased into the current and future fiscal years.

- Implementation of enhanced beneficiary monitoring program to effectively control beneficiaries with high utilization of services while maintaining access to needed care. This program is now fully operational and will be an integral part of the Medicaid contract.

- Implementation of Integrated Care for Persons with Dual Eligibility. This project is 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 and has been phased in through all four demonstration regions. Issue of enrollment, education and awareness, and technology continue to be outstanding issues requiring further attention.

- Implementation of the Healthy Michigan Act---enacting all of the provisions of Public Act 107. This is an enormously 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. With the approval of the second waiver, attention will now focus on outcomes, incentives and appropriate program revisions.

Reform Eligibility

The sooner an eligible person becomes enrolled into a Medicaid Health Plan, the more effective and timely care can be provided and coordinated. Performance standards of care imposed on Medicaid Health Plans under the state's contract are more achievable with timely enrollment. A good example of where improvements can take place is with newborns. Now that the Medicaid Program has moved the Children's Special Health Care Services, CSHCS, enrollment into managed care, it is critical that newborns be identified and enrolled into the same health plan as the mother in the birth month. While this provision is included in the Contract with Medicaid Plans, operationally it is often delayed which creates retroactive enrollment during a critical period of time for coordinating care.

Other efforts should assure that the eligibility re-determination process becomes more transparent in order for Medicaid Health Plans to identify and assist beneficiaries. This effort will result in more continuity of care and improved date and accountability as HEDIS measures are based on "continuous enrollment" files. Finally, the barriers to enrollment of "spend down" or medically needed is the current eligibility requirement. This often results in more state general fund and uncompensated care costs being spent and uncoordinated care. Efforts should now take place to change these criteria.

Streamline and Coordinate Administration and Oversight

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:

- Reduce paper filing requirements in lieu of access of electronic documents and web-based information sites.

- 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.

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 the development of 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.

Maximize non-GF Revenue

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. Medicaid Health Plans have been highly supported in several direct ways:

Additionally, the areas of fraud and abuse are areas that Medicaid Health Plans work closely with the Michigan Attorney General's office and the Medicaid Inspector General—and expect to do so even more in the future years. Cost avoidance through this coordinated effort is one of the expected outcomes.

The area of waste is one area that is of concern to all payers. Health care reform cannot truly take place unless the cost of health care is reduced. This will affect Medicare, Commercial and Medicaid services together and solutions should be seen not just as a Medicaid issue but much broader. We know that at many as 20 percent of admissions are for treatment and care that could be provided in a community outpatient setting—IF—such settings and programs were available. Efforts toward more medical homes and early treatment and interventions—prevention—will also have the benefit of reducing costs. Finally, all citizens, including those on Medicaid need to have incentives to take personal responsibility for managing their own health care. The implementation of Michigan's health and wellness plan—also known as the 4 X 4 Plan is a good start in this effort and the underlying premise of the Healthy Michigan Act has embodied this concept.

Duals Initiative

Through the leadership of MDHHS, health plans chosen to be the responsible carrier to implement this initiative (known also as Integrated Care Organizations, ICOs) have worked closely to activate the Integrated Care for the Duals Project. This process has taken longer than expected due to the unique nature of the Michigan Proposal--and the presence of both a strong physical health and behavioral health system that is unique to Michigan. The challenge of integrating services and maintaining the underlying infrastructure continues to create operational issues in Michigan.

We are encouraged that MDHHS is continuing to hold implementation meetings with key stakeholders. Because this project will be functioning in only four regions of Michigan, there is still opportunity for developing an integrative approach for long term care in the rest of the state—an option that MAHP and other organizations would support and which is incorporated as an expectation in the Healthy Michigan Act.

Healthy Michigan Plan (Medicaid Reform)

The Michigan Legislature enacted and Governor Snyder signed Public Act 107 into law September of 2013. Since then there has been a tremendous amount of activity led by MDHHS with Medicaid health plans who are the delivery system for this program that serves up newly eligible Medicaid beneficiaries. Current health plan enrollment is nearly 500,000 and overall eligibility is about 600,000-- far in excess of the estimated total population of 450,000 when launched. The submission and approval of the initial and second federal waiver for this program and the plan for incentives (providers, consumers and health plans) have been completed. MDHHS and Medicaid health plans have held frequent meetings and conference calls to identify and operationalize necessary tasks for a smooth implementation. Because of the complexity of the law, there are many unchartered waters to maneuver and decisions to be made over the next several years. All observers understand that this is an unprecedented project with many moving parts.

MAHP and members were strong supporters of the reform legislation, knowing that the ultimate accountability would reside in the contract between the States and contracting health plans. A main driver for legislative passage of the Healthy Michigan Act was to take advantage of a long and successful record of value and cost effective care (documented in this paper). Full transparency will now be required to document change, costs, and improvements in health status. The ultimate success of the Healthy Michigan Act will be dependent on these changes to occur and savings to be realized.

Summary

The key points that MAHP will emphasize in various advocacy messages are 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.

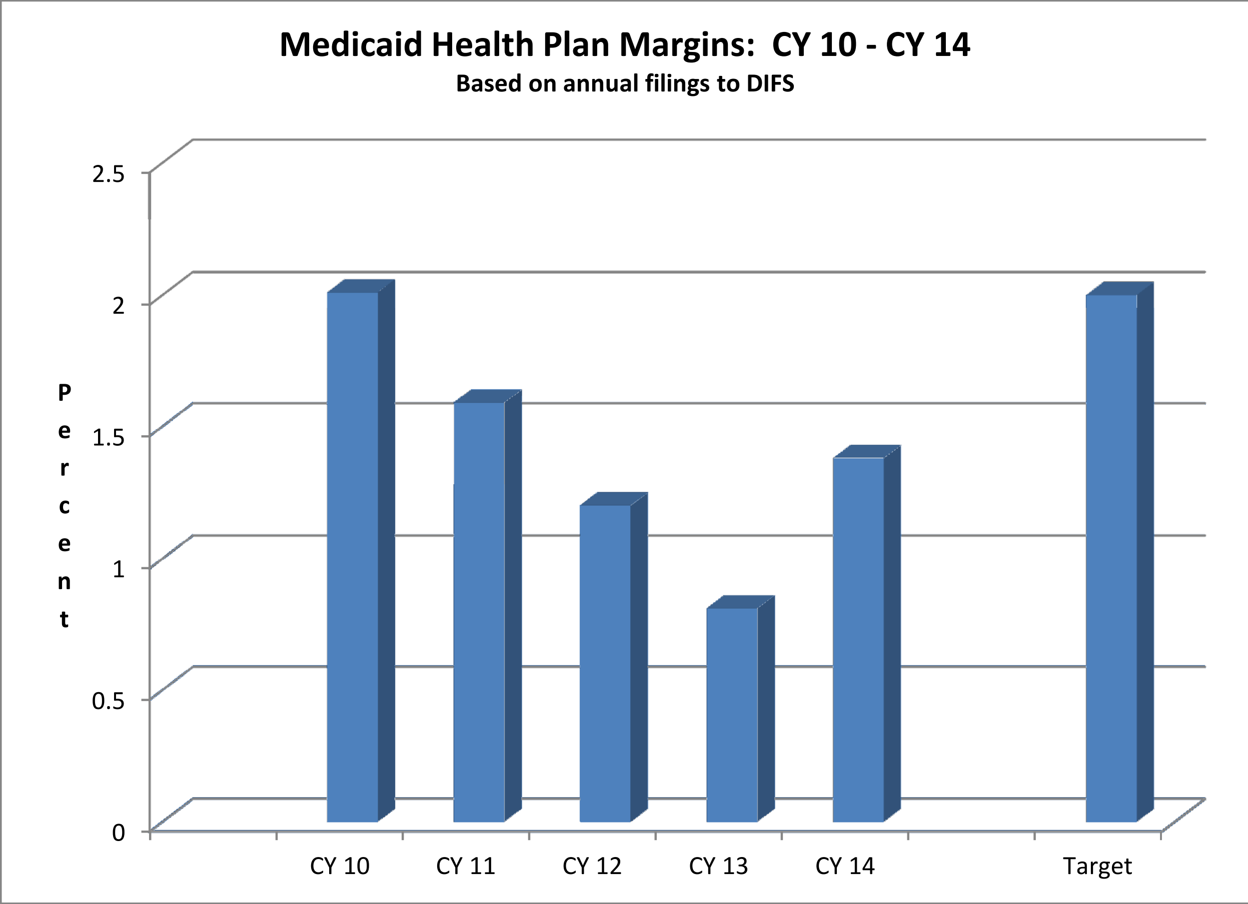
- **Enrollment of Population Groups into Managed Care creates Administrative Efficiencies.** We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools 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.

- **Enrollment of Population Groups into Managed Care will reduce Fraud and Abuse expenses and highlight savings potential that will reduce "Waste".** There are various "best practice" models for state governments to address the ever present fraud and abuse from the Medicaid beneficiary as well as some Medicaid providers. Michigan Medicaid Managed Care applies these best practices creating significant health savings without compromising the quality of care or access to care. In addition, studies have indicated that there are areas of potential savings if the waste in our health systems could be addressed. For example, Medicaid hospital utilization is significantly higher than the commercial utilization. By reducing that difference we could save millions of dollars. Examples of initiatives to address this hospital utilization are programs to tackle of the problem of readmissions to the hospital within 30 days of discharge and the development of a workable observation room policy.

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**."

It other words, **<u>the state's return on investment</u>** — 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.

<u>Why recommendation related to actuarial soundness requirements are so important</u>. To assure the entire managed care program is financially viable and strong full actuarial soundness must be implemented. A key indicator of "actuarial soundness" is the industry average margin for Medicaid Health Plans. A strong and viable system would yield margins minimally between 2 percent and 3 percent each year. However the past four years have resulted in a consistent drop in the average Medicaid Health Plan margins as reported in year-end filings with the Department of Financial and Insurance Services, DIFS and illustrated in the chart below:



Medicaid is a large program because of the volume of Michigan citizens served with a very comprehensive health care program. Between the regular Medicaid Program and the Healthy Michigan program, total Medicaid health plan spending is expected to exceed $7 billion dollars for health plan services in FY 16. The small percentage increases necessary to fund actuarial soundness now become magnified due to size related to the underlying base—e.g., each percentage increase now represent about $70 million gross funding. **The Executive Budget recommendations address this vital component for support and MAHP and members recommend the legislature support this as well.**

Expectations:

"Policy makers, administrators and the public rightfully expect (and we believe receive) value from the Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. While the most obvious strength is cost savings, the benefits in increased access, evidence based policies, and care coordination is leading toward improved health status."

I. Creating Value for the State of Michigan

Expectation of Performance

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

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

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

Unlike other service providers or contracts in the Medicaid program, Medicaid managed care operates in a performance-based environment under a full risk model. Medicaid health plans rely on data from their encounter and claims systems to identify high-cost conditions and cases and then target these conditions through programs and interventions designed to ensure quality care while at the same time reducing costs. Attachment 3 of this Strategic 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 components of population health:

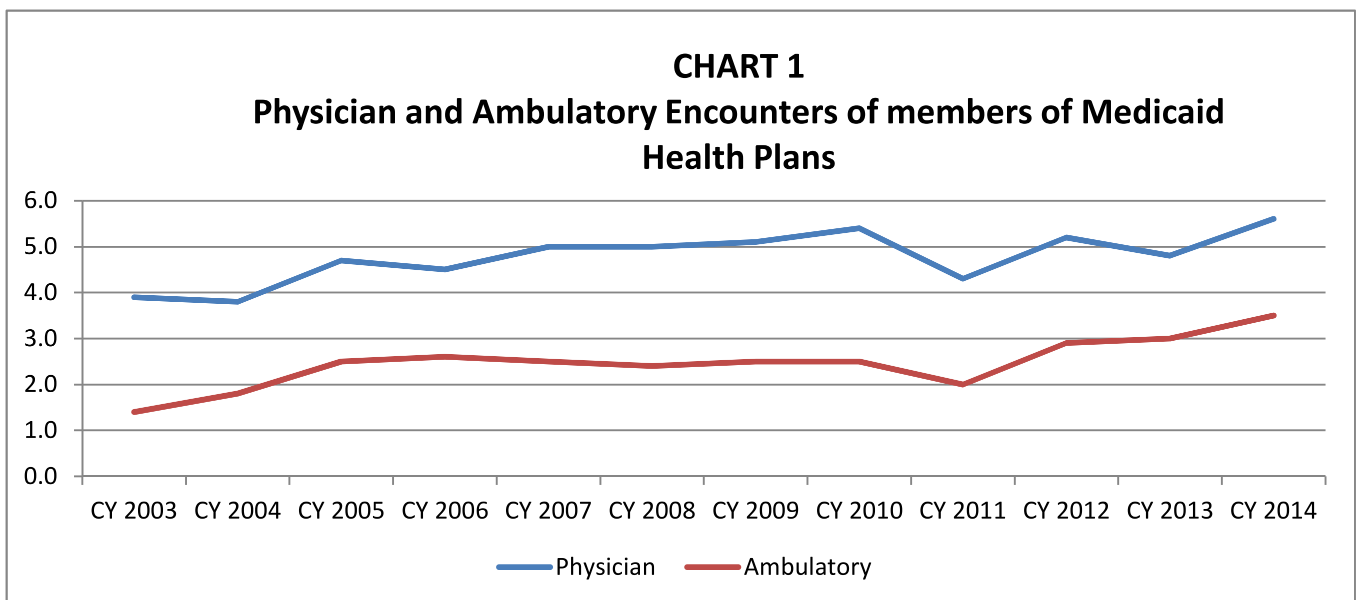
- A focus on preventive health care;

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

- 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.



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.

This set of preventable hospitalizations is further illustrated by the conditions listed in the table below. 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.

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

Ambulatory Care Sensitive Hospitalizations and Rates per 10,000 Population for Patients of All Ages--Michigan Residents, 2007-2013

AMBULATORY CARE SENSITIVE CONDITIONS View ICD-CM Codes	HOSPITALIZATIONS		RATE PER 10,000 POPULATION	
	Average Annual Number for 2008-2012	2013	Average Annual Rate for 2008-2012	2013
ALL AMBULATORY CARE SENSITIVE CONDITIONS	265,627	249,590	268.4± 0.5	252.2± 1.0
Congestive Heart Failure	36,101	32,615	36.5± 0.2	33.0± 0.4
Bacterial Pneumonia	30,493	25,932	30.8± 0.2	26.2± 0.3
Chronic Obstructive Pulmonary	26,424	24,386	26.7± 0.1	24.6± 0.3
Kidney/Urinary Infections	17,614	16,313	17.8± 0.1	16.5± 0.3
Cellulitis	16,034	16,087	16.2± 0.1	16.3± 0.3
Asthma	15,845	14,464	15.8± 0.1	14.6± 0.2
Diabetes	13,629	14,632	13.8± 0.1	14.8± 0.2
Grand Mal & Other Epileptic Conditions	7,522	7,943	7.6± 0.1	8.0± 0.2
Dehydration	7,092	5,098	7.2± 0.1	5.2± 0.1
Gastroenteritis	3,881	3,875	3.9± 0.1	3.9± 0.1
All Other Ambulatory Care Sensitive Conditions	91,477	90,022	92.4± 0.3	91.0± 0.6

***Ambulatory Care Sensitive Hospitalizations** are hospitalizations 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.*

***Hospitalizations** are inpatient hospital stays as measured by stays that were completed during the specified year. The number of hospitalizations is often greater than the number of persons hospitalized since some persons are hospitalized more than once during a year.*

While this represents a snapshot of all of Michigan's population and hospitalizations in 2011, it is not difficult to picture the targeted areas for Medicaid that would include such conditions as asthma and diabetes (conditions that already have well-developed case management programs used in managed care programs). Overall, the Department has projected in its most recent update that many of hospitalizations are preventable. That is, the hospitalizations taking place are for conditions where timely and effective ambulatory care can decrease the number of admissions by preventing the onset of an illness or condition, controlling an episode, or proactively managing chronic disease/condition.

This point was highlight earlier this year in a release of a study in the January 23, 2013 issue of the *Journal of the American Medical Association (JAMA)*. This study illustrated that hospitalizations and re-hospitalizations among Medicare patients declined nearly twice as much

in communities where Quality Improvement Organizations (QIOs) coordinated interventions that engaged whole communities to improve care than in comparison communities. The results show that interventions aimed at improving care transitions—when patients move from one care setting to another, such as from a hospital to their home or a nursing facility—reduced re-hospitalizations for Medicare patients in 14 select communities nationwide, including in Lansing. While the study was specific to the Medicare population, the results are instructive for changes that should be supported in Medicaid.

The 14 communities in the study averaged a 5.7 percent reduction in re-hospitalizations. A less expected result was that Medicare beneficiaries in the communities also experienced a 5.74 percent reduction in hospitalizations over the two-year period. In Lansing, there was a 4.17 percent reduction in re-hospitalizations of Medicare patients and a 4.02 reduction in hospitalizations.

Chart 2 also illustrates a point that bears repeating—that is, the Medicaid population has generally more acute illness and while overall admissions may be less than commercial populations—overall days of care are much more in the Medicaid program.

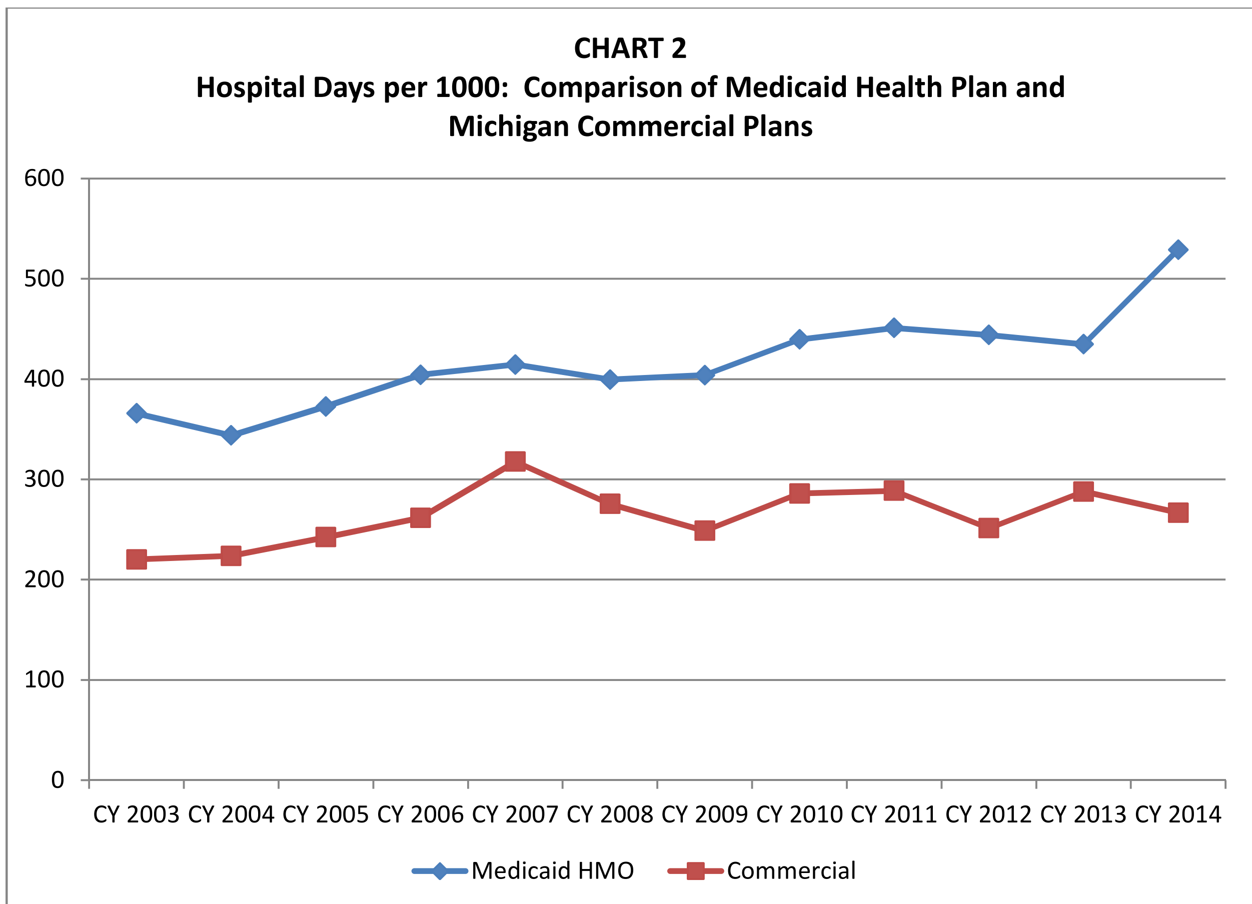
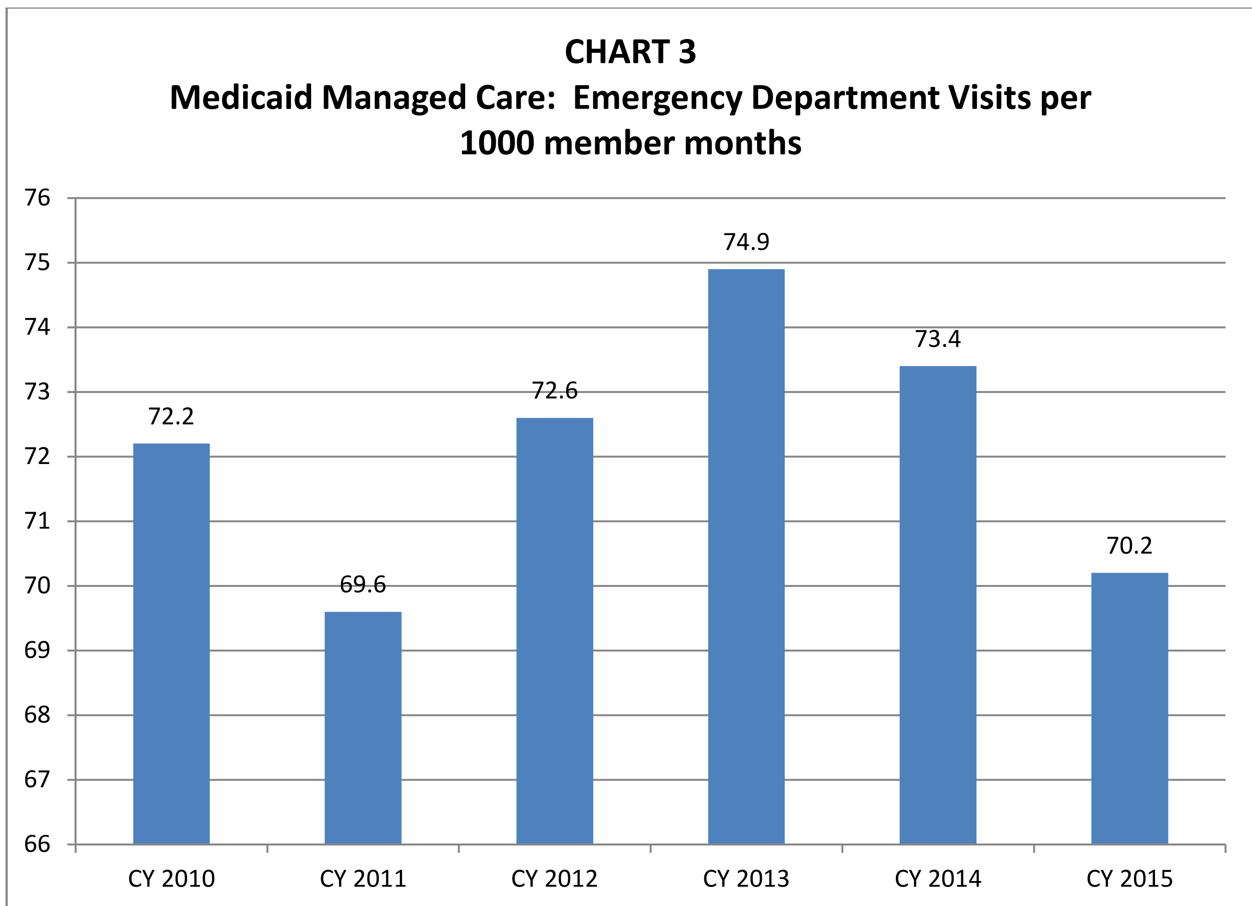


Chart 3 highlights a problem that cuts across all payers—that is, an increasing number of people are using hospital emergency departments for non-urgent care and for conditions that could have been treated in a primary care setting. Nationally, 56 percent, or roughly 67 million visits, are

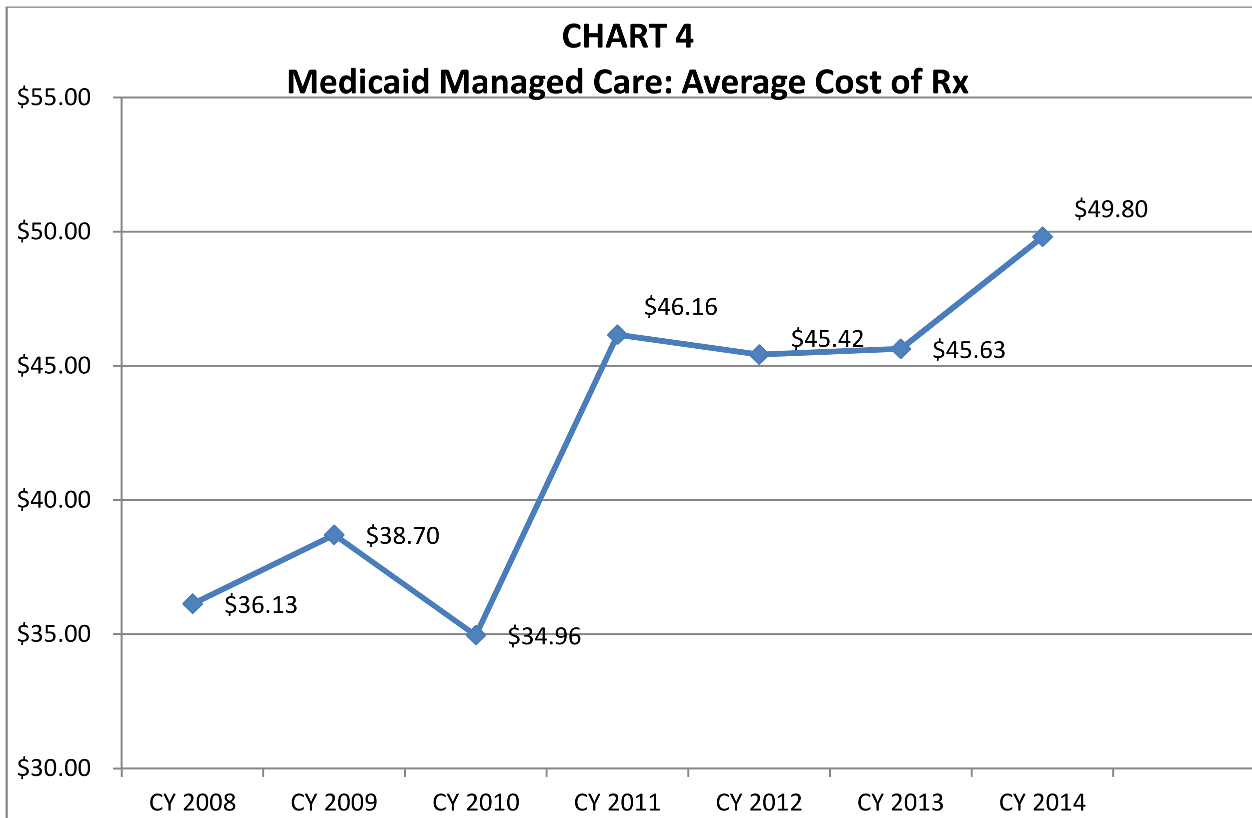
potentially avoidable according to the National Quality Forum. Reducing this trend represents a significant opportunity to improve quality and lower costs in health care. Chart 3 shows the use in Medicaid managed care—that remains too high. According to the National Quality Forum, the average cost of an emergency department visit is $580 more than the cost of an office health care visit—suggesting considerable savings may be realized. What can be done?

Steps are already underway for some solutions in reimbursement and primary care improvements (Patient Centered Medicaid Homes, extended hours for primary care offices, and additional use of tele-health. Additional steps to be considered may be in performance based standards for health plans, incentives for providers, and reductions in co-payment for beneficiaries who used urgent care sites rather than emergency departments. What is also necessary are more accurate data and access in real time to emergency department visits.



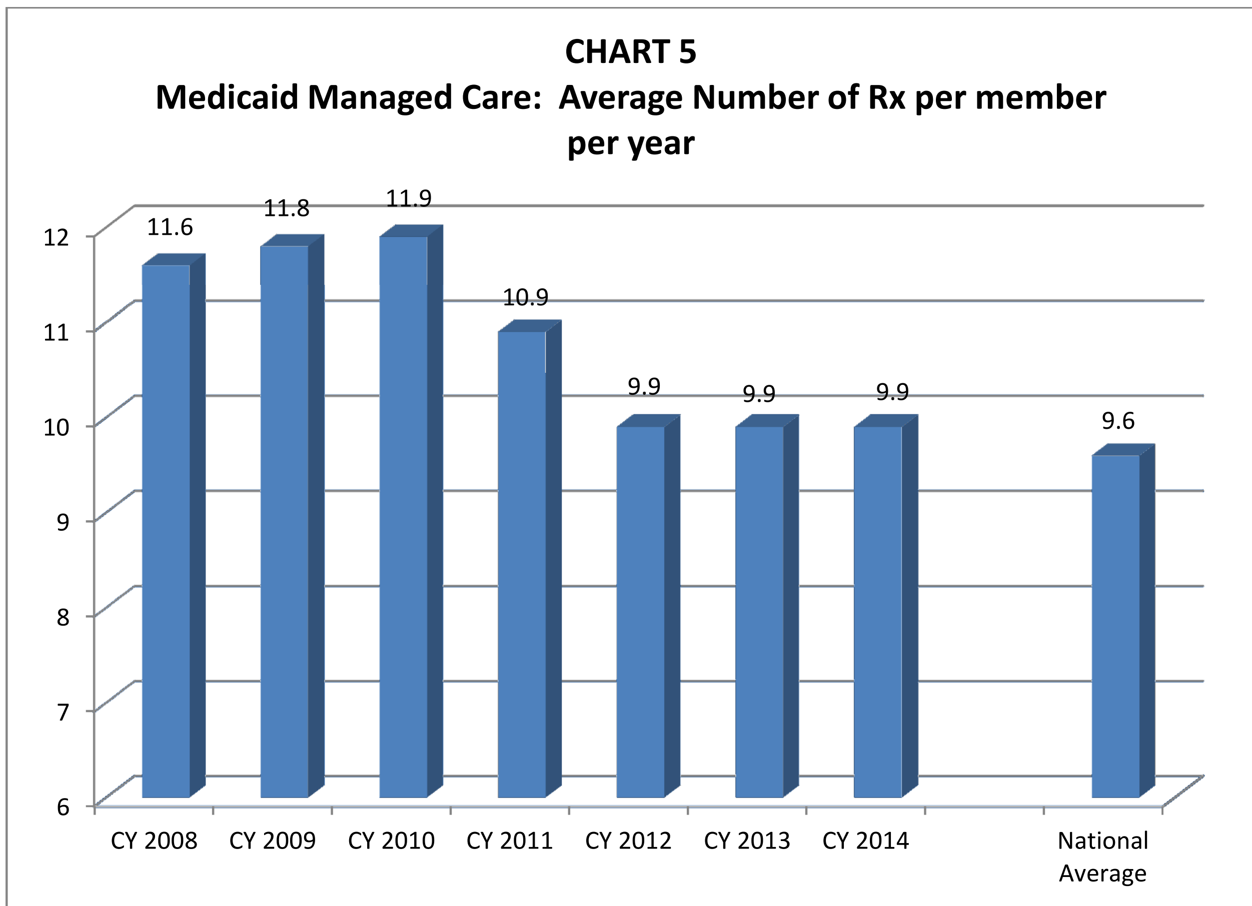
The final challenge in cost-efficiency is in the management of pharmacy benefit. Charts 4 and 5 outlines the current use of Pharmacy—where beneficiaries in managed care average about 11 prescriptions per year. Overall spending on pharmacy has been increasing over the past years. As illustrated in Chart 4, the "average" ingredient cost has increased by nearly 40% over the past several years--but this masks the significant increases taking place in specialty drug spending. The overall utilization by Medicaid members, Chart 5, remains above the national average and with the increased cost of drugs, explains one of the important cost drivers in the Medicaid program.

Medicaid remains one of the largest markets for prescribed drugs ($25 billion nationally and growing). However these outlays are offset by manufacturer rebates at the federal and state level—that totaled nearly $10 billion of total pharmacy spending. Further savings are exacted from generics and Medicaid managed care has historically been prominent in the use of generic prescriptions. However, this is not the case in specialty drugs.



Some of the costs for specialty drugs show up as medical expense due to the setting in which it is provided. Some additional strategies include contracting with specialty drug vendors and re-tooling pharmacy claims processing systems with paid medical claims. This will remain an area that Medicaid health plans and the Medicaid program must work together on to control the increasing use and costs.

While appropriate access to Michigan's hospitals for necessary use of care is part of overall management of care, a more cost effective approach will require the development and use of community based outpatient alternatives—many of these interventions are now underway. Likewise for delivery a more cost-effective pharmacy program, increased management options to encourage the use of generics need to be sustained and all participants need to address the alarming increased use in specialty drugs and how it is administered in both the pharmacy and medical settings.



II. Building the Infrastructure for Medicaid Managed Care

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

Recent History

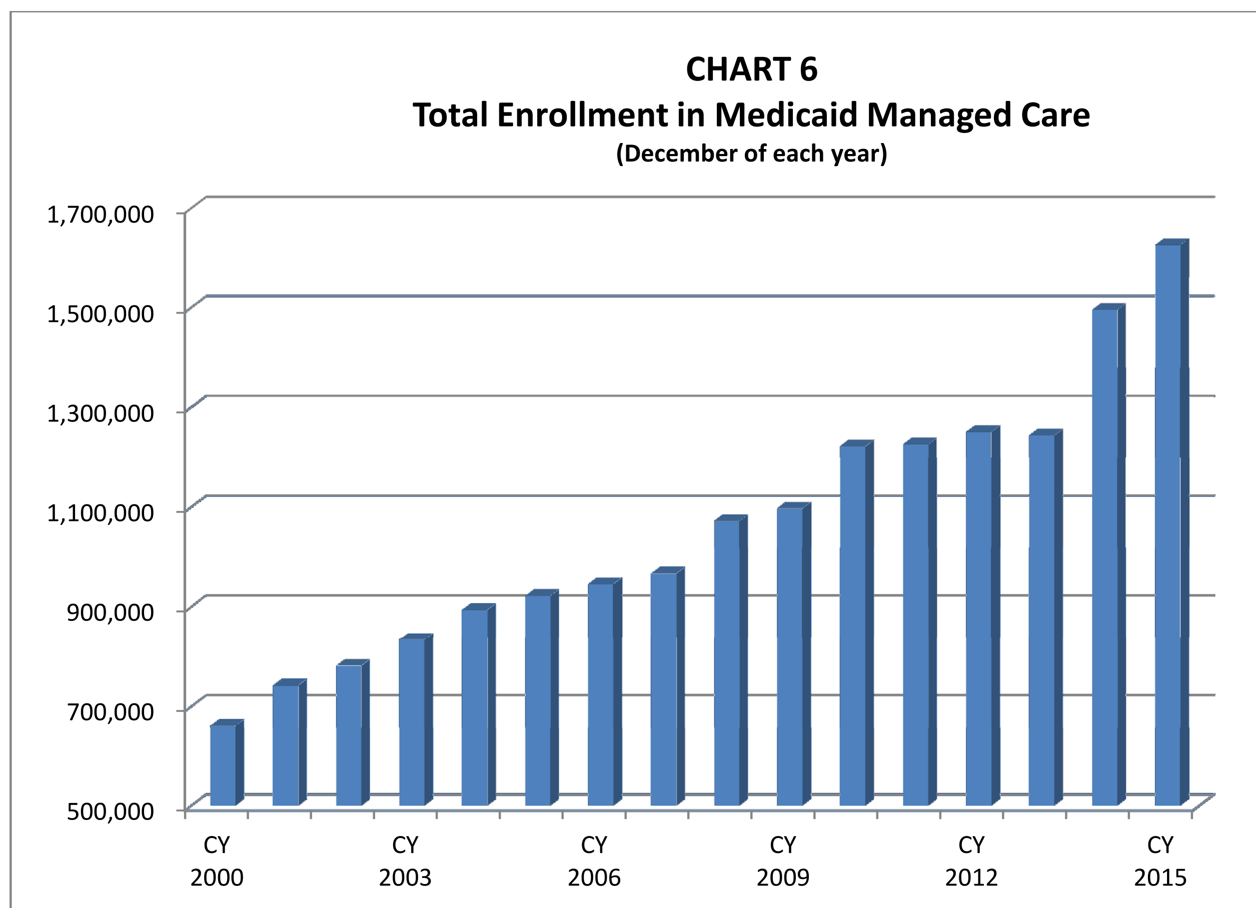
Through competitive bidding (that began in 1997 in SE Michigan; in 1998 for the remainder of state; 2000, 2004, 2009 and again this past year (2015) statewide), the Medicaid managed care program has provided the following results:

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

funding, the annual savings to the state compared to the previous program (fee-for-service) have grown substantially.

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. However, without the cost-effectiveness of Medicaid managed care, the expenditures in fee-for-service would have increased substantially (more than $400 million each year) over the amount currently allocated to Medicaid health plans — and without the improved health status, access and accountability. Chart 6 also illustrates the increased enrollment in the past several years due to the movement of Children's Special Health Care Services beneficiaries in 2012 and 2013, and the Healthy Michigan Program beginning in 2014.



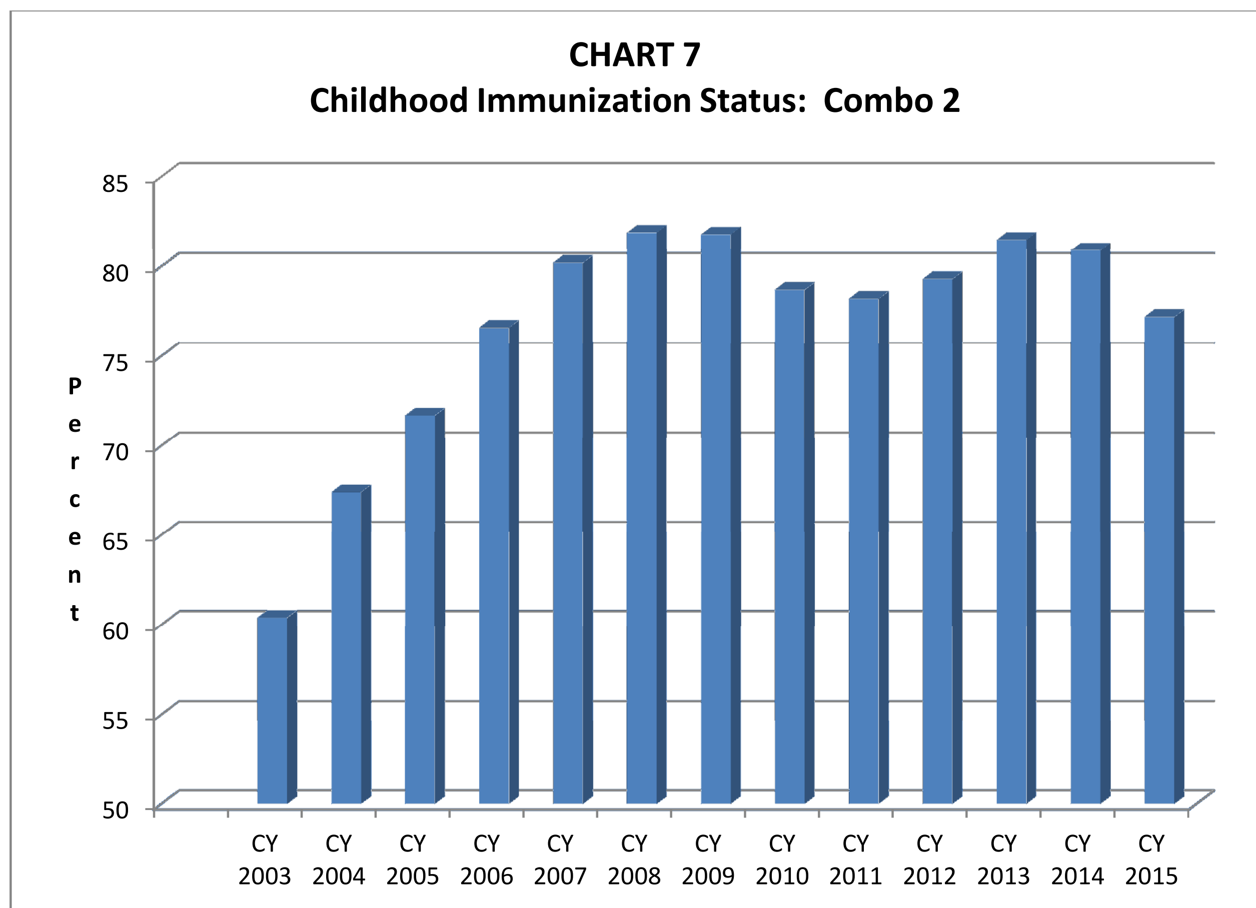
Is there opportunity to extrapolate the principles of managed care to other segments of the Medicaid program? The answer to that question is "yes," most notably in long-term care.

The 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 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.

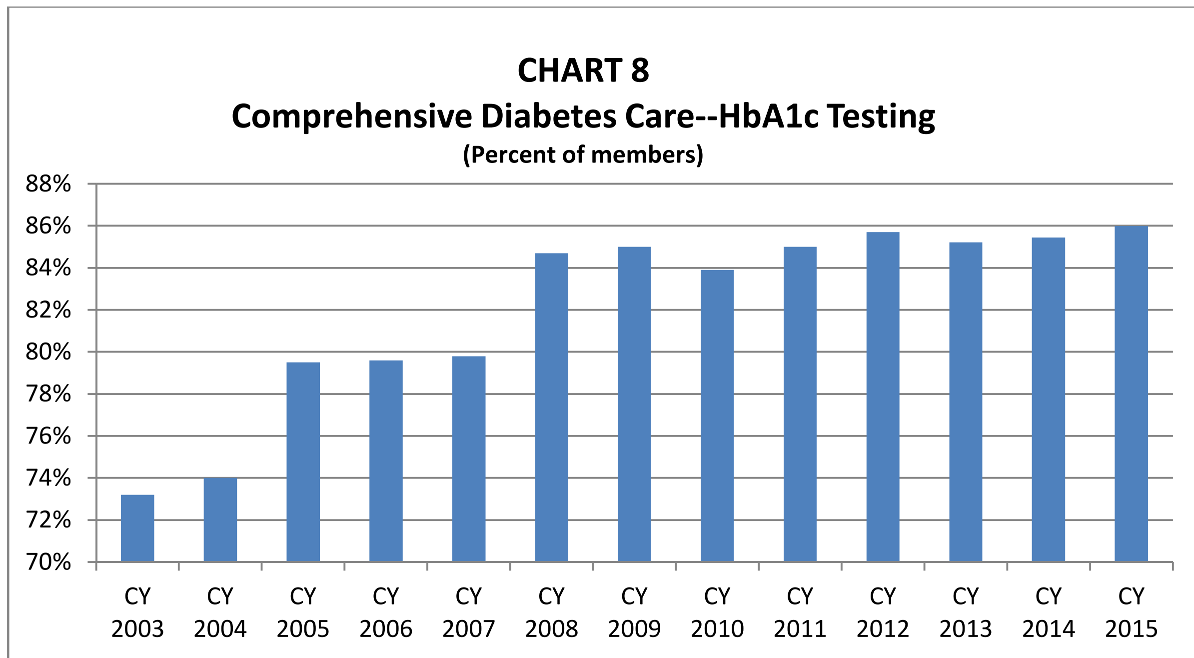
Services provided by Medicaid health plans are accountable under terms of both the state's contract and the HMO requirements in the Insurance Code.

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.



An illustration of the improved performance of Medicaid health plans has been in the area of immunizations. Variations take place from year to year and indicated in the chart and this area will remain a performance measure for health plans. Through the use of HEDIS® data, comparisons can be made regarding the relative performance of Medicaid managed care programs to the industry average in Michigan. 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/MDHHS/0,4612,7-132-2943_4860---,00.html

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 for the Medicaid population.



Another example of audited data showing clinical quality outcomes is diabete*s*. As Chart 8 illustrates, the basic diabetic testing rate has increased substantially over the past several years and is above comparable Medicaid national average

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 in Chart 9 as it illustrates the percentage of women receiving timely prenatal care services.

Over 50 percent of births are Medicaid births. The importance of prenatal care as mentioned above is critical. However, to have as much management and preventive services available for pregnant women and help managed pregnancies to achieve healthy outcomes; the timeliness of enrollment becomes a factor. Chart 10 highlights this issue in Michigan.

The state policy is to have "presumptive" eligibility for Medicaid at the time of pregnancy. The earlier in the pregnancy that enrollment can take place, the sooner the overall management of care by the health plan will be undertaken. Unfortunately, many women do not become eligible under well into their second trimester or later, and the enrollment process (under current system) may take another 60 days. This often results in continuity of care issues in the pregnancy and for the care of the newborn after delivery.

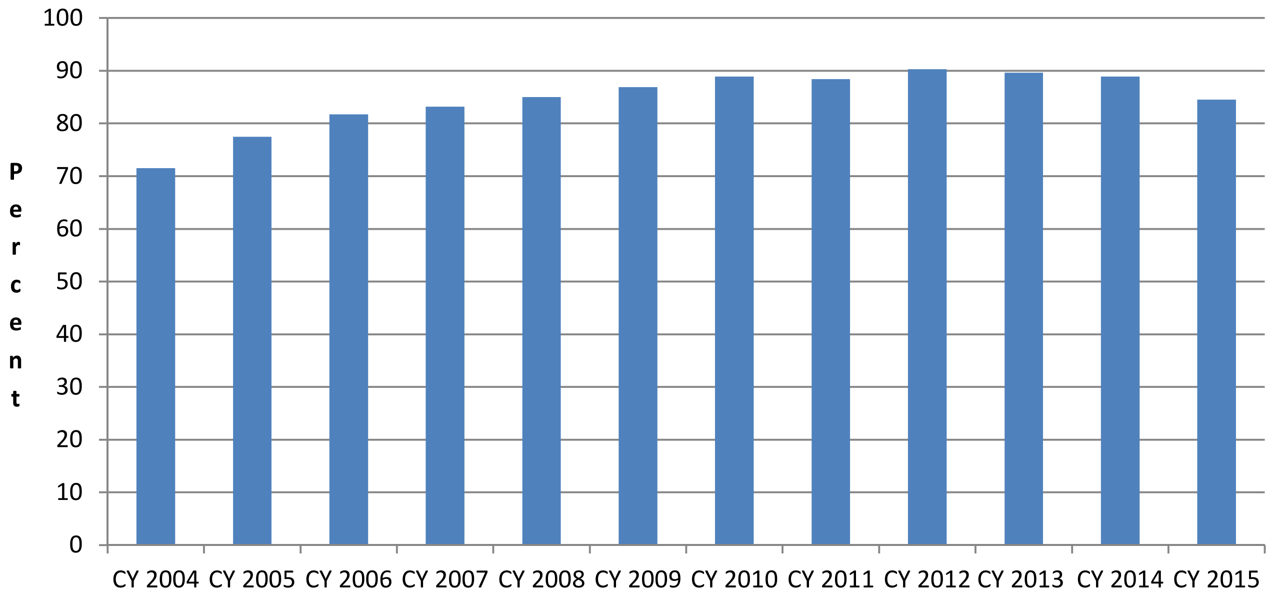
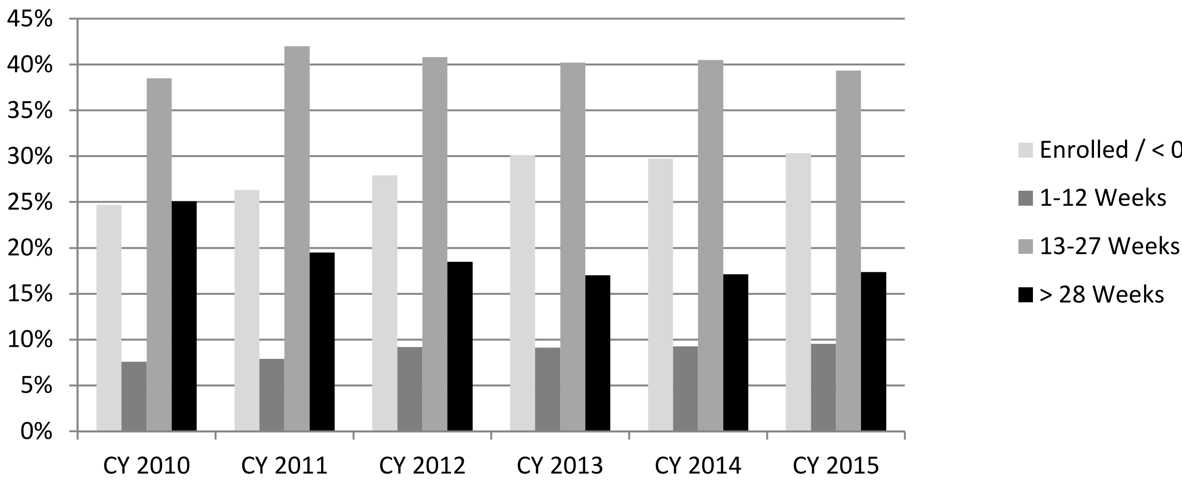


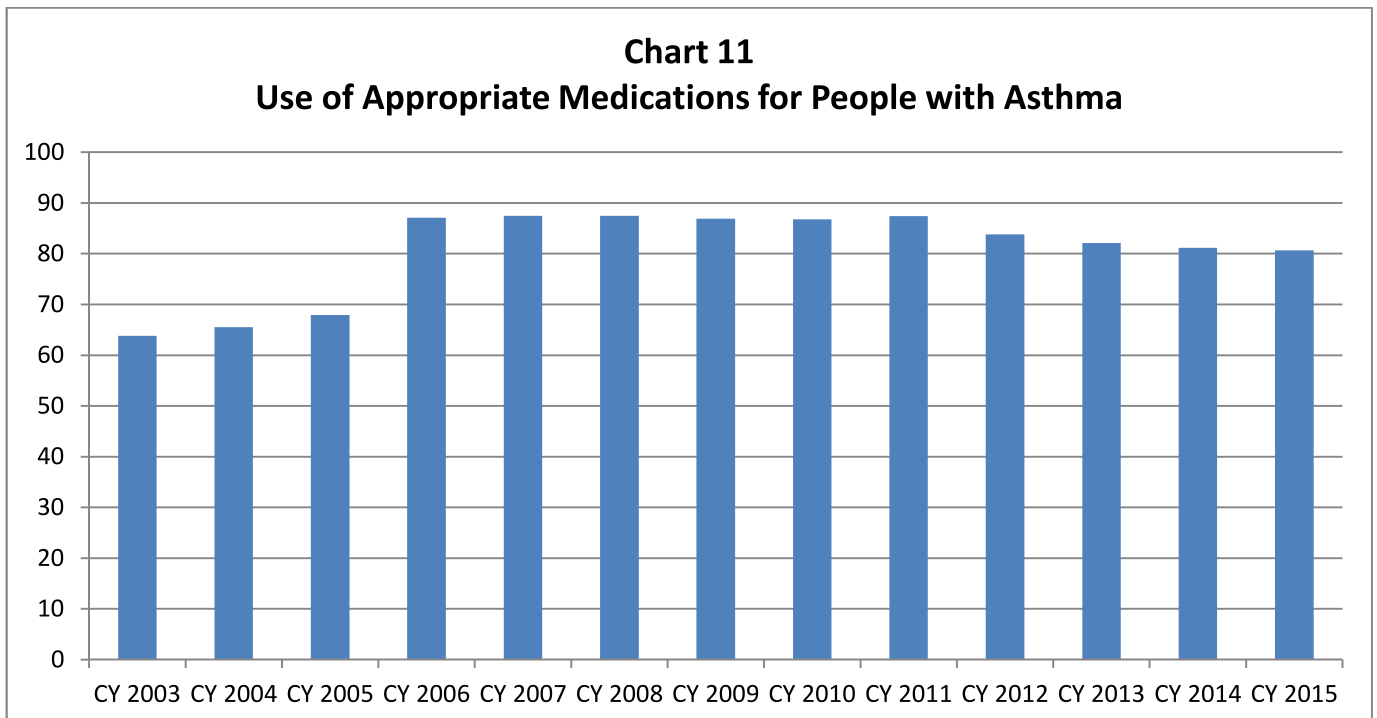
Chart 10 provides the latest data on enrollment of pregnant women. For HEDIS reporting year of 2013, 30 percent of pregnant women were already enrolled in a health plan; 9 percent became enrolled during the first trimester; 40 percent during the second trimester; and 17 percent in the third trimester. While these numbers are improving, efforts to address Michigan's infant mortality will depend in large part to moving the percentages toward first trimester enrollment.



Another example that illustrates improvement in services for a condition that is common for Medicaid, particularly for children, asthma, is displayed below in Chart 11. Michigan's Medicaid health plans are measured by a number of performance standards for different populations served, including the NCQA's "Use of Appropriate Medications for People with Asthma" performance measure. This measure examines how many people diagnosed with asthma are prescribed short- or long-acting medications needed to manage the condition.

This measure reflects the percentage of members aged 5-50 years who were identified as having persistent asthma and who were prescribed recommended medications during the measurement year. Because asthma is estimated to be responsible for more inpatient hospitalizations than any other childhood disease for those aged 5-17 this is a very important measure. Most of the children who participate in Medicaid are in a Medicaid health plan and expectations are very high that the Medicaid health plans will not only provide access to care—but will assure that that accessibility also results in appropriate care for conditions such as asthma.

Further, because asthma control usually requires multiple medications and management of the environment, care must be coordinated among physicians and community resources—a service provided by Medicaid health plans. To keep the performance measures high, Medicaid health plans support patients by facilitating this care coordination and tracking "medication possession" by members to identify when members are not refilling asthma medications or using high levels of rescue medications.



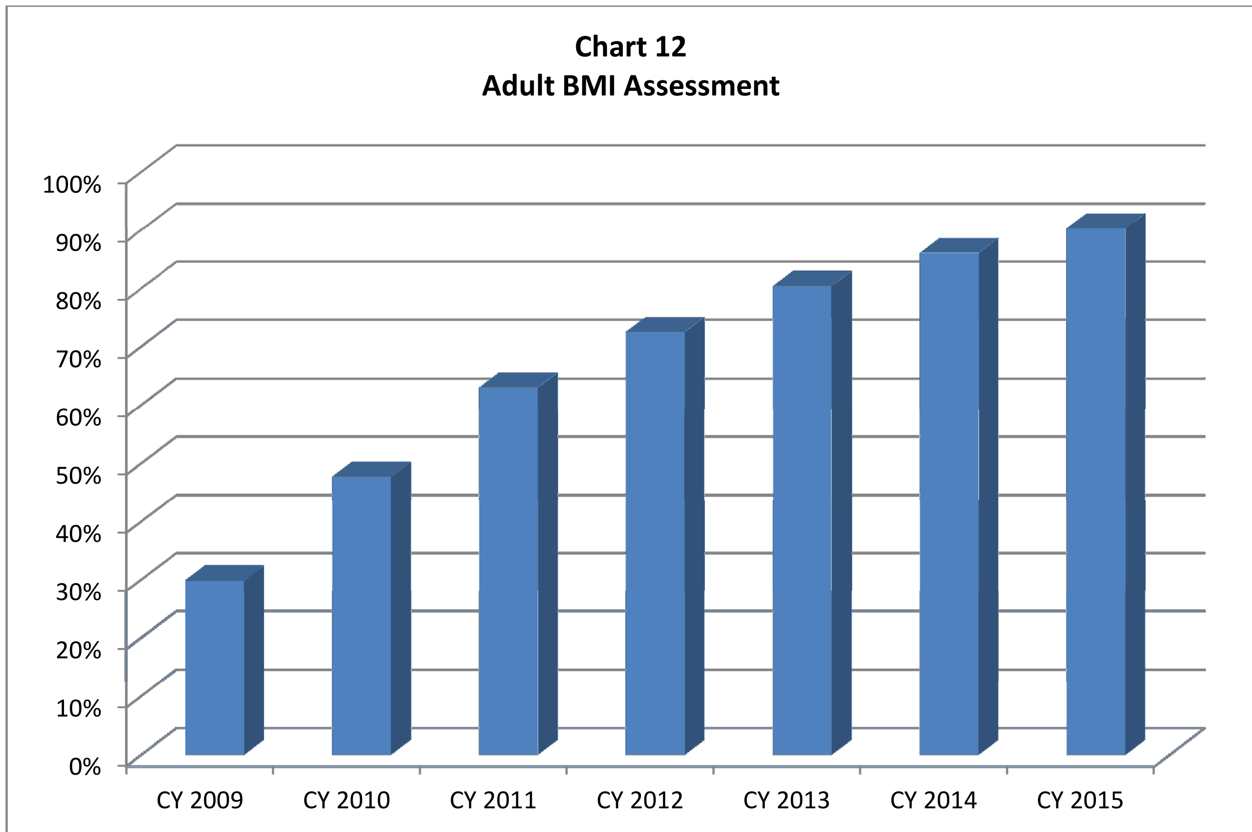
Finally, and consistent with Governor Snyder's dashboard objectives for obesity and health and wellness in Michigan are two performance measures: the measurement of the percent of adults

who have their BMI documented during a physician or ambulatory encounter during the enrollment year and the measure of adults receiving assistance for stop smoking.

As illustrated in Chart 12 below, signficant progress has taken place in the BMI measure for adults. Body Mass Index (BMI) is a number calculated from a person's weight and height. According to the Centers for Disease Control, BMI is a fairly reliable indicator of body fatness for most people. However, while BMI does not measure body fat directly, research has shown that BMI correlates to direct measures of body fat, such as underwater weighing and dual energy x-ray absorptiometry (DXA).

Calculating BMI is one of the simplest methods for population assessment of overweight and obesity. Because calculation requires only height and weight, it is inexpensive and easy to use for clinicians and for the general public. The use of BMI allows people to compare their own weight status to that of the general population.

BMI is used as a screening tool to identify possible weight problems for adults but is not a diagnostic tool. For example, a person may have a high BMI; however, to determine if excess weight is a health risk, a healthcare provider would need to perform further assessments. These assessments might include skinfold thickness measurements, evaluations of diet, physical activity, family history, and other appropriate health screenings. The CDC has created the following link for individuals to see how BMI is calculated and interpreted:
http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html#Interpreted

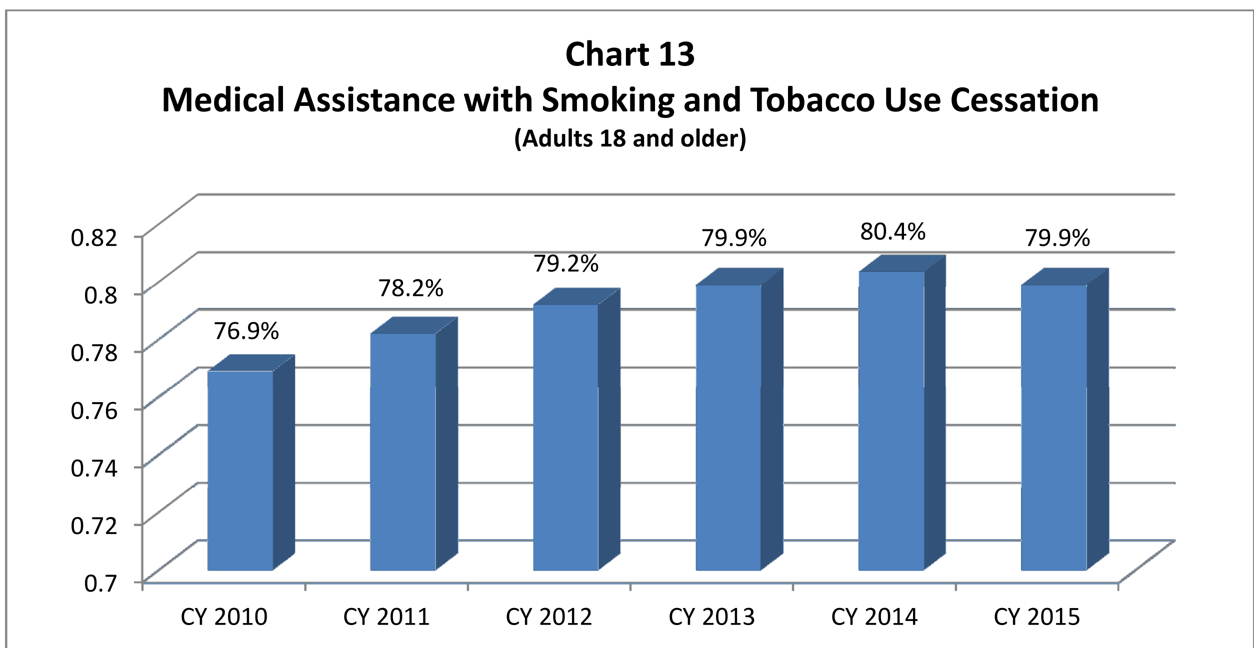


Michigan continues to have too high of percentage of adults who smoke. According to the U.S. Surgeon General, “Smoking cessation [stopping smoking] represents the single most important step that smokers can take to enhance the length and quality of their lives.” As is well documented, smoking is associated with a myriad of health issues, including increased cancer, lung and heart disease rates.

Given the special enrollment population in Medicaid of pregnant women, it is vitally important emphasis be placed in multi-faceted stop smoking initiatives and interventions. Women over 35 who smoke and use birth control pills have a higher risk of heart attack, stroke, and blood clots in the legs. Women who smoke are more likely to miscarry or have a lower birth-weight baby. Low birth-weight babies are more likely to die or have learning and physical problems. Michigan’s strategy for reducing infant mortality rates has stop smoking as a key element.

Fortunately, stopping smoking is an effective strategy for individuals at any age. No matter how old you are or how long you’ve smoked, quitting can help you live longer and be healthier. People who stop smoking before age 50 cut their risk of dying in the next 15 years in half compared with those who keep smoking. Ex-smokers enjoy a higher quality of life. They have fewer illnesses like colds and the flu, lower rates of bronchitis and pneumonia, and feel healthier than people who still smoke. According to the Surgeon General:

- Quitting smoking has major and immediate health benefits for men and women of all ages. These benefits apply to people who already have smoking-related diseases and those who don’t.
- Ex-smokers live longer than people who keep smoking.
- Quitting smoking lowers the risk of lung cancer, other cancers, heart attack, stroke, and chronic lung disease.
- Women who stop smoking before pregnancy or during the first 3 to 4 months of pregnancy reduce their risk of having a low birth-weight baby to that of women who never smoked.



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

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

The third element for accountability is the use of performance standards. These standards are specific to Michigan and are reviewed and revised each year by the MDHHS to reflect important categories of service. This accountability has also been recognized nationally as Michigan's Medicaid health plans were 4 of the top 25 and 8 of top 50 plans in the United States as recognized by the NCQA in based upon performance scores.
http://healthplanrankings.ncqa.org/2014/

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 DIFS relative to denied claims, and third party liability reports);
- financial reporting (quarterly and annual filings with DIFS — available on the DIFS Web site) http://www.michigan.gov/difs/0,5269,7-303-12902_18956-93711--,00.html

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:

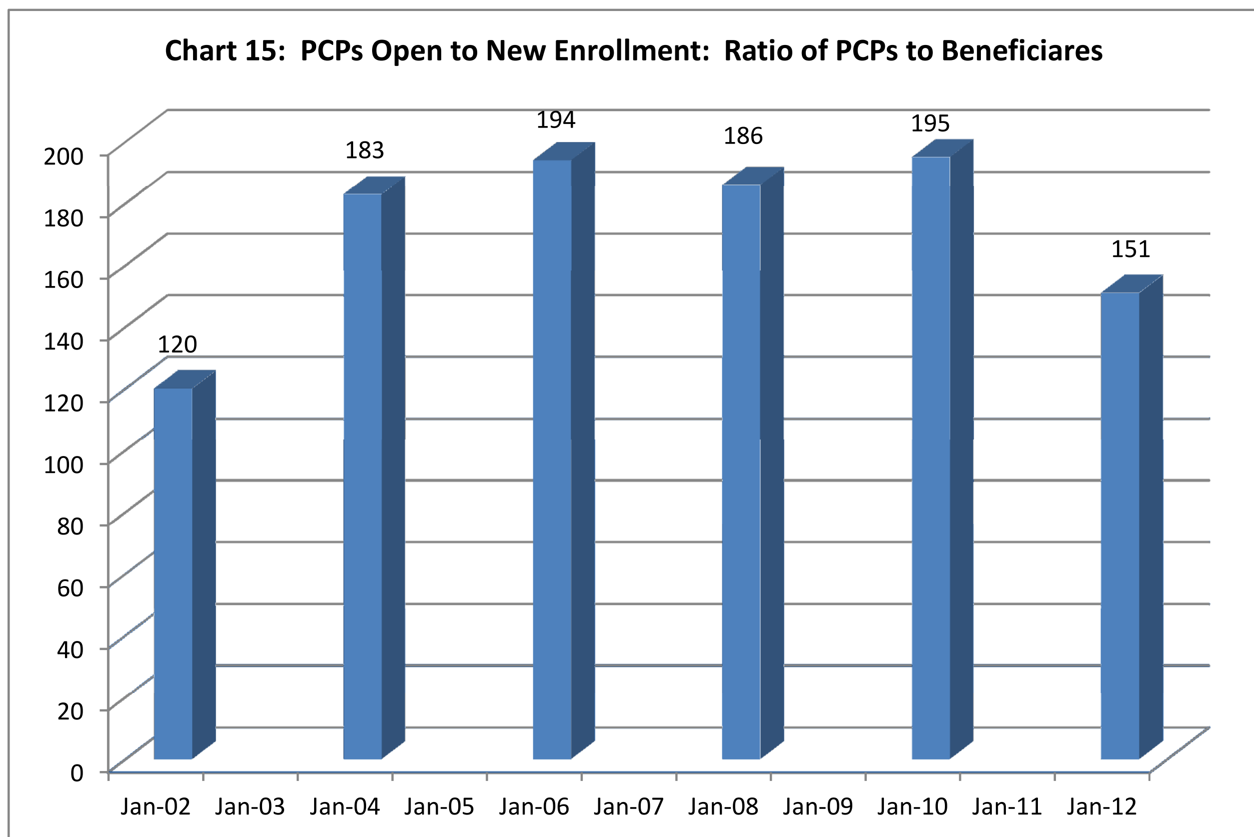
- external quality reviews under contract from MDHHS, (medical record reviews provided by a vendor approved by the federal government);
- annual site visits by both MDHHS and DIFS;
- program audits performed by the Michigan Auditor General's Office;
- federal waiver review conducted by the Federal Centers for Medicare and Medicaid Services (CMS);

- Federal audits performed by the United States Office of Inspector General and the United States General Accounting Office.

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

It is essential that each Medicaid beneficiary have a "medical home." Access to primary care providers (PCPs), as well as choice among PCPs, are the hallmark of the managed care program and provide this "medical home." Also, as shown below, and earlier in Chart 1, beneficiaries have increased access to primary care physicians, indicating continued access to care. Access to care is one of the key performance standards for Medicaid health plans and one that is measured on a monthly basis.

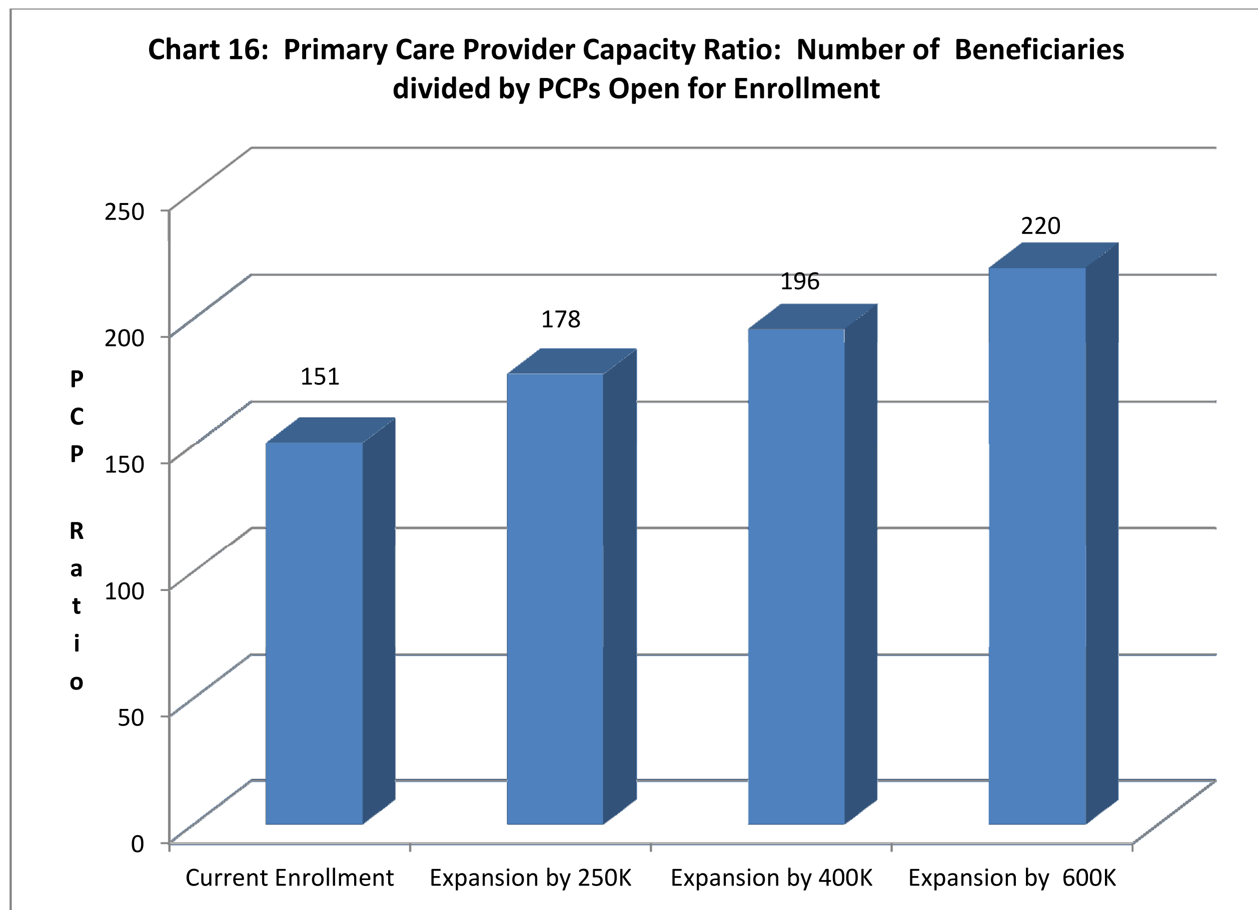
Medicaid health plans are required to submit updated provider files to MI ENROLLS on a monthly basis. It is these files that MI ENROLLS relies on to provide information to Medicaid beneficiaries regarding choices for health plan enrollment and selection of a primary care provider. Because the files are updated monthly and provide information on which providers are open for additional Medicaid beneficiary selection, it is possible to develop an overall view for Michigan. Using an unduplicated count from the MI ENROLLS provider files, Chart 15 illustrates the trend in primary care provider, PCP to beneficiary ratio. In noting this, it is worth putting the ratios in the context of the threshold used by the federal government in determining shortage areas—which is a ratio of 1:1500.



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.

One of the key questions to be asked and answered before implementing the option for Michigan to implement the Medicaid expansion of eligibility is provider capacity. Using the same documentations as listed for Chart 15 above, an analysis was undertaken to determine what the PCP to beneficiary ratio might be under differing expansion scenarios between 250,000 to 600,000 additional beneficiaries—and as we know now, the Healthy Michigan eligibility is about 600,000.

This analysis clearly shows that the existing capacity contracted to Medicaid Health Plans will serve the new population. This was recently corroborated by a University of Michigan and Michigan State Medical Society survey of physicians that also indicated the vast majority of physicians would serve the expanded population.

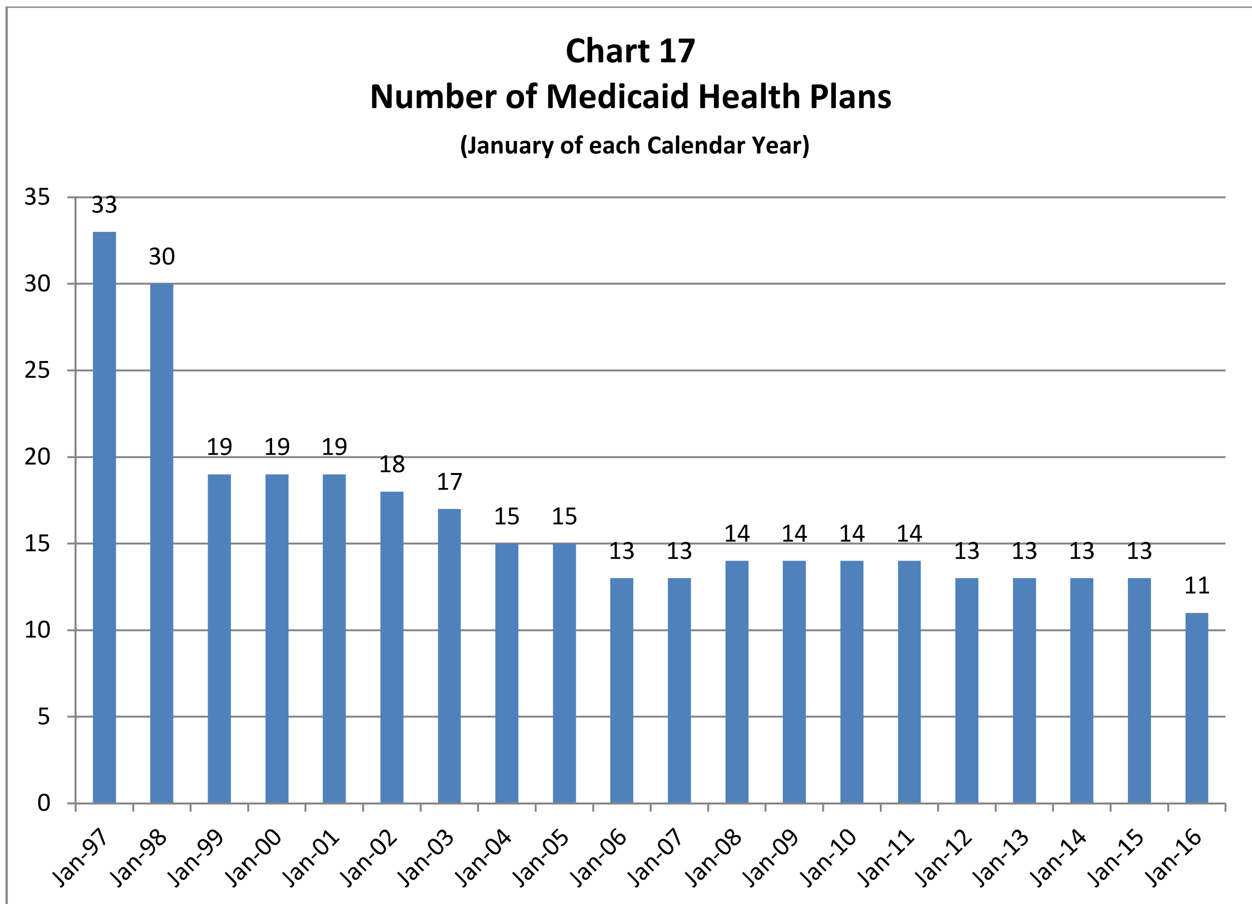


4. <u>Administrative functions are built into state contract.</u>

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. <u>More simply put, it is this structure that continues to generate the state's savings realized through Medicaid managed care</u>.

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.

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. <u>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</u> and were unpredictable. Additionally, the state under fee-for-service does not provide case management services to managed high-cost cases and facilitate improved health outcomes.



An Administrative Function Table is attached to the end of this paper (Attachment 2). 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 2 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 Department of Financial and Insurance Services.

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**, i.e. the smart application of managed care techniques to reduce unnecessary medical utilization and costs.

It other words, the state's return on investment through 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 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. The reader should also understand that this program has achieved a benchmark status not only in terms of its value by any measure but also by its potential to serve as a guide for further improvements in the overall Medicaid program.

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

MAHP Recommendation Principles

Without an underlying basis for reform in Medicaid or other programs, the long-term sustainability will be weakened and opportunity for gaining public support will be missed. MAHP believes the following principles can be used to guide the changes necessary to transition Michigan's Medicaid program through the next year(s) provided they are implemented **within the context of actuarial sound rates to assure long term sustainability**:

- Enroll current beneficiaries into managed care rather than reducing optional benefits;

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

Savings Potential

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

- **Savings from movement of populations into managed care.** There is an underlying rule of thumb that 3-5 percent of medical care treatment costs can be saved by movement into managed care. The tools, techniques, programs, and results of using Medicaid managed care are listed later in the Paper.

- **Savings from Administration Efficiency.** There is no question that Michigan's effort to serve the most vulnerable population has resulted in multiple initiatives and programs—all with administrative costs. By moving toward a comprehensive Medicaid benefit contract, Michigan can begin to reduce state administrative cost and create a more seamless delivery of health care services.

- **Savings from State Administration.** The development over the years of a number of state initiatives to deliver various categorical or limited benefit programs is a state oversight responsibility and contract management or administration. Consolidation within the managed care program will reduce those costs and focus on a more comprehensive management of the managed care contract. This would also utilize electronic submission, the deeming of national accreditation and establishing a program of regulation and oversight by exception. This will result in savings to both the state and to contractors that can be realized in the cost of contracts.

- **Savings from Enabling Contractors to access data and Third Party Liabilities for recoveries**. While Michigan has been very innovative in development of the managed care performance based contract, there has been notable exception in the designation by the State to the Contractors to access third party liability and recovery information. It is estimated that many Medicaid beneficiaries have other insurance coverage from spouse, family, estates, and recoveries related to accidents and auto related injuries.

  The monthly capitation payment premium established under actuarial sound principles makes assumptions regarding the amounts that will be recovered and inserts that amount as a credit in the overall calculation. If Michigan enabled Medicaid contracting health plans to be considered a part of the Medicaid Program for purposes of recovery, then the amount of the credit can be increased and amount of the necessary capitation reduced over time.

- **<u>Savings from development and implementation of policies addressing "waste" in our health system.</u>** There has been must research and studies regarding the waste in the U.S. health system compared to other countries. Further, there is ample documentation of regional variations within each state and between states. By starting to apply best practices and models and tying it to the underlying Medicaid reimbursement model, Michigan can create significant health care savings without compromising quality of care or access. These savings will be more difficult to generate as much of it is embedded in current practice management and protocols and in some instances supported by existing state policies.

  One simple measure that we know is the number of admissions to an inpatient stay that could otherwise be treated in the community with effective coordination and reimbursement policy. Earlier in this paper we show an illustration that Medicaid hospital utilization is 62 percent higher than commercial utilization. If we could lower that difference by half, taxpayers could save millions. There are many more that will be identified over the coming months provided the legislature and administration create a receptive environment to not just receive but act on such recommendations.

This agenda is doable, but will require action to:

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

It is critical that this benchmark remain viable in its partnership with the State of Michigan. <u>The state's obligation to administer this program in an actuarial sound manner is of paramount importance</u>. 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 state and federal requirements.

IV. <u>RECOMMENDATIONS FOR FY 17 AND BEYOND</u>

I. <u>Finance/Revenue Recommendations</u>

1. The Department of Health and Human Services should administer and the Legislature should **appropriate adequate funding to <u>assure actuarially sound rates</u>** in support of all aspects of Medicaid Managed Care, (CSHCS, MI CHILD, Duals (including the model for Integration), Regular Medicaid, and Healthy Michigan Program). **<u>MAHP supports the Executive Budget recommendation for actuarial soundness increases for traditional Medicaid and Healthy Michigan</u>**.

    - Consistent with federal and state requirements for actuarial soundness, costs related to the health insurance premium tax imposed by the Affordable Care Act, and health insurance claims assessment is considered part of actuarial soundness and should be noted in the certification of the health plan rates and included in the contracts with Medicaid plans; and

    - All Medicaid Policy bulletins issued by the Department after federal approval of actuarial soundness should include economic analysis to demonstrate that the existing and approved rates are not compromised by the proposed changes in Medicaid Policy.

2. The Michigan Legislature should **repurpose all of the revenue generated by the use tax** paid by Medicaid Health Plans to explicitly cover non-Medicaid services and coupled this change with continued support of HICA at an effective rate of no higher than 1% (if no use tax is collected and no higher than 0.75% if use tax revenue continues to be collected.

3. The State of Michigan should continue efforts to **<u>maximize all levels of non-GF Revenue</u>** (federal, special use, local revenue, and cost avoidance) to protect Michigan's safety net. This focus would continue and expand efforts for:

    - Medicaid Health Plan "Special Needs Access Fund, SNAF and Supplemental Hospital reimbursement, HRA, Programs" to assure outreach and coverage for Medicaid beneficiaries;

    - Securing additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid;

    - Increasing third party collections for Medicaid managed care plans by providing access to other carrier data, including auto insurance and designating Medicaid Health Plans as "agents of department" for purposes of this function.

    - Improving fraud and abuse coordination through the Medicaid Inspector General Office and working with a variety of organizations regarding the development of more community based care to reduce current high cost utilization of care.

- Continue and expand efforts to support health homes and other forms of diversion from emergency department inappropriate use.

4. The Department should **<u>enhance and improve the Encounter Data Quality Initiative</u>** to assure that encounter data will be accurately used in health plan rate development, hospital DRG rebasing, and special financing initiatives and be available for studies on quality development, special analysis and potentially as proxy for all payer data base.

II. Access/Capacity/Choice for Beneficiaries Recommendations

5. As recommended in the Executive Budget for FY17, the MDHHS should engage stakeholders in a process to arrive at a plan for integrating Medicaid services that will improve overall access, provide choice, reduce administrative complexity, provide a single point of accountability and be implemented in the most cost-effective manner possible. Savings from this initiative should be redirected to provide additional services.

6. Consistent with Healthy Michigan Act, the State of Michigan should implement an **<u>Integrated Long Term Care Initiative</u>** in regions outside of the demonstration initiative for integrated care for those with dual eligibility.

7. The State of Michigan should **<u>continue to improve and reform Medicaid eligibility</u>** by**:**

   a. Operationally, creating a default eligibility and enrollment for newborns to be assigned to the same Medicaid health plan as the mother at the time of birth (consistent with the terms of the Medicaid contract).
   b. Delink Medicaid application from other human services program applications in order to accelerate Medicaid eligibility and enrollment.
   c. Reform the redetermination process, particularly for those in long term care facilities and other institutional settings to assure no loss of eligibility and continuity of care.
   d. Begin a process to reform the criteria use and address the “spend-down” category of eligibility which an end objective to improve coordination of services, continuity of care and reduce uncompensated services while saving general fund dollars.

III. Operational/Administrative Efficiency (Cost Avoidance) Recommendations

8. The State of Michigan should continue its efforts in **<u>streamlining and coordinating the administration and oversight</u>** of Medicaid Health Plans and related contracted entities. This may include such options as:
   a. Reduce and/or eliminate paper requirements in lieu of electronic documents and web-based information sites and begin using “deemed compliance” by virtue of national accreditation such as NCQA or URAC;
   b. Consolidating the internal program administration and coordination of the Integrated Services Plan for the Dual Eligible, MI CHILD, Healthy Michigan

Act and traditional Medicaid managed care program under a single administrative program.

c. Changing the regulatory perspective to a "regulation by exception"—that is a focus on those who are performing below standards established in the contract.

9. Implementation of the Healthy Michigan Act should be **consistent with the legislative intent and principles of managed care** that focus on innovations and flexibility.

10. To help reduce future enrollment and eligibility "churning", **Michigan should consider the economic feasibility of implementing either a bridge plan or basic health plan** in conjunction with the Insurance Exchange.

Expectations:

"*Policy makers, administrators and the public rightfully expect (and we believe receive) value from the Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. While the most obvious strength is cost savings, the benefits in increased access, evidence based policies, and care coordination is leading toward improved health status."*

Medicaid White Paper References

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

Frequently Used Medicaid Related Website Links:

- Kaiser Health News: http://www.kaiserhealthnews.org/Topics/Medicaid.aspx
- Kaiser Family Foundation: www.kff.org
- National Health Policy Forum: nhpf@gwu.edu
- Medicaid Health Plans of America: MHPA.com
- Catalyst for Payment Reform: http://www.catalyzepaymentreform.org/
- Commonwealth Fund Publications: http://www.commonwealthfund.org/Publications.aspx
- Americas Health Insurance Plans, AHIP, Research Center: http://www.ahipresearch.org/
- National Association of State Medicaid Directors: http://hsd.aphsa.org/Home/home_news.asp
- Centers For Medicare and Medicaid: http://www.cms.gov/home/medicaid.asp
- Michigan Department of Insurance and Financial Services, DIFS: http://www.michigan.gov/difs/0,5269,7-303-12902_18956-93711--,00.html (HMO Financial Reports)
- Michigan Department of Health and Human Services: www.mdhhs.gov http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42544_42644-150910--,00.html (Medicaid Health Plan information)

1. **February 2012**, "Options for Managing Medicaid Funding and Cost Growth ", Report 376, **Citizens Research Council of Michigan.**

2. January 2010, "The Cost Burden of Disease: United States and Michigan. Issue Brief, Center for Healthcare Research & Transformation, www.chrt.org

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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 MDHHS and DIFS. Additionally, MAHP has collaborated with Sanofi-Aventis to produce a publication, "Managed Care Digest Series/Michigan HMO Data Summary". These have been produced since 2003 and are distributed as part of the annual Summer Conference of MAHP. Interested parties may contact MAHP to obtain the most recent copies of this publication.

ATTACHMENT 1

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 2

TABLE OF ADMINISTRATIVE FUNCTIONS PROVIDED BY MEDICAID HMOS

(Reflects functions performed for the Core Medicaid Managed Care Program and does not yet include new administrative functions required under the Healthy Michigan Act)

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.

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 • DIFS external reviews (PRIRA)

	• 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 Infant Health Program (MIHP) • 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 • Beneficiary Monitoring Program
Administrative Cost: Quality of Care Assurance	• Providers who are credentialed every three years • External Health Plan Accreditation (e.g., NCQA, URAC) • Individual Site Visits/medical record reviews of Plan Providers • Focused Clinical Studies and Quality Improvement Plans to improve care identified as less than optimal • Health Care Standards and Policies, including Access Standards • Fraud & Abuse policies and activities • Development and distribution of Clinical Guidelines • Profiling and reviewing physician practices for quality measures
Administrative Cost:	• Data Reporting to the Department of Community Health

HMO Public Accountability	○ 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 DIFS Web Site) • Customer Satisfaction Surveys (CAHPS), including adolescent CAHPS (available as tool only for Medicaid Products) • Provider Satisfaction Surveys • External Quality Reviews (performed by MDHHS) • Administration of annual site visit by DIFS and MDHHS • External Accreditation from a National Organization
Administrative Cost: Provider Services	• Provider Hotline and other provider communications • Provider Manuals, Education, Orientation & Training • Administration of Provider Complaint and Appeals • Electronic Billing Capacity • Coordination of Benefit Activities • Physician and Provider Profiling Reports • Implement all Information Technology Solutions, including ICD-10

ATTACHMENT 3

ACTUARIAL SOUNDNESS: REQUIREMENTS FOR STATES THAT FUND MEDICAID HEALTH PLANS

Background on Actuarial Soundness

Medicaid health plans are paid by states on a prepaid, monthly capitation basis for providing Medicaid benefits. The Social Security Act §1903(m) (2) (A) (iii) requires states to pay Medicaid health plans rates that are actuarially sound. The Centers for Medicare and Medicaid Services (CMS) has defined actuarial soundness through regulation [42 CFR §438.6] as (1) developed in accordance with generally accepted actuarial principles and practices; (2) appropriate for the populations to be covered and the services to be furnished; and (3) certified as meeting applicable regulatory requirements by qualified actuaries.

Further, in 2003, CMS developed a detailed checklist for states to use in the rate-setting process to ensure payments to health plans are appropriate to cover the cost of medical care and support services, administrative costs, taxes and fees. This actuarial soundness requirement is an important safeguard to ensure low-income beneficiaries have access to care but also to ensure that health plans are not overpaid. In August 2010, the Government Accountability Office (GAO) issued a report (GAO-10-810) finding inconsistent CMS oversight in reviewing states' compliance with the actuarial soundness requirements, and considerable variation by CMS Regional Offices in review practices. The GAO recommended that CMS implement a uniform mechanism to track state compliance with the requirements, clarify guidance to Regional Offices on rate-setting reviews, and confirm the quality of the data used by states to set rates.

State of Michigan Guidance

In addition to federal requirements, Michigan Medicaid policy has also been adopted to affirm the same requirements and provide a process to document the development of Medicaid health plan rates. According to the Medicaid Policy Bulletin, (MSA 07-34), actuarially sound rates for MHPs are capitation rates that meet the following requirements:

- Developed in accordance with generally accepted actuarial principles and practices.
- Appropriate for the populations included and services covered under the State's contract with the MHPs.

Procedurally, the State of Michigan contracts with a certified actuary to develop actuarially sound rates for the MHPs. Under their methodology described in the certification letter, the State's Actuary establishes a rate range for each rate cell covered under the Medicaid Managed Care program. As mandated by the federal requirement, the State's Actuary certifies these rates are actuarially sound. This is validated through a formal rate certification letter signed by the Actuary. Michigan transmits this certification letter to CMS as part of their requirements in meeting the federal rules.

New Dynamic—ACA Premium Tax

Beginning in 2014, certain Medicaid Health Plans will be required to submit a premium tax payment to the federal government to help underwrite the expenses of the Affordable Care Act. Nationally, this tax is to generate $8 billion dollars. The effective rate of the tax will be determined once all carriers have filed their 2013 revenue. Medicaid Health plans providing services to about 80 percent of enrolled beneficiaries are affected by this tax.

The precedence of Medicaid Plans paying excise taxes is decades old as Michigan has evolved through "quality assurance assessment program" (QAAP) fees, to a use tax allocation to Medicaid health plans to the current Health Insurance Claims Assessment, HICA. In all instances, the tax has been considered a legitimate cost of doing business and included in the rates paid to health plans. The imposition of the ACA tax identical in principle—a fee/tax to be paid by Medicaid Health Plans and be incorporated into the rates paid to plans by the State.

The ACA places an $8 billion annual fee on the health insurance industry, which gradually increases to $14.3 billion in 2018. The fee applies to commercial, Medicare, Medicaid and CHIP health risk revenues. Applying the fee in Medicaid and CHIP taxes the benefits of our poorest citizens and raises costs to states and the federal government because of the actuarial soundness requirement. The brunt of this fee will be borne by financially strapped state Medicaid programs just as a major expansion of those eligible for Medicaid occurs in 2014. **It is estimated that the cost to states will be approximately $800 million in the first year of the tax.** Because two-thirds of every dollar spent on Medicaid is federally funded, the tax will also be passed along to the Federal Government and is essentially the Federal Government taxing itself.

The significance of ACA premium tax is its magnitude that will grow considerably each year. Because this is related to the actuarial soundness of Medicaid Health plans this becomes an issue of concern for MAHP and member plans.

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