Background

Over the past months a number of statements regarding the values and merit of managed care have been publicly stated. Rather than engage in rebuttal that serves no purpose and takes the focus away from discussing meaningful reform, our industry has chosen to quietly "correct" mis-statements with facts. We assumed once the budget was done, we would be able to focus on the legislative direction but such erroneous and misleading statements continue, including that in the text box below. The comments generally focus on "risk", and that relationship to denial of services.

> *"Managed care has created a system of denial of services. Risk must only be managed at the state level where the budget decisions are made. Delegation of risk creates conflicts of interest for healthcare professionals and imposes real risks on the welfare of persons in need of services. It has no value for improving care, and cost savings are derived from denial of needed services"*

We have asked the MDHHS to allow us to provide an information sheet on these issues that stakeholders may have for future reference.

Risk

Unlike, PIHPs, All Medicaid Health Plans are licensed by the State of Michigan, (Department of Financial and Insurance Services), DIFS, and are regulated and monitored for financial viability, provider contracts (DIFS determines service area), and customer services (DIFS administers the Patient Right to Review Act, PRIRA). This is in addition to Medicaid contract oversight by MDHHS. Operating in transparent manner, all health plans, including Medicaid plans, provide quarterly and annual reports to DIFS which is also shared with the data base operated by the National Association of Insurance Commissioners, NAIC. The website for anyone to view these reports can be found at: http://www.michigan.gov/difs/0,5269,7-303-12902_18956-93711--,00.html Only a licensed HMO may operate at full risk—meaning in exchange for a monthly capitation (payment), the health plan is totally "at risk" to cover the entire cost of care for enrolled population. The development of sound actuarial rates is critical to this process—but equally important is managing risk.

Under full risk, Medicaid Health Plans cannot use wait lists or other means to delay or defer services. To be successful, health plans must quickly identify and manage risk through timely interventions—not deny or avoid risk. Audited data over the past years clearly shows that health plans are providing more care—not less. The utilization charts of key measures (Physician and Ambulatory Encounters, Prescriptions, and Hospital Admissions) should be clear indication that services are being appropriately provided and not denied as alleged in the various statements. We hope that all future discussion can be focused on how best to serve consumers—and once that is established, the delivery model can be determined.

(Charts on back side of this document)

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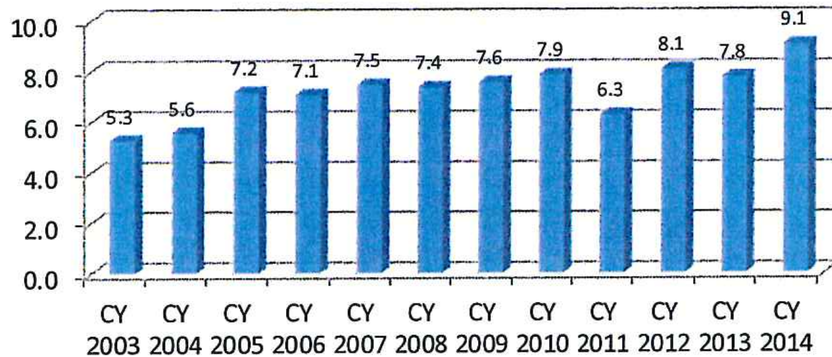

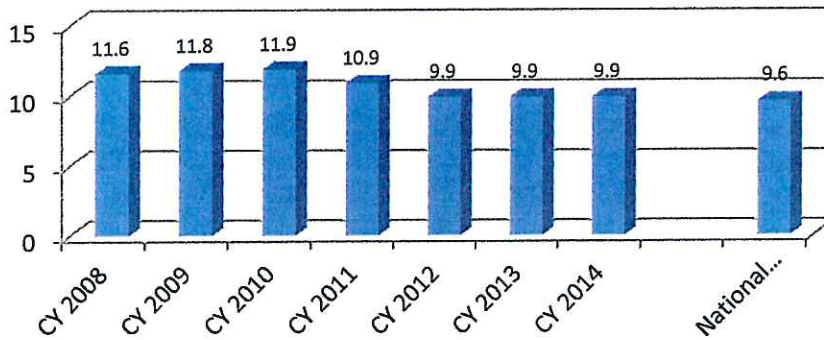

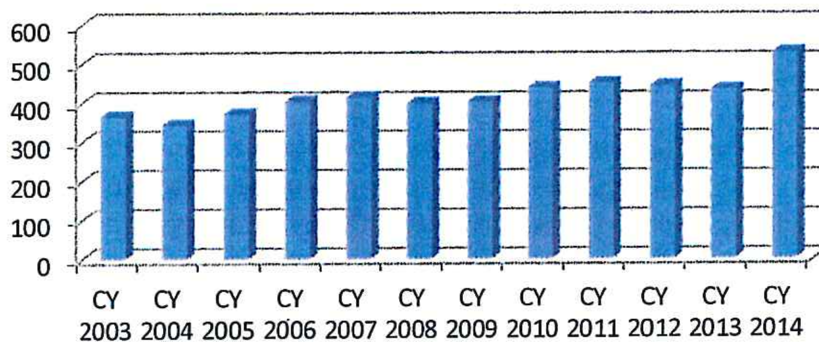

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