Performance, Value, Outcomes: Medicaid Managed Care

FY 2017-2018

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 18

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RECOMMENDATIONS FOR FY 18 AND BEYOND

I. Finance/Revenue Recommendations

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

    - 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 **reinstitute and repurpose all of the revenue generated by the use tax** paid by Medicaid Health Plans to explicitly cover non-Medicaid services and dedicate Personal Income Tax revenue of an equal amount to be expended for the purpose of maintaining actuarial soundness payments to the health plans.

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

    - Seeking alternatives for Medicaid Health Plan "Special Needs Access Fund, SNAF and Supplemental Hospital reimbursement, HRA, Programs" to assure outreach and coverage for Medicaid beneficiaries; in light of the recently enacted Managed Care Rules by CMS

    - 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.

    - 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.

5. MDHHS should work with Medicaid Health Plans to confirm that encounters submitted to the data warehouse are utilized during the rate development process.

II. Access/Capacity/Choice for Beneficiaries Recommendations

1. The department shall be responsible for advancing pilots and demonstration models that will integrate the Medicaid behavioral and physical health benefit. The demonstration models are based on a goal to achieve total Medicaid benefit and financial integration by September 30, 2020 that will rely on a single contracting model between the State of Michigan and licensed Health Plans, regulated by both the Department of Financial and Insurance Services to assure financial viability and the Department of Health and Human Services to assure overall programmatic performance.

2. On or before July 1, 2018, and consistent with Healthy Michigan Act, the State of Michigan should implement a **Managed Long Term Services and Supports program.** The Department's implementation should first incorporate Long Term Care Support Services in the regions used for the Integrated Care Demonstration Initiative. Subsequent implementation of Long Term Support Services should take place in the other remaining Medicaid Prosperity Regions.

3. 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 used and address the "spend-down" category of eligibility with 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

1. 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 continue to identify "deemed compliance" opportunities 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, HEALTHY KIDS DENTAL 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.

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

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 17, 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 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.

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 2016 ratings cited Michigan Health Plans (commercial, Medicare and Medicaid) as high performing in all three categories: consumer satisfaction, prevention and treatment.

Specifically, Michigan's private Medicaid Health Plans are among four in the top 40 and five in the top 60. These numbers clearly demonstrate the quality care provided to our Medicaid population.

What's next?

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:

- Is statewide;
- Included disabled population as mandatory enrollment;
- 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. 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 now fully operational and 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 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. 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 has been 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. The proposed path of the second waiver directs individuals who have been in the program for 48 months without committing to a healthy behavior to the Marketplace, which will likely be costlier to the State then the current HMP program.

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. Given 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 data 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:

- 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.

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.

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.

Additionally, the areas of fraud and abuse are areas that Medicaid Health Plans work closely with the Michigan Attorney General's office and the Office of 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.

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 over 500,000 and overall eligibility is over 640,000-- 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 held frequent meetings and conference calls to identify and operationalize necessary tasks for a smooth implementation, that continue to work on implementation of the second waiver. 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. According to a recent New England Journal of Medicine article, there are clear economic benefits in continuing Medicaid Expansion in 2017 and beyond, such as adding economic activity, projected to yield approximately $145 million to $153 million annually in new state tax revenue. The article goes on to add that, "state-budget gains outweigh the added costs for at least the next 5 years…".

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.

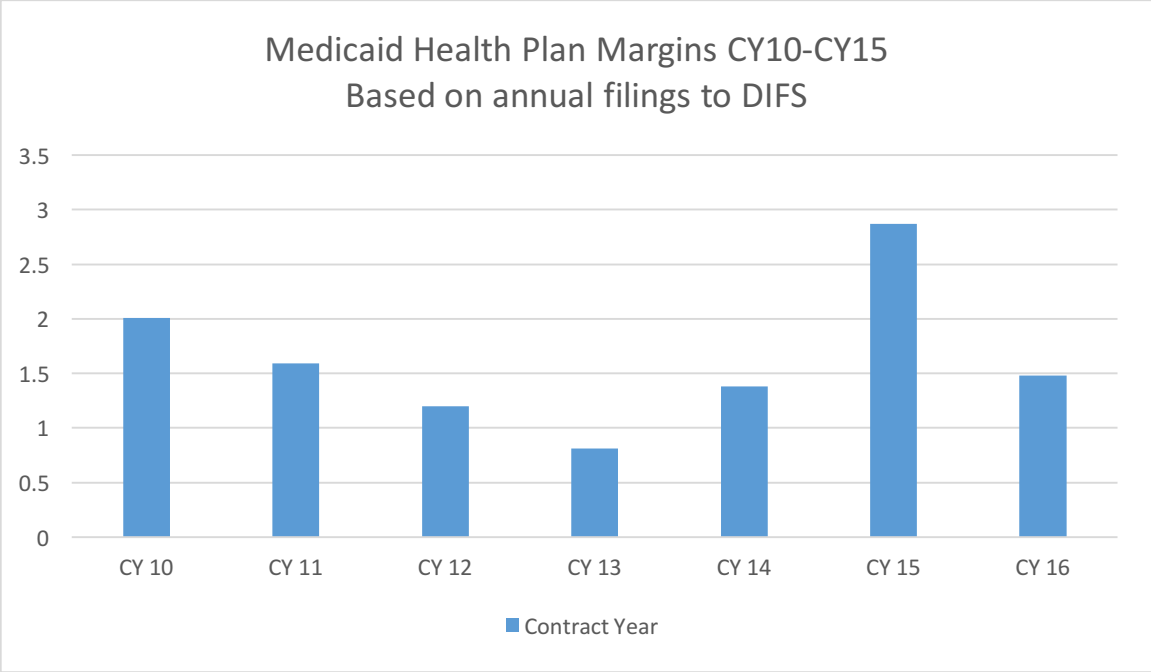
- **Enrollment of Population Groups into Managed Care creates Administrative Efficiencies.** We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools 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 programs using Community Health Workers to help individuals address the social determinants of health that play a role in their hospital utilization.

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.

Why recommendation related to actuarial soundness requirements are so important. 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 as you can see 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 17. 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.**

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].

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

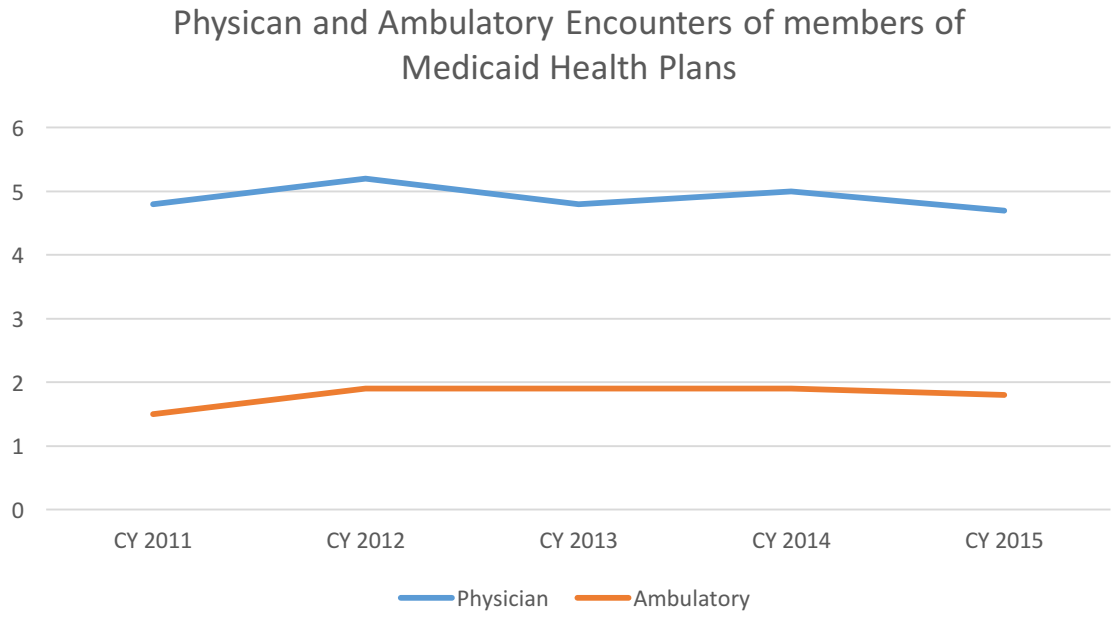
Other evidence-based guidelines come from the United States Preventive Health Task Force, whose work can be found on the following website: http://www.ahrq.gov/clinic/uspstfix.htm

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;
- 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 Health and Human Services[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.

Ambulatory Care Sensitive Hospitalizations and Rates per 10,000 Population for Patients of All Ages--Michigan Residents, 2008-2014

AMBULATORY CARE SENSITIVE CONDITIONS View ICD-CM Codes	HOSPITALIZATIONS		RATE PER 10,000 POPULATION	
	Average Annual Number for 2008-2014	2014	Average Annual Rate for 2008-2014	2014
ALL AMBULATORY CARE SENSITIVE CONDITIONS	261,668	247,18	264.4±	249.4±
Congestive Heart Failure	34,969	34,484	35.3± 0.2	34.8± 0.4
Bacterial Pneumonia	29,267	23,903	29.6± 0.2	24.1± 0.3
Chronic Obstructive Pulmonary	25,980	22,537	26.3± 0.1	22.7± 0.3
Kidney/Urinary Infections	17,598	16,787	17.8± 0.1	16.9± 0.3
Cellulitis	16,169	15,963	16.3± 0.1	16.1± 0.2
Diabetes	14,034	14,592	14.2± 0.1	14.7± 0.2
Asthma	14,609	13,090	14.8± 0.1	13.2± 0.2
Grand Mal & Other Epileptic Conditions	7,794	8,142	7.9± 0.1	8.2± 0.2
Dehydration	6,473	4,439	6.5± 0.1	4.5± 0.1
Gastroenteritis	3,948	4,087	4.0± 0.1	4.1± 0.1
All Other Ambulatory Care Sensitive Conditions	90,826	89,104	91.8± 0.3	89.9± 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*.

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

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 2014, 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.

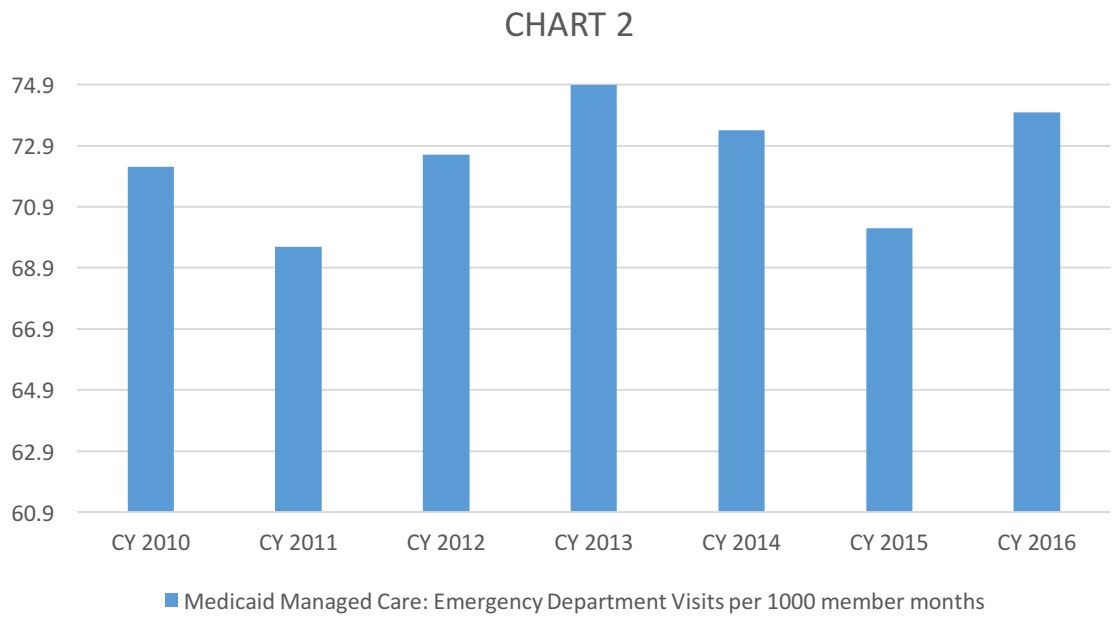
This point was highlighted in a release of a study in the January 23, 2013 issue of the *Journal of the American Medical Association (JAMA)*. This study illustrated that hospitalizations and re-hospitalizations among Medicare patients declined nearly twice as much in communities where Quality Improvement 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 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 visit—suggesting considerable savings may be realized. What can be done?

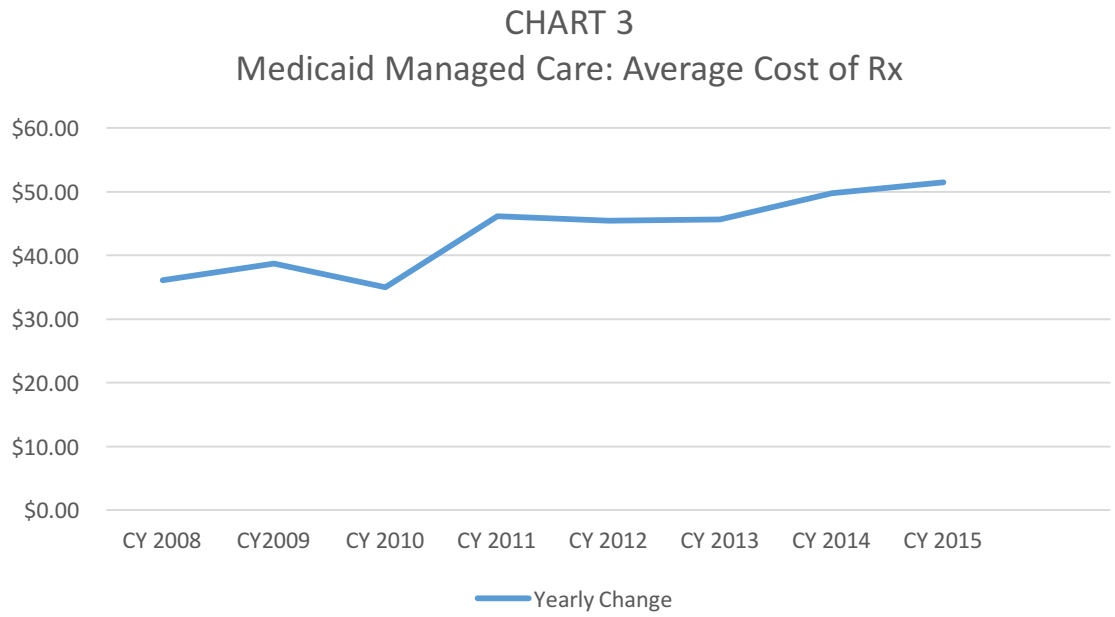
Steps are already underway for some solutions in reimbursement and primary care improvements (Patient Centered Medicaid Homes, extended hours for primary care offices, and additional use of tele-health. Additional steps to be considered may be in performance based standards for health plans, incentives 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 3 and 4 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 4, 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 ($57 billion nationally and growing). 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.

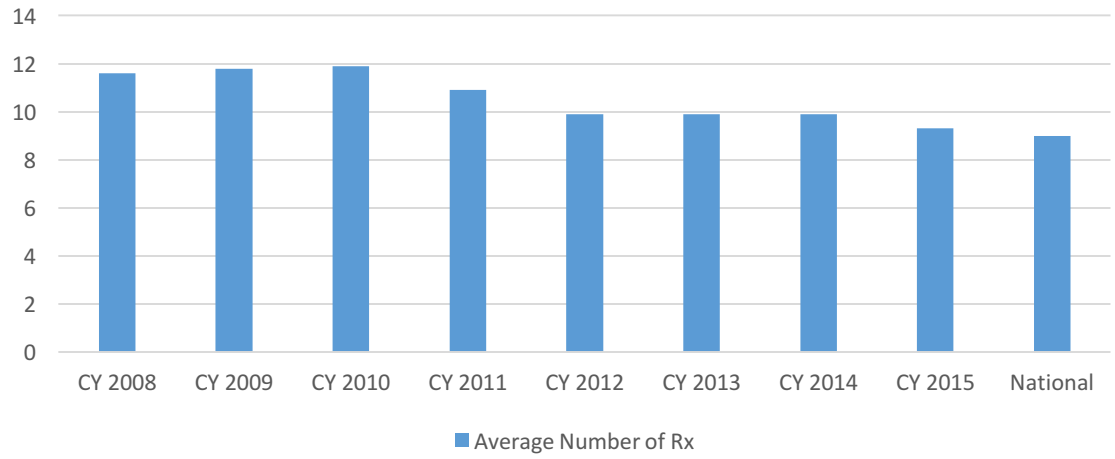


Some of the costs for specialty drugs show up as medical expense due to the setting in which it is provided, which may not be accurately accounted for in rate development. Some additional strategies include contracting with specialty drug vendors and re- tooling pharmacy claims processing systems with 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. As you can see below, pharmacy expenditures continue to rise at an alarming rate.

Medicaid FFS RX Expenditures		
Fiscal Year	Actual Expenditures	Change year to year
2013	$248.4 million	
2014	$263.7 million	5.8%
2015	$268.0 million	1.6%
2016	$319.4 million	16.0%
2017	$537.5 million (allocated)*	40.0%

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. According to the most recent Performance Monitoring Report produced by MDHHS, Adult Generic Drug Utilization for Managed Care members was at 84.47% compared to the Fee-For-Service rate of 44.79%.

CHART 4
Medicaid Managed Care: Average Number of Rx per member per year



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.

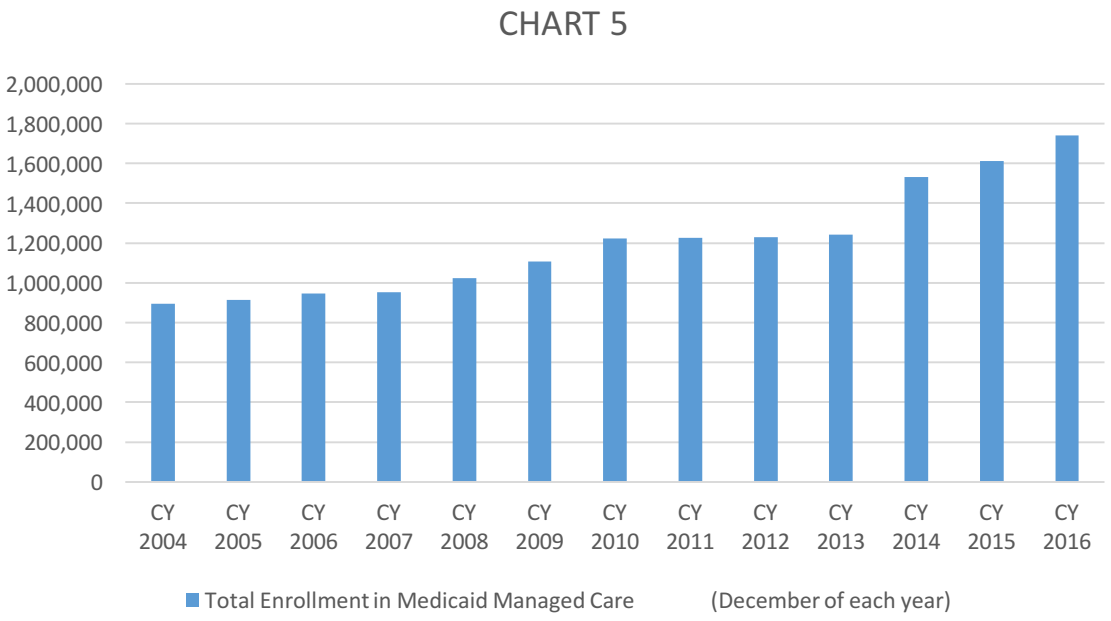
Recent History

Through competitive bidding (that began in 1997 in SE Michigan; in 1998 for the remainder of state; 2000, 2004, 2009 and 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 5 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.



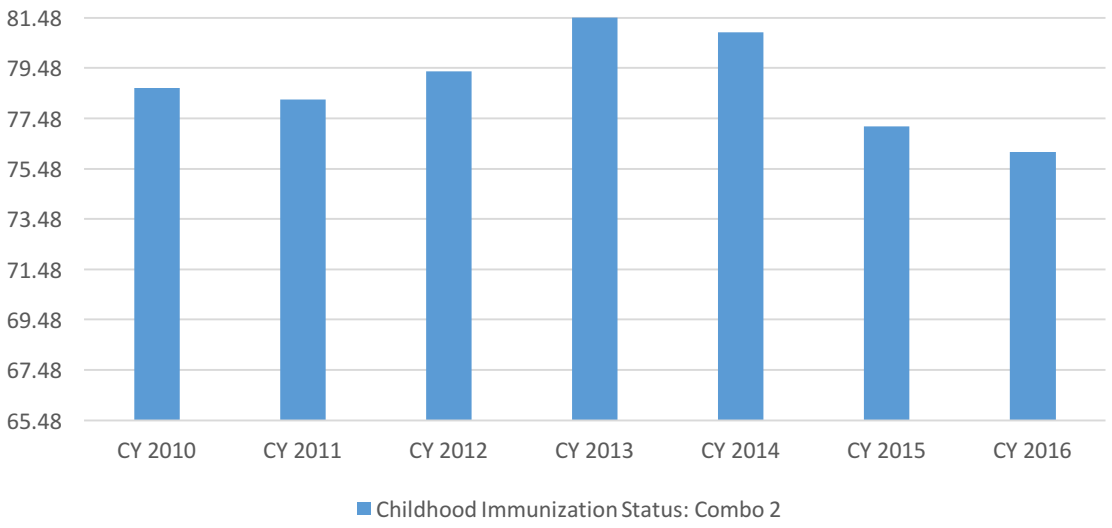
Is there opportunity to extrapolate the principles of managed care to other segments of the Medicaid program? The answer to that question is "yes," most notably in long-term care, which is an expectation in the Healthy Michigan Act.

The Medicaid beneficiaries enrolled in managed care (see Chart 5) 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.

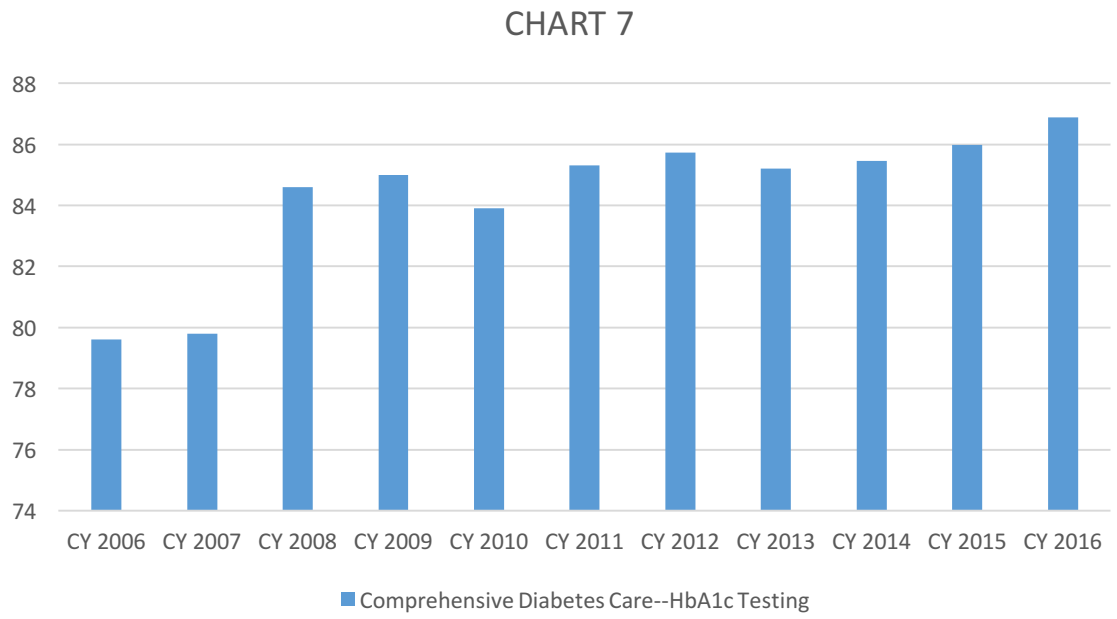
There are five major elements to the Medicaid managed care program that give meaning to "accountability." The first element is the use of audited data related to the clinical quality of care. Among the sources for this is the data developed for the National Committee on Quality Assurance (NCQA). This 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.

CHART 6



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 diabetes. As Chart 7 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 8 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 9 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 to last trimester, and the enrollment process (under current system) may take another 60 days. This often results in little to no prenatal care as well as continuity of care issues in the pregnancy and for the care of the newborn after delivery.

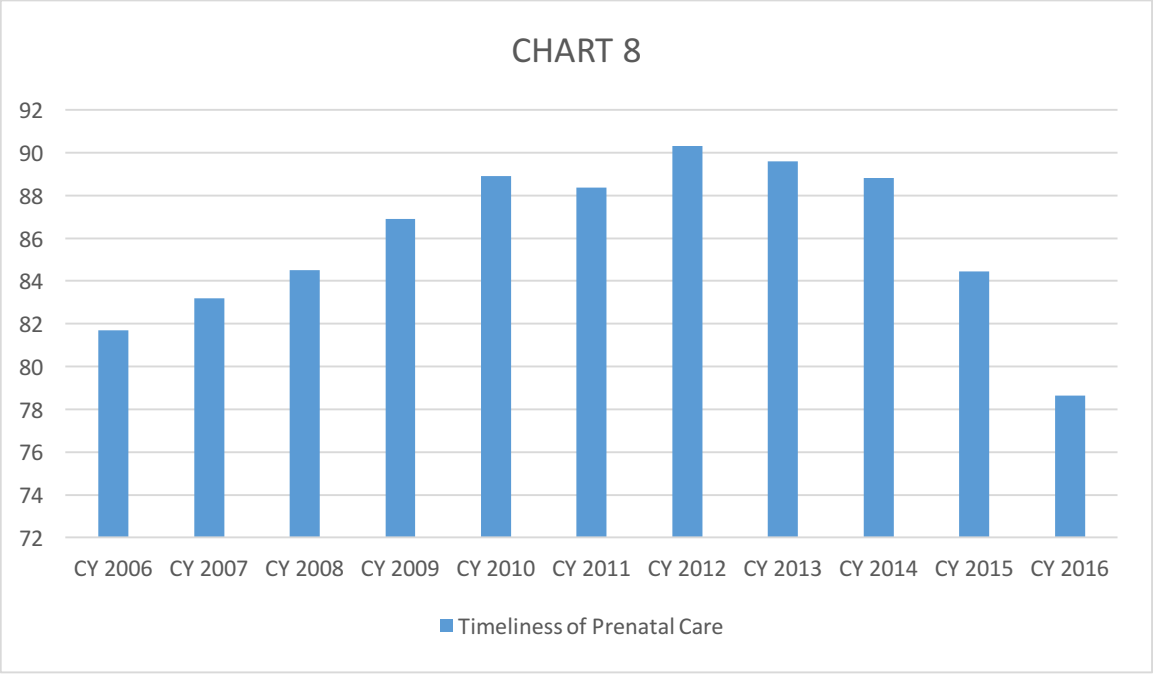
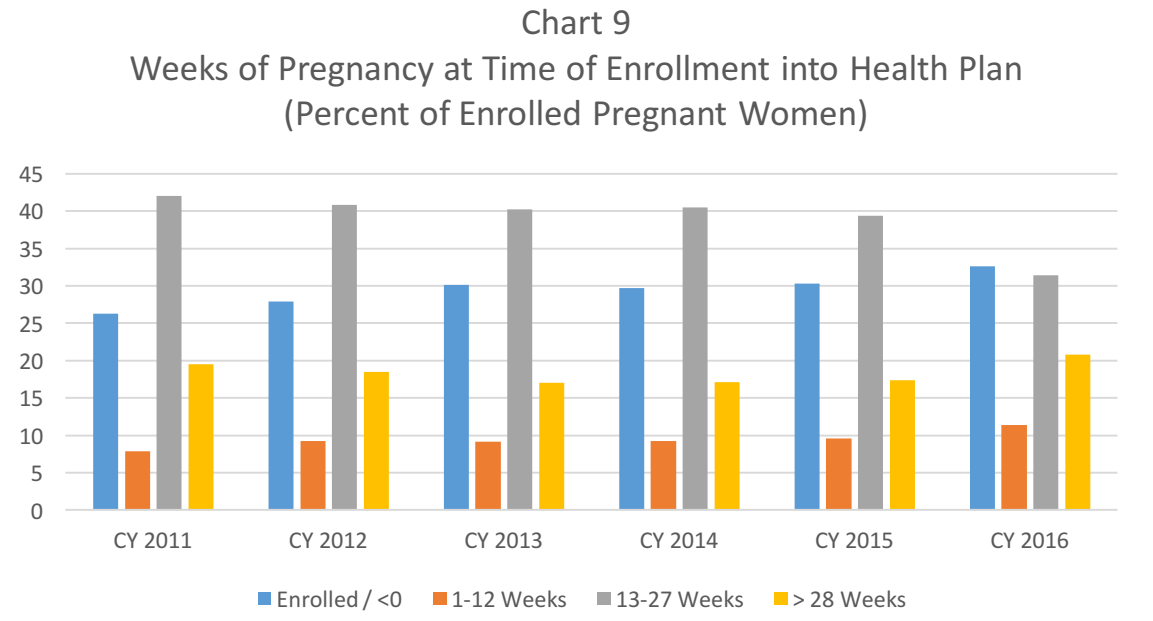


Chart 9 provides the latest data on enrollment of pregnant women. While these numbers are improving, efforts to address Michigan's infant mortality will depend in large part to moving the percentages toward first trimester enrollment.

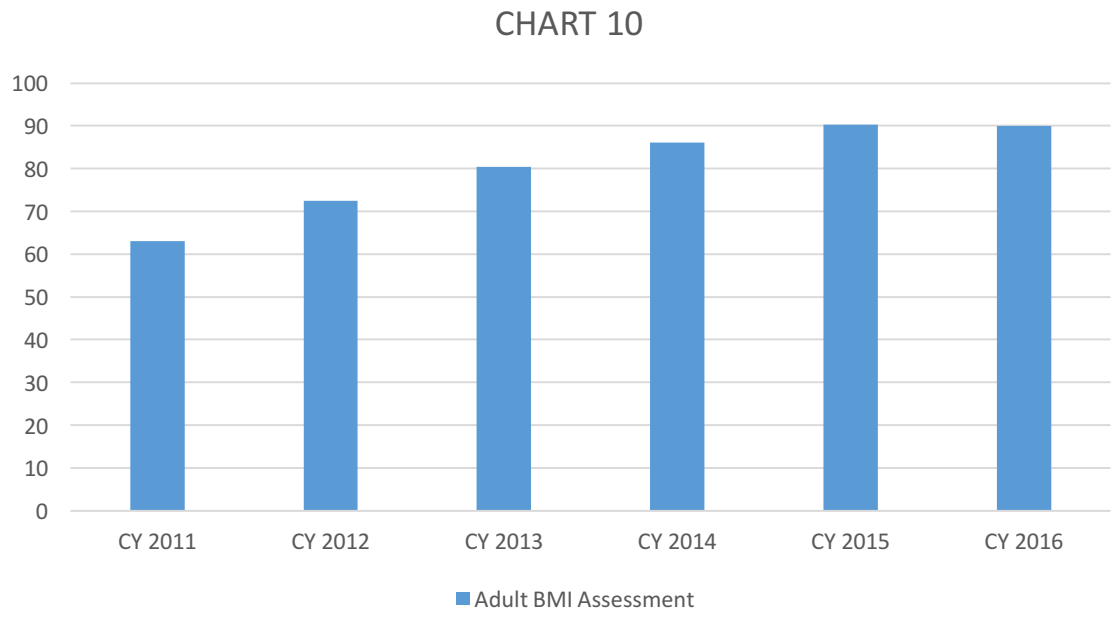


Finally, and consistent with Governor Snyder's dashboard objectives for obesity and health and wellness in Michigan are two performance measures: the measurement of the percent of adults who have their BMI documented during a physician or ambulatory encounter during the enrollment year and the measure of adults receiving assistance for stop smoking.

As illustrated in Chart 10 below, significant 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

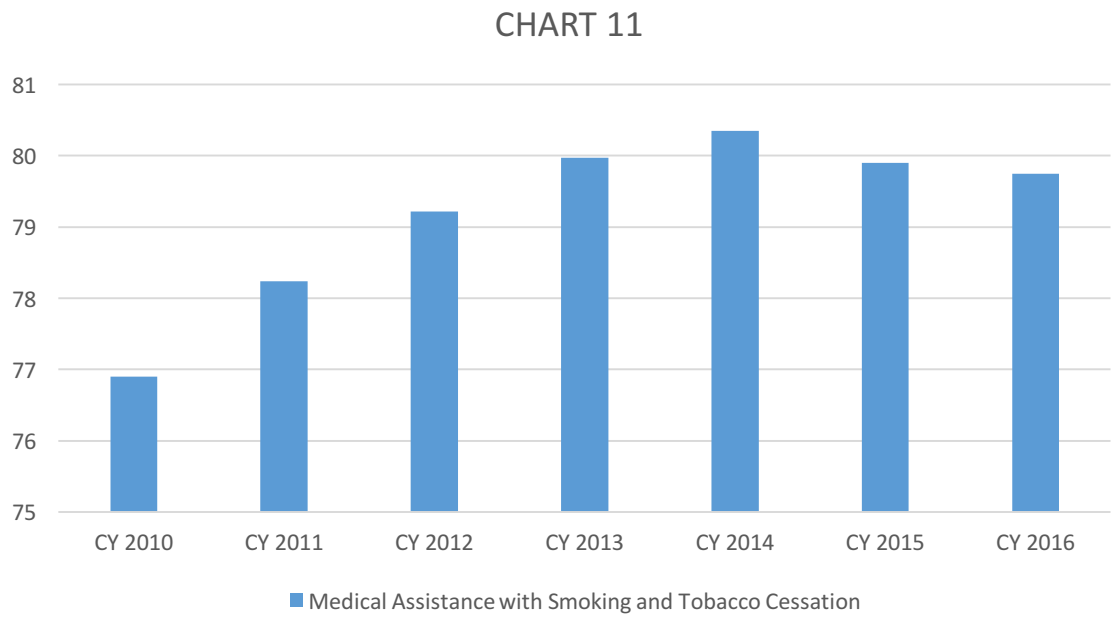


Michigan continues to have too high of percentage of adults who smoke. According to the U.S. Surgeon General, "Smoking cessation [stopping smoking] represents the single most important step that smokers can take to enhance the length and quality of their lives." As is well documented, smoking is associated 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 40 and 5 of top 60 plans in the United States as recognized by the NCQA in based upon performance scores.
http://healthinsuranceratings.ncqa.org/2016/Default.aspx

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.

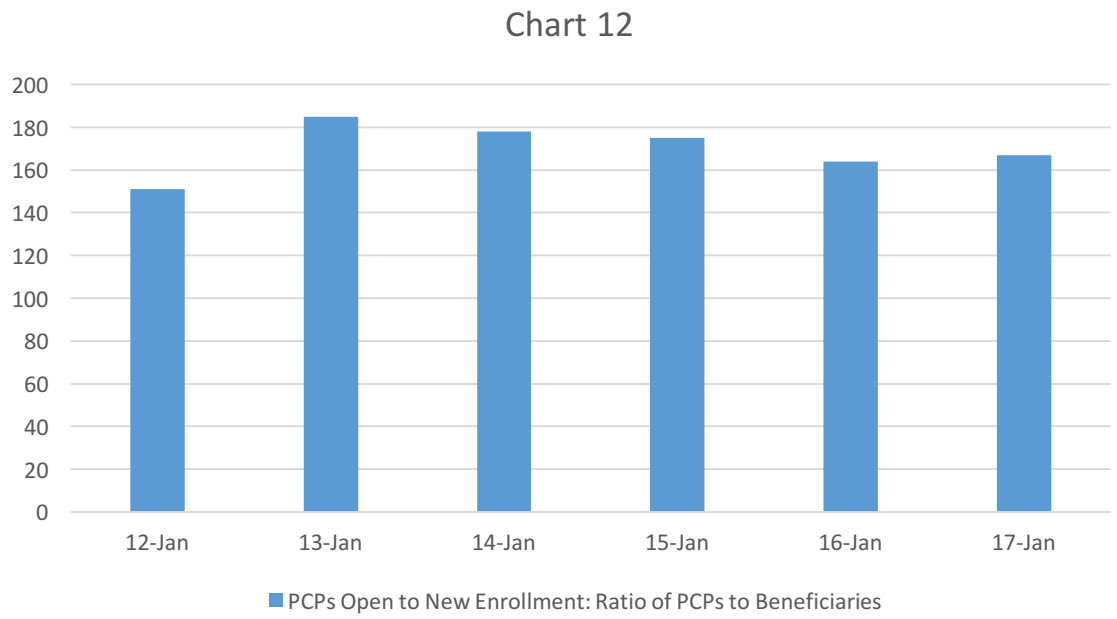
Additional accountability is provided through:

- 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, OIG 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.

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." As shown 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 12 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 1:500.



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.

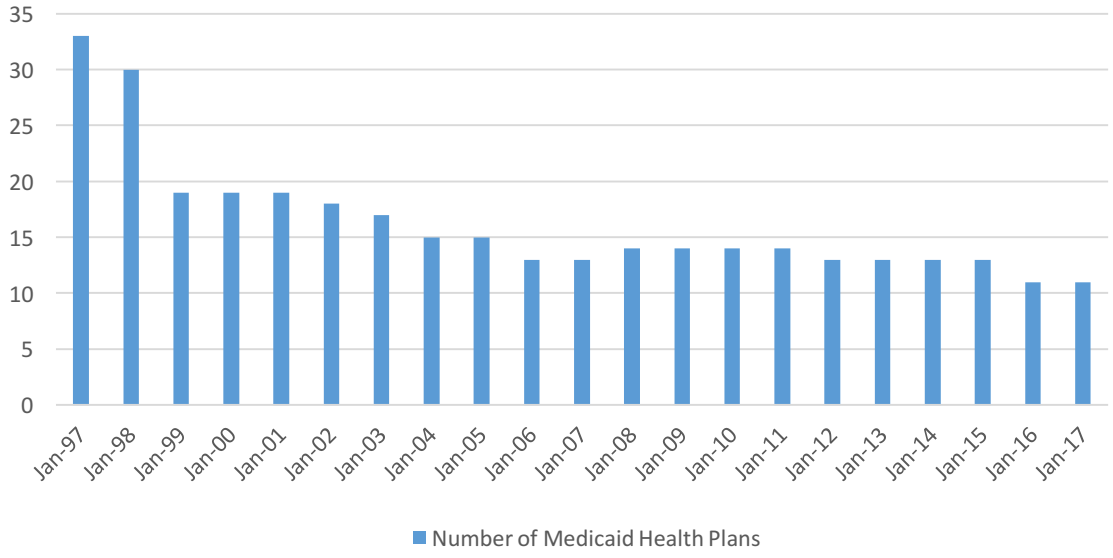
Administrative functions are built into state contract.

To gain cost predictability and control without sacrificing medical benefits and to improve quality, the state engaged Medicaid health plans *to perform functions that had previously never been performed for Medicaid beneficiaries*. The underlying administrative infrastructure that is required for each HMO must be understood as critical to their ongoing performance and part of what insulates the state from open-ended expenditures. More simply put, it is this structure that continues to generate the state's savings realized through Medicaid managed care.

Administrative costs savings have been created through efficiency in operations and continuous quality improvement practices. Because the state's contract allocates the number of approved plans for each of the ten regions, the number of health plans selected in each region is limited to the capacity sought by the state. That capacity is established each time the contract is bid as illustrated in the graph below.

Historically, in the Medicaid fee-for-service program, the state's major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed either as to unit or utilization cost increases and as a result, state budget expenditures increased significantly from year to year and were unpredictable. Additionally, the state under fee-for-service does not provide case management services to managed high-cost cases and facilitate improved health outcomes.

CHART 13



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 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.

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 throughout this 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 development and implementation of policies addressing "waste" in our health system.** There has been 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. 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 state and federal requirements.

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
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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
Administrative Cost: Beneficiary Services-Member Information	• Member Enrollment Packet (Welcome letter, IC 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 disenrollments
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, Waste and Abuse policies and activities • Development and distribution of Clinical Guidelines • Profiling and reviewing physician practices for quality measures
Administrative Cost: HMO Public Accountability	• Data Reporting to the Department of Health and Human Services o Utilization of Services (Encounter Reporting-Monthly) o Paid Claims (Monthly) o Grievance and Complaints (Quarterly) o Data Quality Improvement Reviews (Semi-Annual) o Provider Network (Monthly updates) o Physician Incentive (Annual) o Litigation Reporting (Annual) o Fraud, Waste and Abuse (including TPL activities) (Quarterly) • 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, MDHHS and OIG • External Accreditation from a National Organization
Administrative Cost: Provider Services	• Provider Hotline and other provider communications • Provider Manuals, Education, Orientation and Training • Administration of Provider Complaints and Appeals • Electronic Billing Capacity • Coordination of Benefits Activities • Physician and Provider Profiling Reports • Implement all Information Technology Solutions, including ICD-10 and MiHIN

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. Medicaid Health plans providing services to about 80 percent of enrolled beneficiaries are affected by this tax. Congress acted to suspend this tax for CY17. However, absent federal action the moratorium will expire 12/31/17.

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**.** Estimates for FY18 show the potential cost to the state around $170 million gross ($40 general fund). 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. MAHP continues to support federal legislation which would repeal the tax indefinitely.

References/Citations on Actuarial Soundness

1. **2002. Federal Rules,** 42 CFR § 438.6(c)
2. **August 2005, HEALTH PRACTICE COUNCIL PRACTICE NOTE, ACTUARIAL CERTIFICATION OF RATES FOR MEDICAID MANAGED CARE PROGRAMS, Developed by the, Medicaid Rate Certification Work Group of the American Academy of Actuaries**
3. **2007, Medicaid Policy Bulletin, MSA 07-34, Medicaid Health Plan Rate Development and Certification**
4. **2013. PA 107 of 2013. Healthy Michigan Act. (Section 105d (14))**
5. **2013. December 2013, Exposure Draft, Developed by the Medicaid Rate Setting and Certification Task Force of the Health Committee of the Actuarial Standards Board, American Academy ofActuaries.**
6. **January 2014 Update: ACA Health Insurer Fee, Estimated Impact on State Medicaid Programs and Medicaid Health Plans**, Prepared for: **Medicaid Health Plans of America** by **Milliman, Inc.**

ATTACHMENT 4

MINORITY REPORT AND COMMENTS REGARDING
SECTION 298 BOILERPLATE DRAFT INTERIM REPORT TO THE LEGISLATURE

I. Overview

Movement Toward a Comprehensive Model—Why Section 298 Evolved.

Managed care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with managed care organizations (MCOs) to provide all or some physical health benefits for beneficiaries Although the Medicaid population has a complex array of behavioral and physical needs and high associated costs, many are served in fragmented systems of care with little to no coordination across providers, often resulting in poor health care quality and high costs.

Increasingly states are seeking ways to better coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization. One strategy gaining traction is the move to integrate behavioral health services within a comprehensive Medicaid managed care environment that traditionally covered physical health services only.

More states in recent years have adopted integrated payment and delivery models that cover all or some combination of physical, behavioral health, long-term services and supports (LTSS), and other social supports needs. A rapidly growing number of states are adopting managed care models in which a single entity is responsible for both behavioral and physical health services, thus "carving-in" behavioral health services.

As of January 2016, 16 states currently provide or are planning to offer behavioral health services through an integrated managed care benefit — up from just a handful a few years prior. By combining physical and behavioral health services in a comprehensive managed care arrangement, Medicaid programs can align system incentives and increase accountability for managing a more complete range of services. In doing so, states can provide more seamless care for beneficiaries.

To be sure, administering integrated systems of managed care for high-need beneficiary populations is a complex undertaking. These programs require: (1) specialized clinical expertise at the health plan level; (2) state capacity for robust oversight and monitoring; (3) innovative strategies for advancing whole-person care to address beneficiaries' complex needs; and (4) mechanisms for achieving and maintaining provider and other stakeholders'

support.

Creation of Section 298

With the above commentary as backdrop, the Snyder Administration recommended that Michigan join many of the other states and develop a more comprehensive approach for serving all of the physical and behavioral needs of the Medicaid beneficiary in an integrative manner. Unfortunately, the proposed changed took form in the executive budget for fiscal year 2017 without significant and meaningful prior public discussion and review.

As we know, many interest groups objected to the proposal. This led to a creation of an ad hoc group convened by Lt. Governor Calley. Several representatives of Medicaid Health Plans were represented on this group as well as the Michigan Association of Health Plans. The total membership (in excess of 100) of the Calley Group was dominated by behavioral interest representatives (consumers and providers) and the final "Calley Report" recommendation reflected that bias.

It is important to note that while there was value in the production of the "Calley Report", the legislature was not seeking to endorse the report—and they did not. Rather, the legislature adopted replacement boilerplate to that proposed by the Governor that would inform and guide the legislature on a future path toward integration through MDHHS and the Section 298 Facilitation Workgroup. It is important to note that while the membership of the Facilitation Workgroup is significantly less than the Calley Group, it continues to represent the bias of behavioral health interest. The workgroup consists of twenty-three voting members, with the following make-up:

- three individuals representing private behavioral health providers who currently contract with the existing PIHP and CMHSP financing model
- three individuals representing the existing PIHP and CMHSP financing model
- three state employees
- eight behavioral health advocates
- one Medicaid Health Plan representative
- one Association of Health Plans representative
- one Hospital representative
- one Hospital Association representative
- one representative from the Primary Care Association
- one Tribal representative

It is the provisions of this Boilerplate (Section 298) that the current draft recommendations are based upon. A quick review of the Boilerplate requirements will help the reader understand if the intent of the legislature has been achieved:

Boilerplate Provision	Response	Comment
The department shall work with a workgroup to make recommendations regarding the most effective financing model and policies for behavioral health services	A much smaller group (about 20) than the 100+ Calley Group was convened by MDHHS and met the compositional requirements of the boilerplate. MDHHS had "voting" members on the group as well as staff.	MDHHS determined that the workgroup would make decisions; a voting or consensus process was followed for the most part.
The workgroup shall consider the following goals in making its recommendations: • ***Core principles of person-centered planning, self-determination, full community inclusion, access to CMHSP services, and recovery orientation.*** • ***Avoiding the return to a medical and institutional model of supports and services for individuals with behavioral health and developmental disability needs.*** • ***Coordination of physical health and behavioral health care and services at the point at which the consumer receives that care and those services.*** • ***Ensure full access to community-based services and supports.*** • ***Ensure full access to integrated behavioral and physical health services within community-based settings.*** • ***Reinvesting efficiencies gained back into services.*** • ***Ensure transparent public oversight, governance, and accountability.***	Universal agreement on core principles Total Agreement among group Point of service coordination Part of Mental Health Code Agreement on this point by all Objective of the recommendations Agreement	These principles have evolved in all of managed care and are part of the requirements of the new Managed care rules Many believe point of service is part of the continuum of integration but not end point. Integration provides that single point of accountability
The workgroup's recommendations shall include a detailed plan for the transition to any new financing model or policies recommended by the workgroup	Not Included	Any Transition plan toward integration requires this.

The workgroup shall consider the use of 1 or more pilot programs in areas with an appropriate number of consumers of behavioral health services and a range of behavioral health needs as part of that transition plan.	Not Included….Intent is to solicit for inclusion in supplemental report	Legislature should consider seeking as well.
The workgroup's recommendations shall also recommend annual benchmarks to measure progress in implementation of any new financing model or policy recommendations over a 3-year period and ensure that actuarially sound per member per month payments for Medicaid behavioral health services are no less than the per member per month payments used for Medicaid behavioral health services in the fiscal year ending September 30, 2017.	Not Included	Funding is tied to legislature and revenue. New rules to implement and the change in National Administration may make this difficult.
The department shall provide, after each workgroup meeting, a status update on the workgroup's progress and, by January 15 of the current fiscal year, a final report on the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office.	Report/Recommendation are intended to be submitted by MDHHS on or before January 15th.	

The format and the structure of the Draft Report and Recommendations however is based on the Calley Report Design elements and provides a method to link the work of the CalleyWorkgroup to that of the Section 298 Workgroup.

I. General Commentary of Document

Because of timing and delays in reaching this set of recommendations the draft report that was circulated for public comment **did not include the following**:

- Any proposed new or revised pilot or demonstration model to pursue;
- Any fiscal note that describes the cost and/or savings of any of the recommendations;
- Any discussion regarding operational issues/concerns; and of course
- Any discussion on potential impacts to the overall Medicaid program and thereby these recommendations of federal reform on Medicaid that may be adopted by the Trump Administration.

That does not diminish the value of the recommendations if the reader sees the set of recommendations as a series of consumer driven and designed elements for delivering behavioral services. In that sense, this is extremely valuable report and the recommendations should be part of the new vision for service delivery by any publicly or privately supported program.

The one clear message from the report's summary of findings from the various stakeholder (affinity group) meetings is that the status quo is unacceptable.

While not discussed in any detail during the workgroup meetings, there was an understanding that there will be significant and dynamic change taking place in Medicaid over the next year— many of the changes were taking place regardless of the national election. However, the future direction of Medicaid is now part of the national discourse. Therefore, we believe that the reader should also be aware of the underlying context of the recommendations as noted in the selection below from the Report—a caveat that MAHP endorses:

> **Preface to Recommendations:** ***The workgroup recognizes that the following recommendations are being made during a time of dramatic change and extraordinary innovation in health policymaking. The workgroup acknowledges that the recommendations may be affected and shaped by substantial changes in federal policy and funding over the next few years. The workgroup also strongly believes that future state policymaking on physical health and behavioral health integration should be informed and guided by the results of demonstrations and pilots, which include (1) demonstrations and pilots that are currently operational and (2) new models that are***

established as part of the Section 298 Initiative. Finally, the workgroup recommends that the State of Michigan make every effort to achieve the goals and fulfill the values that are identified as part of the report regardless of changes at the federal or state level.

This is a prudent and appropriate statement and may in part define why some of the omission from the expectations stated in the boilerplate we noted earlier, regarding fiscal impact, operational detail and related transition steps are not yet in place. We fully expect there will be significant public debate at the national and state level regarding Medicaid, Medicaid Expansion, and funding of Medicaid. The outcome of this debate may fundamentally change the nature of how Michigan and other states approach the Medicaid program.

We would also argue that reasonable pilot and demonstration projects make more sense in this environment and will encourage our members and those interested groups to make well thought out suggestions for integration and how that may be tested.

The boilerplate clearly calls for consideration of Pilot/demonstration models. **The report does not yet include such recommendations.** It is also unclear at this time how they may be solicited or evaluated for its inclusion and whether that should be a responsibility of the MDHH to do the technical aspects of review and evaluation that go into pilot development and administration.

II. Specific Recommendations and Objections by MAHP

The Michigan Association of Health Plans has been an active member of the Section 298 Workgroup through attendance, participation in discussion and development of the public process, group facilitation of meetings, and voting to establish the final draft recommendations. In taking the position during this process, MAHP and its members have been very consistent due to a board-adopted position on Integration that governs our comments. The principles of the Board position and consistency with the many of the draft recommendations are noted below:

MAHP recommends that Behavioral Integration must be inclusive of:

- Recommended core values developed by consumer Stakeholder process; (Included in the draft Recommendations)
- Requirements for core principles of person-centered planning, self-determination, and recovery orientation; (Included in the Draft Recommendations)
- Provisions to assure continuity of care for consumers of behavioral services during any transition and avoidance of disruption of services and supports; (Included in

the draft Recommendations)

- A definition of Integration at both the service and pay payment level; (Point of service integration included—payment level recommendations for integration are not included)

Under a new MDHHS Integrated Contract, MAHP expects that Medicaid Health Plans will:

- Have a fully contracted behavioral health provider network consistent with the requirements of the Mental Health Code. (Consistent with the draft recommendations)
- Explore innovative reimbursement models for value-based contracts, credentialing, care coordination and quality incentives. (Consistent with the Draft Recommendations)
- Support consumers living in the homes of choice and fully participating in their communities across their life-span (Consistent with the draft recommendations)

MAHP Recommends that MDHHS assure progress toward full implementation of Integration through:

- Annual benchmarks to measure progress toward complete implementation of Medicaid payment and system integration by September 30, 2020; (Boilerplate requirements as well—not included in the draft report)
- Assurance that no less than the resources used for Medicaid behavioral services in fiscal year 2016-2017 continued to be allocated for such purposes on a go forward basis. (Consistent with Boilerplate and Draft Recommendations)
- Promotion of incentives for early adopters. (Not included in draft recommendations)

MAHP Objections to Specific Draft Recommendations

The deliberation of the Section 298 Workgroup was to seek consensus. By definition, that means not unanimous and on some issues there were strong and opposing positions. Early in the process, representatives from several of the advocate groups took an approach to "walk out" when the "consensus" approach didn't work for them. Others, including MAHP could have chosen the same path to emphasize points—but chose to continue to participate within the workgroup structure. Early discussion also led many to believe there would be a section of the report to reflect a minority view of the recommendations. However, at the end, MDHHS indicated there would be no minority report within the submitted document to the Legislature— but members were absolutely free to submit their views. In that vein, the following specific points are being raised by MAHP regarding several of the report's

recommendations.

Objection to Recommendation # 1.1

This section initially proposed to move the "mild to moderate" behavioral benefit currently provided by Medicaid Health Plans to PIHPs and to adopt language that would permanently secure support for a publicly funded and governed delivery system for behavioral services. That approach would fundamentally eliminate any flexibility to consider the use of other delivery systems, such as those administered by Medicaid Health Plans. Further, the initial draft recommendation to move the "mild-moderate" benefit violates one of the sections of the Boilerplate regarding transfer of programs and funds.

> **T**hrough joint agreement, and in recognition of the overall "preface statement" a recommendation was proposed by MAHP and MACMHB that would minimize disruption and sustain current funding streams for both systems at this time. Further, there was joint agreement, to extend that recommendation to sustaining the public system for NON- MEDICAID services, and support for further point of service coordination. It was understood that the recommendation for movement of mild-moderate recommendation was to be deleted. This recommendation would then give time for the public debate on Medicaid to take shape as well as the selection of various pilots and demonstration models and implementation before final determination of overall administrative models.

While most of the proposal by MAHP/MACHMB was agreed to, the final version for the draft report extended the recommendation of sustaining a public system for Medicaid as well as "Non-Medicaid". It is this point that is contrary to the agreement reached with MACMHB in our recommendation as this "clarification" would appear to lock-in a public model and limit the future discretion of the Legislature and future administrations.

Objection to Recommendation # 4.1

This is a recommendation, curiously labeled, "Protection for mental health and epilepsy drugs" that if implemented will do the opposite. For that reason and more, MAHP opposes the inclusion of this recommendation. To be very clear, we believe that all consumers should have access to the psychotropic and epilepsy pharmaceutical products as they do today. Our objection is related to seeking further legislative provisions to limit the ability of health plans to managed those products. Those supporting this recommendation are very clear that their intent is to extend to all of Medicaid the prohibition on the use of any prior authorization or utilization management technique employed by

those responsible for the management and payment for these products. We believe that position is misguided and not consistent with sound health policy.

The rapid increase in pharmacy costs over the past several years continues to "crowd out" services and benefits that would be otherwise available to meet consumer needs. Extending the current prohibition on prior authorization for all Medicaid programs and services is a budget-busting proposal. Hundreds of millions of dollars have been spend on psychotropic products in Medicaid over the past decade since the limit on prior authorization. There has been no evaluation of this policy, nor a review of future cost exposure. MAHP believes at the very least this assessment should take place and if any legislation should be introduced it should be to assure the provision of all of the pharmacy benefit with the prudent administration of prior authorization requirement. For those currently receiving the pharmacy benefit, this can be accomplished and coupled with "grandfathering" of the current prescriptions for those currently on Medicaid.

Because of the diminishing revenue available to support Medicaid, if the legislature and the administrative do not take action on the overall pharmacy pricing and management, the limited resources that are expected to be available for Medicaid will be consumed by just this benefit. We believe it is time to review this issue in the context of the hundreds of millions of state resources being used (which crowd out other purposes of those dollars). Further our concern is that any further legislative action may enable other pharmaceutical classes from being identified as protected and eliminate health plan ability to manage the benefit.

Objection to Recommendation #9.1 & 9.2 & 9.3 & 9.4

The recommendations in this section focus on several key issues related to health information sharing. We appreciate that this was an issue raised by many consumers and providers during the affinity group meetings. Rightfully so, the state of Michigan must address the ability to communicate "informed consent".

There are strong differences from a consumer perspective (as expressed by the advocate groups) and those representing provider groups and the recommendations did not find consensus. Therefore, we continue to believe this is a problem still in search for a solution and the report highlighted the various views. This section will need further work before any meaningful recommendations can be established.

Objection to Recommendation # 11

The objection by MAHP to the recommendations in this section is not related to those included in the report as they are well stated. The objection relates to the failure of the report

to address recommendations that were raised in affinity group meetings, and other submissions regarding the need to have the overall administrative structure of MDHHS organized to manage an integrated benefit.

While the recommendations in this section focused on the all too many layers that consumers find in navigating through the behavioral system they do not address the need for overall assessment to arrive at an administrative simplified structure that will enable the type of state oversight desired and assessment of performance by contracting entities. There is the recognition that MDHHS is still working through the initial reorganization from the merger of MDCH and MDHS but this administrative feature is the nexus to achieving any of the recommendations in the report.

Objection to Recommendation #12.1

As this section of the report surfaced, critical concerns of benefit uniformity appeared. That is, the need to assure that the same Medicaid benefit is being offered across the state and not simply a facet of that some consumers received services and others didn't due to geography. On that point, MAHP agrees.

However, the initial recommendation focused also on an aspect of access to care that inappropriately raised expectations of consumers and would place providers in a defensive posture. This was a recommendation to have "on demand" services—not just for the behavioral program but also for all Medicaid services.

Of course all consumers want to have access for services at the point they need them—however, provider supply, scheduling, and resources are reality. Those consumers in the commercial and Medicare environment face this reality as well and Medicaid – on this point – should be no different.

What is necessary and essential is to assure that urgent and emergency services are available 24/7—that is required under current contracts, that is required under federal rule and that principle should not be questioned. MAHP was successful in amending those recommendations to assure that "on demand" only referred to urgent/emergent care, but felt this issue of sufficient importance to include in this document.

Objection to Recommendation #13.1

The recommendations initially focused on "risk incentives" and fears of the advocate community that incentives would drive providers and payers away from serving needs of beneficiaries. That is, incentives are used to deny services or access to care. The final set of recommendations tied the use of incentives to contract requirements. While MAHP believes

this is an appropriate recommendation that we supported, we also believe that several underlying issues continue to be erroneously used. This includes the discussion on "risk".

Medicaid Health Plans operate under "full risk" contracts with the state of Michigan. This means that not only must they accept all the enrollment of Medicaid beneficiaries into their health plans; they must also cover 100% of the cost of their health care.

Performance in this area is rigorously reviewed and monitored through performance contracts and capitation withholds.

To be successful, Medicaid health plans must quickly identify the health care needs and conditions of their enrollee and develops coordinated care management plans. Otherwise, the beneficiary will seek services in the most expensive setting after opportunities for prevention and maintenance are gone.

This is absolutely contrary to the "myth" communicated by several that Medicaid health plans avoid risk. It should be noted that Prepaid Inpatient Health Plans do not have full risk contracts with the state as they are not licensed by the state, do not have financial reserves to guard against insolvency and are prohibited (under the Insurance code) to enter into such arrangements. Instead, MDHHS has shared risk arrangements with PIHPs.

The use of incentive programs and contracts between the state and Health Plans also extends to the same type of incentives built into provider contracts that stress performance objectives. This was a key feature included in the expansion of Medicaid— the Healthy Michigan Plan.

MAHP Summary and Considerations for Next Steps:

1. The Section 298 Report is a good representation by consumers of the failures within the current system. "Status quo not acceptable". However, by all measures, the "report" is not yet a roadmap for integration.

2. We agree with others, including consumer groups who have commented that the report does not address the administrative or financial solutions necessary to take the next steps nor does it give a road map yet for how pilot or model programs can be selected and used.

3. Several specific recommendations are noted by MAHP as either being inappropriate, or through final drafting, created an acceptable—but not preferable approach. We must do better and MAHP encourages the Legislature to consider the MAHP commentary on those points.

4. As others will do, MAHP is encouraging members to communicate to MDHHS and the legislature proposed models and pilots. This is healthy and part of an innovative phase that should be embraced. We have seen several of the proposals from members and are encouraged by the direction and comprehensive of approach as we encourage the legislature to view them in that direction as well.
5. The preferred future role for the Section 298 workgroup is to recommend a common format or template for organizations to submit model/pilot proposals. Once the pilot/models have been received by the MDHHS within a prescribed time frame, they should be included in the second report submitted by MDHHS to the Legislature. Neither the MDHHS or the Section 298 workgroup should screen or eliminate for consideration any proposal submitted at this time.
6. It is recommended that the Legislature create incentives for "early adopters" in the approval of models/pilots that include system and payment integration as well as clinical integration.
7. MAHP will collaborate with others in working through the dynamics of new Medicaid mega rule, Medicaid payment reform, and population health initiatives and will encourage a healthy dialogue with the legislature on the future of Medicaid. This will start with a "Medicaid 101" series in early February that MAHP is sponsoring and hosting at the State Capitol. All of these individually and collectively will influence future delivery of Medicaid and the behavioral benefit within Medicaid.
8. Finally, while no one wants to repeat the countless sessions that took place by the Section 298 workgroup, there has been much goodwill that has been generated by this process. It is important for dialogue to continue into the future in some sustained fashion and foster the change that must take place.