Performance, Value, Outcomes: Medicaid Managed Care

FY 2016-2017

The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

Executive Summary

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RECOMMENDATIONS FOR FY 17 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 supports 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 **repurpose all of the revenue generated by the use tax** paid by Medicaid Health Plans to explicitly cover non-Medicaid services and coupled this change with continued support of HICA at an effective rate of no higher than 1% (if no use tax is collected and no higher than 0.75% if use tax revenue continues to be collected.

3. The State of Michigan should continue efforts to **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:

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

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

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

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

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

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

II. Access/Capacity/Choice for Beneficiaries Recommendations

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

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

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

   a. Operationally, creating a default eligibility and enrollment for newborns to be assigned to the same Medicaid health plan as the mother at the time of birth (consistent with the terms of the Medicaid contract).
   b. Delink Medicaid application from other human services program applications in order to accelerate Medicaid eligibility and enrollment.
   c. Reform the redetermination process, particularly for those in long term care facilities and other institutional settings to assure no loss of eligibility and continuity of care.
   d. Begin a process to reform the criteria 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

8. The State of Michigan should continue its efforts in **streamlining and coordinating the administration and oversight** of Medicaid Health Plans and related contracted entities. This may include such options as:

a. Reduce and/or eliminate paper requirements in lieu of electronic documents and web-based information sites and begin using "deemed compliance" by virtue of national accreditation such as NCQA or URAC;
b. Consolidating the internal program administration and coordination of the Integrated Services Plan for the Dual Eligible, MI CHILD, Healthy Michigan Act and traditional Medicaid managed care program under a single administrative program.
c. Changing the regulatory perspective to a "regulation by exception"—that is a focus on those who are performing below standards established in the contract.

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

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

EXECUTIVE SUMMARY DISCUSSION

The Michigan Association of Health Plan's Board Adopted Vision for 2020 is to have improved coverage, access, value and choice for the State's population to be achieved through improved competition within the industry, and demonstrated continuous quality improvement in key health status areas for Michigan residents. To implement this vision and promote the growth and sustainability of our managed care system, critical objectives are necessary at the beginning and through the program's duration. These objectives align with those of the State to achieve value and continue to raise the "performance bar" for improved outcomes from Medicaid Health Plans.

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

Value in Managed Care

Without dispute, there continues to be an estimated savings each year due to the Medicaid Managed Care program compared to offering the service through a fee for service program. This savings has now yielded over $**6 billion in total savings to state taxpayers** between FY 00 and FY 16 or over $400 million each year. The savings reflect the cumulative impact of competitive bidding, performance contracting, and more efficient and accountable management of health care in a partnership with the state **in exchange for actuarially sound funding**.

This return on investment enables both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas

while preserving access to quality health care services for the vulnerable populations served by Medicaid program.

Of even more value is the **high quality that is the hallmark of managed care**. The continued national high performance ranking of Michigan's Medicaid Health Plans is a testament of the dedicated efforts of each of the health care partners in this arrangement; state administrators who set the standards, providers who deliver the care as part of the provider networks, and contracting health plans who put it all together.

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

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:

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

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

Clearly, there is still much more work to be done. Following the leadership of MDHHS and in partnership with MDHHS, the Medicaid health plans have been very active in working through operational details and enrolling special populations into managed care to improve access, coordinate care and provide more cost effective and accountable care for Michigan's most vulnerable citizens. These special efforts include the following, (most notably the Initiative for persons with Dual Eligibility and implementing the Healthy Michigan Act which will be further described below):

- Completed the transition of enrollment of Children's Special Health Care Services, CSHCS. This began October 1, 2012 and continued well into 2013. While there were bumps along the way, the transition was quite unremarkable due to the tremendous amount of work by the health plans in partnership with MDHHS.

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

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

- Implementation of Integrated Care for Persons with Dual Eligibility. This project is very complicated, taking an enormous amount of finesse and guidance from both MDHHS and the federal government. Implementation began during the first quarter of calendar year 2015 and has been phased in through all four demonstration regions. Issue of enrollment, education and awareness, and technology continue to be outstanding issues requiring further attention.

- Implementation of the Healthy Michigan Act---enacting all of the provisions of Public Act 107. This is an enormously complicated implementation because of the many reforms from the base Medicaid Program and the administrative requirements necessary to meet legislative intent and related federal waiver requirements. With the approval of the second waiver, attention will now focus on outcomes, incentives and appropriate program revisions.

Reform Eligibility

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

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

Streamline and Coordinate Administration and Oversight

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

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

- Continue the identification of areas that can be considered "deemed compliant" as a result of national accreditation and change the focus of contract oversight to raising the performance of those contractors that are under the state average.

- Coordinate efforts for identifying and managing beneficiaries who have high utilization of care, particularly in emergency departments and in pharmacy.

- High level interactions with health plan operational staff and Department staff and consultants responsible for assuring encounter data validity and utility.

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

Maximize non-GF Revenue

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

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

The area of waste is one area that is of concern to all payers. Health care reform cannot truly take place unless the cost of health care is reduced. This will affect Medicare, Commercial and Medicaid services together and solutions should be seen not just as a Medicaid issue but much broader. We know that at many as 20 percent of admissions are for treatment and care that could be provided in a community outpatient setting—IF—such settings and programs were available.

Efforts toward more medical homes and early treatment and interventions—prevention—will also have the benefit of reducing costs. Finally, all citizens, including those on Medicaid need to have incentives to take personal responsibility for managing their own health care. The implementation of Michigan's health and wellness plan—also known as the 4 X 4 Plan is a good start in this effort and the underlying premise of the Healthy Michigan Act has embodied this concept.

Duals Initiative

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

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

Healthy Michigan Plan (Medicaid Reform)

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

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

Summary

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

- **Enrollment of Population Groups into Managed Care Improves care and Saves Dollars**. In addition to the cost savings that the management of this population will realize, the actual care and treatment in a managed environment lends to better and more efficient health care as documented by external auditors and performance contract requirements by the State of Michigan. This point has been well documented by MDHHS and various federal and state audits.

- **Enrollment of Population Groups into Managed Care creates Administrative Efficiencies.** We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools for contract management, a realization of savings to the contractors and thus a savings in the state administrative cost of the contracts would be accomplished.

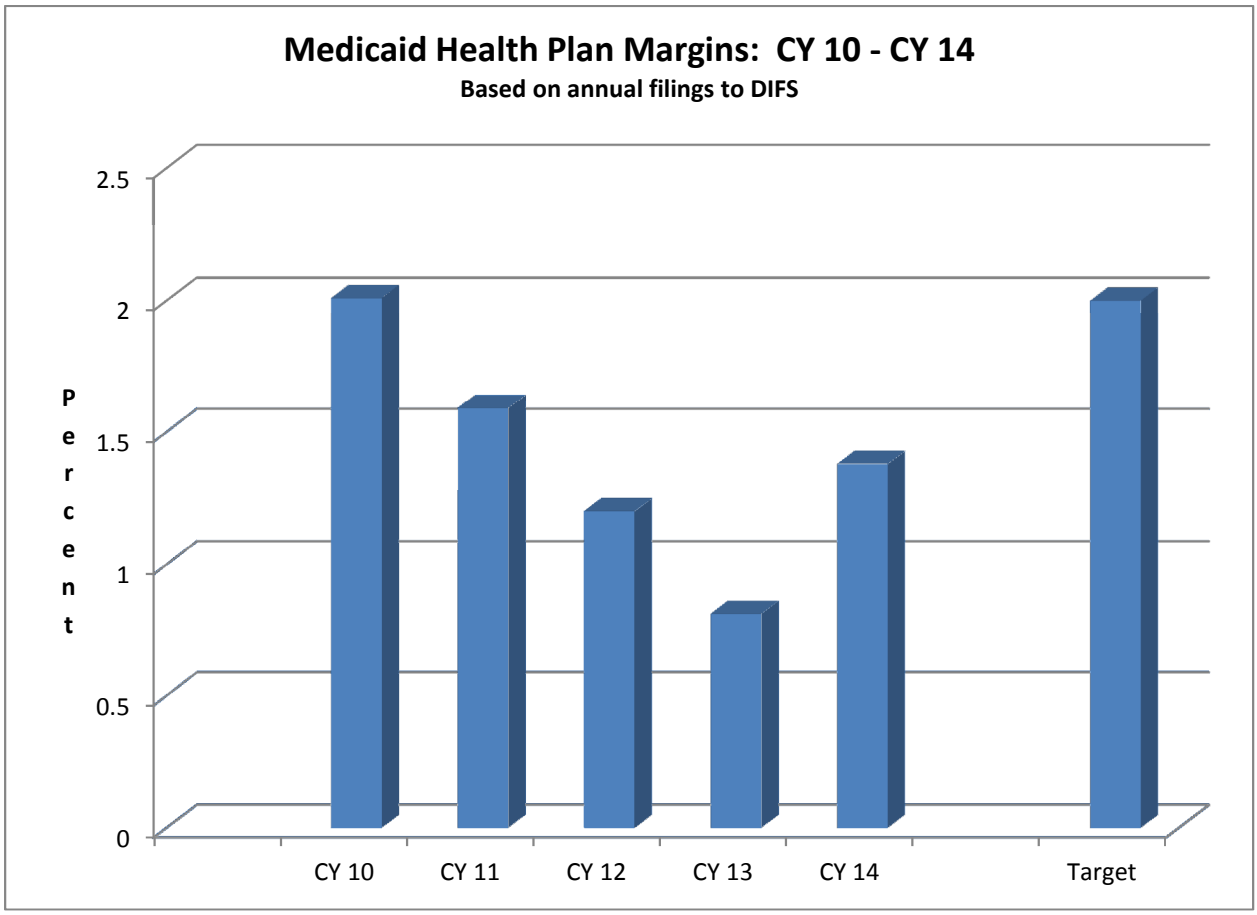
- **Enrollment of Population Groups into Managed Care will reduce Fraud and Abuse expenses and highlight savings potential that will reduce "Waste".** There are various "best practice" models for state governments to address the ever present fraud and abuse from the Medicaid beneficiary as well as some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

By virtue of the state's contract, each Medicaid health plan has "purchased" all of the risk from the State of Michigan to provide all services and meet the technical and quality requirements of the contract. While most observers are familiar with the medical benefits included in the Contract with Medicaid health plans, many have not linked the essential fact that the costs and expenditure savings to the State **are the product of "administrative costs**."

It other words, **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. However the past four years have resulted in a consistent drop in the average Medicaid Health Plan margins as reported in year-end filings with the Department of Financial and Insurance Services, DIFS and illustrated in the chart below:



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

Expectations:

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