Michigan Department of Health and Human Services
PA 107 of 2013 Report §105(d)(11)

Initiatives to Improve the Cost-Effectiveness
of the Medical Assistance Program

Pursuant to Section 105(d)(11) of Public Act 107 of 2013, the Michigan Department of Health and Human Services (MDHHS) has explored a range of programs and initiatives recommended by multiple national organizations to improve the cost-effectiveness of the medical assistance program. The Public Act required review of the following organizations, at a minimum:

- the council of state governments;
- the national conference of state legislatures; and
- the American legislative exchange council.

A summary of the findings of this review is presented below.

Program/Initiative: Integrated care for Medicaid-Medicare Enrollees

Recommended by: Council of State Governments (CSG), National Council of State Legislatures (NCSL), American Legislative Exchange Council (ALEC), and others, such as the Center on Budget and Policy Priorities (CBPP) and Kaiser Family Foundation (KFF)

Overview and rationale:
Medicaid and Medicare were originally designed with different populations in mind. Medicare is a federal program that was constructed to meet the needs of the nation's aged population, as well as those with certain disabilities; whereas the Medicaid program, a state and federal partnership, is intended to provide health coverage to individuals with limited financial resources, including children, pregnant women, and aged or disabled adults.

As a consequence of these key differences, the two programs generally do not work together effectively. Benefits and regulations do not align across programs, complicating the health coverage landscape for the more than ten million dual eligible beneficiaries who are covered by both Medicare and Medicaid. Tackling these challenges and improving coordination of care for this group is especially important given that dual eligibles are typically among the most indigent and the sickest beneficiaries covered by these programs and, as a result, account for a disproportionate share of spending in both programs.

An integrated care model is one in which one entity is accountable for coordinating delivery of primary, acute, behavioral health, and long-term services and supports. A key aspect of integrated care is the blending of funding streams to streamline care, eliminate incentives for cost-shifting, and spur innovation among payers.

Research has shown that integrated care for dual eligibles is cost-effective, with savings stemming from reduced emergency room utilization, hospitalizations and readmissions after discharge. Additionally, early adopters of the model, such as Wisconsin, have found improved health outcomes and quality for life for participating beneficiaries.

Feasibility in Michigan:
On April 3, 2014, the Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) announced a new partnership to test an initiative to integrate care for dual eligible beneficiaries. Under the MI Health Link demonstration, MDHHS and CMS will contract with health plans, called Integrated Care Organizations (ICOs), which will provide an integrated set of Medicare and Medicaid benefits to enrolled beneficiaries in four regions of the state.

Benefits of MI Health Link include:

- No co-payments or deductibles for in-network services, including medications
- One health plan to manage all Medicare and Medicaid covered services
- One card to access all MI Health Link services
- Person-centered care with a focus on supports for community living, not just doctor-driven medicine
- Access to a 24/7 Nurse Advice Line to answer questions
- Access to an Integrated Care Team that will work with the enrollees to identify goals and preferences for care and services
- Assignment of a Care Coordinator who will:
  - Work with the enrollee to create a personal care plan based on the enrollee's goals;
  - Answer questions and make sure that health care issues get the attention they deserve; and
  - Connect the enrollee to supports and services needed to be healthy and live where the enrollee wants.

MI Health Link enrollment began in March 2015, for the first two Regions, the Upper Peninsula and eight counties in Southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren) and the remaining regions (Wayne and Macomb counties) initiated enrollment in May 2015. As of December 2015, 34,832 duel eligible beneficiaries are enrolled in MI Health Link.

Region	Enrollment December 2015
Macomb	4,359
Southwest	7,882
Upper Peninsula	3,743
Wayne	18,848

CMS contracted with RTI International to evaluate the impact of the MI Health Link demonstration on beneficiary experience, quality, utilization, and cost. Data is currently being collected on the first few months of full program implementation and annual reports will be produced as part of this evaluation. Results will be used to inform future actions relative to continuation of the demonstration, as well as the potential implementation of a broader managed long term supports and services strategy.

Program/Initiative: Health Homes

Recommended by: CSG, NCSL, and others, such as CBPP and RAND Health

Overview and rationale:
The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes dedicated to coordinating care for Medicaid beneficiaries who have chronic conditions. Health Homes are designed to increase access to and coordination of primary and acute physical health, behavioral health and long-term, community-based services. Core services for health homes include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient & family support, and referral to community & social support services. These core services are eligible for an enhanced federal matching rate--90% for the first eight quarters of implementation.

Similar to the aforementioned dual eligible model, Health Homes center on integrated care, which has been shown to be an evidence-based mechanism to deliver high-quality, cost-effective care to Medicaid beneficiaries.

Feasibility in Michigan:
In 2013, the state's Mental Health and Wellness Commission issued a report detailing their findings and recommendations to improve both the lives of and the outcomes for Michiganders living with mental illnesses, developmental disabilities and substance use disorders. Among their recommendations was that the state "take actions necessary to begin implementation of Section 2703 Medicaid Health Home in order to provide integrated physical and behavioral health care for priority populations."

In accordance with the Commission's recommendation, MDHHS piloted Health Homes in three regions for Medicaid beneficiaries with a serious mental health condition in July 2014. The Community Mental Health Service Programs (CMHSPs) in Manistee, Grand Traverse, and Washtenaw counties were designed as the state's first Health Home providers. Each of these Health Homes must maintain a team of healthcare professionals that consists of the following:

- Health Home Director (Leadership and Administration Functions)
- Registered Nurse Care Manager (Comprehensive Care Management Functions)
- Primary Care Liaison (Physical Healthcare Consultation Functions)

There are currently 683 beneficiaries receiving integrated and coordinated care through this pilot program.

Effective April 1, 2016, MDHHS will launch a new primary care Health Home model called the MI Care Team. As part of MI Care Team, designated Federally Qualified Health Centers and/or Tribal Health Centers will be identified to provide Health Home services to Medicaid beneficiaries who have a diagnosis of depression and/or anxiety in addition to a diagnosis of one of the following:

- Asthma
- Diabetes
- Hypertension
- Heart Disease
- Chronic Obstructive Pulmonary Disease

An Invitation-to-Bid process is currently underway to determine the MI Care Team providers and the regions covered by the model. The selected MI Care Team providers will assure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The on-site care team must consist of, at a minimum, the following:

- Primary Care Provider
- Behavioral Health Consultant
- Nurse Care Manager
- Community Health Worker
- Health Home Coordinator
- Access to a Psychiatrist/Psychologist for consultation purposes (may be off-site)

It's expected that between 10,000 and 20,000 beneficiaries will enroll in the MI Care Team program.

In both models, the Health Home team serves as the central point for directing patient-centered care. They're accountable for reducing avoidable health care costs (specifically preventing hospital admissions/ readmissions and avoidable emergency room visits) and providing timely post-discharge follow-up. Additionally, both models are intended to improve beneficiary outcomes by addressing whole-person health care needs.

MDHHS has chosen to target individuals with behavioral health challenges for Health Home services for a variety of reasons. We know, from countless studies, that there is a high prevalence of individuals with chronic physical health conditions that co-occur with, and are often exacerbated by, behavioral health conditions. Since many Medicaid patients with several physical problems also have a behavioral health issue, integrating the care of their physical problems with their behavioral health needs is vital. Additionally, independent research has shown that persons with Substance Use Disorder (SUD) and co-occurring SUD/Serious Mental Illness (SMI) are highest utilizers of high cost services in Michigan. Nationally, the highest utilizers of high cost services represent just 5% of the national Medicaid population, but account for upwards of 50% of Medicaid expenditures. Improved coordination of care for this population provides a unique opportunity to reduce Medicaid costs.

Program/Initiative: Broad-Based Payment Reforms

Recommended by: CSG, NCSL, ALEC, and others, such as CBPP and the Heritage Foundation

Overview and rationale:
As health care costs grow, so too does the push for sustainable reforms that improve the quality of health care services while reducing costs. Medicaid-specific payment reform is a powerful cost containment lever given the program's status as the largest insurance program in the country. Traditionally, Medicaid providers across the country have been paid on a fee-for-service (FFS) basis—a delivery system in which providers are paid for each service (e.g. an office visit, test, or procedure). This model is prone to uncontrolled costs and ineffective care as it effectively rewards volume versus value.

In contrast, payment reform models seek to incent providers to eliminate siloed care models, focus on high value services, such as preventive care, increase access to primary care, and improve quality

and reduce costs. An array of payment reforms are currently being implemented by state Medicaid programs. These include:

- Managed care- A model in which managed care organizations (MCOs) assume financial risk for the beneficiaries enrolled in their plan. As a result, there are inherent incentives to emphasize primary care and prevention-based interventions, to improve access to care, manage utilization and to ensure coordination of the beneficiary's care.
- Reduced or non-payment for undesirable outcomes- A model in which Medicaid programs reduce or eliminate reimbursement for preventable adverse events, such as medical errors, or undesirable beneficiary outcomes, such as early elective induction of labor or hospital readmissions.
- Patient-Centered Medical Homes- An enhanced model of primary care that utilizes a team of health professionals to coordinate a patient's care across all elements of the broader health care system, which may include share savings or some level of provider risk.
- Bundled payments- A model in which a single "bundled" payment is made for all services (tests, office visits, hospitalizations, etc.) associated with an episode of care, rather than the Medicaid program reimbursing for each individual service or procedure provided.
- Global payments- A model in which a group of health care providers are issued a fixed rate per beneficiary for a range of services over set time period, most commonly a month or a year, and any services provide outside of this are reimbursed on a FFS basis.

Feasibility in Michigan:
The state is currently utilizing or exploring many of the models described above. Details about several such payment reform initiatives can be found in the below summary.

Medicaid Health Plans- History

Michigan's Medicaid program first launched a statewide managed care model for most beneficiaries in 1997. Today, approximately 80% of the state's Medicaid beneficiaries are enrolled in a managed care plan at any given time. These contracted MCOs receive an actuarially sound per-member per-month payment and assume full-risk for their Medicaid beneficiaries' comprehensive physical health care coverage. The managed care structure has played a crucial role in minimizing cost escalation in the Medicaid program. Medicaid per member per month spending increased around 31% between 2000 and 2012, as compared to the 83% increase in national health expenditures per capita and the 94% Medicare spending per enrollee in the same period.

Medicaid Health Plans-Future

MDHHS recently completed the procurement of Medicaid Health Plans for the next five years with the option for three, one-year extensions. The procurement was transformational in nature, focusing on furthering innovations in health care. Successful bidders demonstrated commitments to the four critical pillars of the rebid:

1) population health management;
2) integration of care;
3) payment reform; and
4) structural changes to improve efficiencies.

Through this procurement, eleven organizations were awarded contracts that will begin January 1, 2016. The awarded plans will now work in partnership with MDHHS to implement payment reform initiatives that pay providers for value rather than volume. Paying for value in the Medicaid population will require plans to move away from FFS models and embrace accountable and transparent payment structures that reward and penalize based on defined metrics. Payment reform initiatives that will be explored throughout the term of the Contract include "bundled" episodic payment, global capitation, and patient-centered medical homes.

MI Choice and PACE

Michigan's Medicaid program has embraced managed care, outside of the Medicaid Health Plans, for the administration of two long-term care programs as well.

1) MI Choice is a Medicaid waiver program that furnishes an array of home and community-based services to assist aged and disabled Medicaid beneficiaries to live in the community who would otherwise be institutionalized. The goal of the program is to provide home and community based services and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. MI Choice is a Medicaid managed care program under which participants receive services from entities classified as Prepaid Ambulatory Health Plans (PAHPs), commonly referred to as the MI Choice waiver agencies.

2) Program of All-Inclusive Care for the Elderly (PACE) is a managed care program, authorized through the Medicaid State Plan, that provides comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals who wish to remain at home to receive services instead of having to go to an assisted living facility or a nursing home. Michigan currently has 11 centers receiving capitated payments to provide the full range of PACE services to enrollees residing within their approved geographic area.

Both the MI Choice waiver agents and the approved PACE centers assume risk and responsibility for care for the covered populations, regardless of setting or need.

Michigan Primary Care Transformation Project (MiPCT)

The Michigan Primary Care Transformation Project (MiPCT) is a five-year multi-payer demonstration project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship. Focus areas for transformation under the demonstration include care management, self-management support, care coordination and linkages to community services.

The demonstration will be used by the Center for Medicare and Medicaid Services (CMS) to evaluate whether Patient-Centered Medical Home practices that receive additional financial support from Medicare, Medicaid, and Commercial health plans, will:

1) reduce unjustified variation in utilization and expenditures;
2) improve the safety, effectiveness, timeliness, and efficiency of health care;
3) increase the ability of beneficiaries to participate in decisions concerning their care;

4) increase the availability and delivery of care that is consistent with evidence-based guidelines in historically underserved areas; and
5) reduce unjustified variation in utilization and expenditures under the Medicare program.

MiPCT, which began in 2012 and will run through 2016, is currently the largest Patient-Centered Medical Home project in the nation. Approximately 355 primary care practices and 1900 primary care physicians and mid-level providers affiliated with one of 37 physician/physician hospital organizations across the state are currently receiving payments.

State Innovation Model (SIM)

MDHHS has also received $70 million in federal SIM funding over the next four years to support innovative health care system enhancements that benefit families. These U.S. Department of Health and Human Services dollars will fund Michigan's Blueprint for Health Innovation, a plan that guides the state as it pursues better coordination of care, lower costs and improved health outcomes.

The project, which centers around the belief that Michigan can achieve better health and better care while containing costs, will focus on transforming service delivery and payment models through Patient-Centered Health Homes; coordination and accountability of the medical neighborhood; a care-bridge to behavioral health and long-term care; and integration between and among health care and community resources, including the Pathways community hub model.

The state's plan recognizes that reforming the FFS payment model is integral to the proposed health system reinvention. In keeping with this, the project promotes multi-payer alignment in testing innovative approaches to paying for value. The Blueprint proposes staging a continuum of health care reimbursement models that require increasing amounts of provider accountability. Benefit design elements that encourage patients to make healthy choices are desired, and a performance recognition program that makes information about provider quality and outcomes publicly available engages consumers in driving the demand for value- based payment models.

Payment reform models that will be tested through the four year project period include:

- Bundled- or episode-of-care payments
- Shared savings: financial reward or loss based on a percent of aggregate total cost of care savings achieved during a specified performance period.
- Pay-for-Performance: Incentives that reward providers for achieving target performance levels or specific outcomes over a defined period: this form of payment is designed to encourage health care providers to produce incremental improvements in performance on health outcomes over time.

Model: Medicaid Block Grant

Recommended by: American Legislative Exchange Council (ALEC) and others, such as the Cato Institute and Heritage Foundation

Overview and rationale:

The Medicaid program, as it is currently structured, is an entitlement program that is funded jointly by the federal government and the states. States must abide by federal guidelines, including assuring coverage to certain mandatory populations, in order to qualify for the federal share of funding. The vision behind the Medicaid block grant is that states would accept a fixed amount of funding from the federal government, instead of the open-ended matching funds available in the current structure, and, in exchange, have greater flexibility in designing their Medicaid program.

ALEC recommends this model for a number of reasons (described below):

1) The federal government's control over Medicaid policy restricts the ability of states to implement reforms that may be needed to better meet state needs.
2) States are encouraged to expand and spend more to get additional federal funding, which causes unsustainable growth in both the federal and state's budget.
3) Federal Medicaid funding is currently based solely on spending versus rewarding states based on quality and performance.
4) The accomplishments of welfare reform evidence that a similar arrangement with Medicaid would be similarly successful.

Vermont and Rhode Island are the only states in the nation with a Block Grant-like structure. In order to implement these state-specific models, the states secured federal approval for a Section 1115 Medicaid waivers. These waivers, which are still in place today, impose a cap on the amount of federal Medicaid funding available to the states. In exchange, the waivers give the state's flexibility to reduce benefits, increase cost sharing and cap enrollment for many Medicaid beneficiaries. While these structures are similar to the Medicaid Block Grant proposed by ALEC, they required federal approval and therefore grant more limited flexibility than the organization's ideal model.

Feasibility in Michigan:
Changes to federal legislation and/or regulations would be necessary to make a Block Grant model that does not necessitate a federal review or waiver possible. Legislation to covert the Medicaid program, as a whole, to a Block Grant has been proposed in the last several years—most recently in the House and Senate budget blueprints for FY16. Ultimately, these proposals have failed to move forward legislatively to date.