

Michigan Department of Health and Human Services
PA 107 of 2013 Report §105(d)(10)

Innovations and Initiatives to Improve the Effectiveness and Performance
of the Medical Assistance Program

Pursuant to Section 105(d)(10) of Public Act 107 of 2013, the Michigan Department of Health and Human Services (MDHHS) has explored a range of innovations and initiatives to improve the effectiveness and performance of the medical assistance program. The Public Act required that the following items be reviewed:

- a) The value and cost-effectiveness of optional medicaid benefits as described in federal statute.
- b) The identification of private sector, primarily small business, health coverage benefit differences compared to the medical assistance program services and justification for the differences.
- c) The minimum measures and data sets required to effectively measure the medical assistance program's return on investment for taxpayers.
- d) Review and evaluation of the effectiveness of current incentives for contracted health plans, providers, and beneficiaries with recommendations for expanding and refining incentives to accelerate improvement in health outcomes, healthy behaviors, and cost-effectiveness and review of the compliance of required contributions and co-pays.
- e) Review and evaluation of the current design principles that serve as the foundation for the state's medical assistance program to ensure the program is cost-effective and that appropriate incentive measures are utilized. The review shall include, at a minimum, the auto-assignment algorithm and performance bonus incentive pool. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.
- f) The identification of private sector initiatives used to incent individuals to comply with medical advice.

Value and Cost-Effectiveness of Optional Medicaid Benefits

Since the passage of PA 107 of 2013, MDHHS has implemented several evidence-based innovations and initiatives within the Medical Assistance Program that have demonstrative value and cost-effectiveness. While the list of optional benefits per federal statute is extensive, MDHHS has focused its efforts on the benefits and services that maximize return on investment to both the Medicaid beneficiary and the Michigan taxpayer. Of optional Medicaid services, those specifically highlighted in this report include dental services, no-cost preventive services for Healthy Michigan Plan beneficiaries, primary care Health Homes for Medicaid beneficiaries, pharmacy innovations, and long-term care innovations.

Dental Services

Dental conditions are preventable conditions that all too often end up being treated in emergency rooms. Nearly half of all visits to the emergency room for dental conditions are for routine cavities that could have been treated effectively and economically in a dental office. These costly visits may also have been prevented with proper checkups and dental care. Cost, lack of insurance coverage, and limited provider access are among the most common reasons for people to seek dental care in an emergency room. Under Federal regulations, (Medicaid) adult dental services is an optional benefit and it is the choice of the individual state to implement an adult dental benefit if they choose. Michigan has removed and reinstated adult dental benefits several times in the past and found there to be no cost-savings during times of rescinded adult dental benefits, but an increase in emergency room costs for dental-related problems. Nationally, less than 20 percent of Americans age 75 and older have any form of dental insurance.¹

¹ Centers for Disease Control and Prevention (CDC). Surveillance for Use of Preventive Health Care Services by Older Adults, 1995-1997. Morbidity and Mortality Weekly Report.

MDHHS estimates that there were over 1,000 hospitalizations for preventable dental conditions in the year 2013.² These hospitalizations represent inpatient hospital stays, meaning that in addition to the emergency room visit and charge, these patients were actually admitted to the hospital for further care and recovery. Based on Medicaid claims data, dental codes billed with a hospital admission often include procedure codes for restorations, extractions, abscesses, and cysts which are conditions that generally do not require hospitalization.

With an average cost of \$290 per emergency room visit for a preventable dental condition, the 7,286 emergency room visits for Medicaid beneficiaries in the year 2011 cost a total of \$2.1 million. Given an average cost of \$12,448 per inpatient stay for a preventable dental condition, the 1,000 such hospitalizations in Michigan cost a total of \$13.3 million.³

The average total payment for preventative and diagnostic care for a Michigan adult patient in 2012 was \$217.26 based on the Delta Dental PPO rates. If even one instance of hospital care could be prevented, the potential savings would be significant. Avoiding a single inpatient stay at the average cost of \$12,448 would pay for over a decade of preventative and diagnostic care, and typically requires little to no out-of-pocket costs.

No Cost Preventive Services for Healthy Michigan Plan Beneficiaries

Michigan's Medicaid program has embraced innovative approaches to reimbursement for evidence-based high-value services, such as the elimination of cost sharing for preventive visits among the Healthy Michigan Plan population. This includes services such as immunizations, tobacco cessation visits, and cancer screenings. This also includes eliminating co-payments for high-value medications that effectively manage chronic diseases. These measures prevent or mitigate serious and chronic diseases, thereby leading to greater population health and reduction in future costly expenditures associated with specialty and inpatient care. Research shows that eliminating financial barriers increases appropriate preventive service utilization, lowers out of pocket spending for patients, and does not increase total spending for payers.⁴ The underlying idea is that more health is produced for the money spent, thus increasing value and cost-efficiency.

Primary Care Health Homes for Medicaid Beneficiaries

MDHHS, along with the Michigan Primary Care Association, is in the process of implementing primary care health homes, or Section 2703 of the Affordable Care Act (ACA), for Medicaid beneficiaries with chronic conditions inclusive of those with depression or anxiety. The program will provide reimbursement for services not typically covered, including intensive care management, care coordination, health promotion, transitional care, patient and family support, and appropriate community referrals. Health Homes programs seek to shift utilization from high cost settings such as the emergency department and hospital to more efficient utilization of the primary care provider's office and medications. Community supports, including the use of Community Health Workers, will help round out the beneficiary's social and environmental needs, leading to sustained behavioral changes that will reduce costs and increase health. Funding for the Health Homes program is matched 90 cents on the dollar by the federal government, offering a lucrative option for Michigan. Missouri has implemented an innovative Health Homes program similar to what Michigan is planning, which has shown a six percent and 10 percent reduction in hospitalization and emergency department utilization rates per 1,000 beneficiaries, respectively.

² Michigan Department of Community Health, Division for Vital Records and Health Statistics, "Ambulatory Care Sensitive Hospitalizations by Selected Age Groups. Retrieved from <http://www.mdch.state.mi.us/pha/osr/CHI/HOSP/PH13TT17.ASP>. Accessed in August 2013.

³ Delta Dental Plan of Michigan, Analysis: The Cost of Dental-Related Emergency Room Visits in Michigan; Anderson Economic Group, LLC, 2014.

⁴ University of Michigan Institute for Healthcare Policy & Innovation (2015). Value-Based Insurance Design. Retrieved from <http://www.ihpi.umich.edu/initiatives/value-based-insurance-design>.

Translated into dollars, Missouri's program has saved nearly \$5.6 million dollars, or 70 percent of the per member per month costs of implementing the program.⁵

Pharmacy Innovations

Coverage of prescription drugs is another optional Medicaid benefit provided to beneficiaries. In addition to the medications exempt from cost-sharing for Healthy Michigan Plan beneficiaries, other value-based innovations of pharmacy policy have been implemented. These include broadening access to immunizations by covering pharmacist administration of immunizations, streamlining claim submissions for certain physician-administered injectable drugs, developing a common formulary across all contracted health plans and thus reducing beneficiary interruptions and administrative burden for providers, and revising audit policies to better ascertain fraud and abuse.

Long Term Care Innovations

Michigan Medicaid's Long Term Care program has also pursued many transformative initiatives. One of the main endeavors is Home Help Modernization - a reinvention to provide better services and more effective oversight, while reducing the demand on state resources. This includes the development of an Electronic Service Verification System, enrollment of Home Help providers into CHAMPS (allowing for background checks on all providers), replacement of an outdated case management system, and development of a consolidated Home Help policy chapter in the Medicaid Provider Manual. MDHHS is also upgrading its reimbursement model for its MI Choice program, which will utilize capitation and reimburse more for the beneficiaries who require more services. In addition, a conflict-free level of care determination system is being implemented, which will transition care determination assessments from individual providers to one or more independent entities. This objective body will more accurately recommend services, benefitting MDHHS, providers and beneficiaries. It is expected to be incorporated into the MI Health Link, MI Choice, and Program of All Inclusive Care for the Elderly (PACE) programs in early 2016 and to nursing facilities later that year. Among other highlights, MDHHS has been working with the Veterans Affairs Administration and the Governor's office to establish both Medicare and Medicaid certification for skilled nursing services provided by the VA homes in Grand Rapids and Marquette. The certification will allow greater stability of the operation of the homes and will provide opportunities for increased quality of services provided to the residents.

In cooperation with the Centers for Medicare and Medicaid Services (CMS), MDHHS is participating in a demonstration project to integrate care for people who are dually eligible for Medicare and Medicaid in certain areas of the state. There are currently just over 41,000 people enrolled in areas that include Wayne and Macomb counties in southeast Michigan, eight counties in the southwest corner of the state and the entire Upper Peninsula. The goals of the initiative are 1) to integrate services and payments, 2) to better align services and supports, 3) to break down program silos, 4) to serve enrollees in a manner that is efficient and cost effective, and 5) to achieve improved health outcomes and a better experience for enrollees. Management entities, including Integrated Care Organizations and PIHPs, will be responsible for the delivery of integrated physical and behavioral services as well as long term care services and supports.

MDHHS has implemented optional Medicaid benefits with value for beneficiaries that have been cost-effective for Michigan. This is made evident through new Medicaid dental benefit initiatives, no cost sharing with preventive visits for Healthy Michigan Plan beneficiaries, through the development of primary care Health Homes, and innovations in pharmacy policy and long term care services. Moving forward, MDHHS will continue to pursue programs that maximize return on investment and bolster the health and wellness of Michiganders.

⁵ MO HealthNet (2013). Missouri Primary Care Health Homes, Interim Evaluation Review Summary. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/mo_health_et_primary_care_hh_interim_evaluation_report_summary.pdf.

Comparison of Private Sector Health Coverage Benefit Differences Compared to Medical Assistance Program Services

Private Sector Benefits

The Patient Protection and Affordable Care Act ensures that new health plans in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of services, known as the minimum essential health coverage benefits. The ten essential health benefits include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Michigan Medicaid Benefits

In comparison, the Michigan Medicaid program has historically covered the essential health benefits along with services generally not covered by the private sector. These additional services include non-emergency medical transportation, dental, vision, certain mental health and substance abuse services, long-term supports and services (LTSS) and an expanded maternal infant health home-visiting program.

Pursuant to federal regulation, States are required to ensure necessary transportation for Medicaid beneficiaries to and from providers.⁶ Non-emergency medical transportation (NEMT) services help individuals access medical, preventive, prenatal and behavioral health services. Access to appropriate medical care and treatment decreases more costly emergency room visits and hospitalizations.

Oral health and eye care are significant for improving individuals' general health and increasing their quality of life. Proper dental care has been proven as a first line of defense in identifying health issues resulting in referrals for proper medical treatment before a more serious condition or illness lead to further health issues. For adults with oral pain, an emergency department visit may be their only option for treatment, and millions of Medicaid dollars are spent each year on these visits. The emergency department is not equipped to meet these needs and the patient leaves with minimal palliative treatment (pain medication and antibiotics) and the dental disease continues. Similarly, regular eye examinations may detect previously undiagnosed critical health issues, such as diabetes, hypertension, glaucoma and other systemic diseases that manifest in the eye. These medical conditions can lead to greater and unnecessary health care costs if left undetected and untreated. Additionally, individuals with access to vision and dental services are more likely to become independent and are better prepared to enter and remain in the workplace.

The Medicaid program also provides comprehensive outpatient behavioral health and substance use disorder services. People who experience behavioral health and substance use disorders can achieve a full and satisfying life in the community, especially when they are able to access effective services and support systems.

Long-term supports and services are extremely important and are relied upon by individuals with functional impairments. In the home and community, LTSS assist people in performing their activities of daily living to maintain their quality of living and, when possible, their independence. LTSS is inclusive of, but not limited to, medical, social, personal care, housekeeping, chore services and transportation. Home Help is the most widely utilized and cost effective long term care service offered by Medicaid. This service seeks to offset more costly nursing facility placements. It allows the state to offer long-term care services in the least restrictive setting, consistent with the Olmstead decision. In the Olmstead decision,

⁶ 42 CFR § 431.53.

the U.S. Supreme Court held that individuals with disabilities should be offered community-based services and supports when certain criteria are met.⁷

The State of Michigan has recognized infant mortality as a major public health issue.⁸ The most frequent cause of infant deaths is low birth weight/prematurity. The Maternal and Infant Health Program (MIHP) is a home-visiting program available to all Medicaid enrolled pregnant women and infants. This evidence-based program promotes healthy pregnancies, positive birth outcomes, and healthy infants. MIHP supplements medical prenatal and infant care through home-based care coordination, referrals, and interventions based on individual care plans.⁹

The benefits covered by the Michigan Medicaid program provide its beneficiaries with access to comprehensive health care and a better quality of life. When beneficiaries have access to non-emergency medical transportation, dental, vision, certain behavioral health and substance use disorder services, LTSS, and an expanded maternal infant health home-visitation program, it allows them to live more productive lives.

Minimum Measures and Data Sets Required to Effectively Measure Return on Investment

As indicated earlier, savings accrue when preventable costs are avoided. Most preventable costs are associated with chronic conditions, so measuring quality of care related to these conditions is key to developing a return on investment estimate. Medicaid Health Plans are required to report the entire set of measures in the Healthcare Effectiveness Data and Information Set (HEDIS) to MDHHS annually. This set includes measures related to diabetes, chronic obstructive pulmonary disease (COPD), hypertension, asthma, obesity, cardiovascular disease, behavioral health disorders, as well as immunizations, access to primary care, flu shot, tobacco cessation, and access to recommended cancer screenings. These data, in combination with actuarial data and detailed utilization data from the encounter data warehouse provide the basis for determining return on investment for the Medicaid program.

Review and Evaluation of the Effectiveness of Current Incentives for Contracted Health Plans, Providers, and Beneficiaries AND Review and Evaluation of the Current Design Principles to Ensure Cost-Effectiveness and Appropriate Use of Incentive Measures

The use of performance-based incentives is a standard, accepted practice in healthcare delivery systems. Federal Medicaid regulations allow health plans to pay financial incentives to providers and members for meeting criteria the plan has established. While Michigan Medicaid does not pay individual provider or beneficiary incentives, there is a successful, long-standing performance recognition program in place for the Medicaid Health Plans. This program includes both a quality-based autoassignment algorithm that rewards higher performing plans with more members, and the use of financial incentives. The table below includes metrics used for the current performance bonus and autoassignment algorithm.

2015 Performance Recognition Measures	Algorithm	Performance Bonus
Breast Cancer Screening	X	X
Cervical Cancer Screening	X	X
Chlamydia Screening	X	X

⁷ Olmstead v. L.C. ex rel. Zimring, 119 S. Ct. 2176 (1999).

⁸ State of Michigan (August 2012). Infant Mortality Reduction Plan.

⁹ Meghea C. (2013). Medicaid Home Visitation and Maternal and Infant Health Utilization. *American Journal of Preventive Medicine*. 45(4), 441-447.

2015 Performance Recognition Measures	Algorithm	Performance Bonus
Prenatal Care	X	X
Postpartum Care	X	X
HbA1c test	X	X
HbA1c control	X	
Controlling High Blood Pressure	X	X
Appropriate Asthma Meds-Combined Rate	X	X
Appropriate Asthma Meds - Ages 5-11		X
Adult BMI	X	X
Well Child Visits, 0-15 months - 6+ visits	X	X
Well Child Visits, 3-6 years	X	X
Well Child Visits, adolescent	X	X
Children BMI	X	X
Child Weight Assessment & Counseling - Nutrition	X	
Childhood Immunizations - Combo 3	X	X
Blood Lead	X	X
Appropriate Testing for Children with Pharyngitis	X	
Appropriate treatment for Children with URI		X
Access to Care, 12-24 months	X	X
Access to Care, 25 months - 6 years	X	X
Access to Care, 7-11 years	X	X
Access to Care, 12-19 years	X	X
Access to Care, 20-44 years	X	X
Access to Care, 45-64 years	X	X
CAHPS - Getting Needed Care, Adult		X
CAHPS - Getting Care Quickly - Adult		X
CAHPS - Health Plan Rating - Adult		X
CAHPS - How Well Doctors Communicate, Child	X	
CAHPS - How Well Doctors Communicate, Adult	X	
CAHPS - Rating of Specialist, Adult	X	
CAHPS - Advising Smokers and Tobacco Users to Quit		X
CAHPS - Discussing Cessation Strategies		X
CAHPS - Discussing Cessation Medications	X	X

Members are automatically assigned to a health plan only if they have not picked their own plan. Approximately 75 percent of all new members pick their own plan, and 25 percent are autoassigned. The proportion of new members that go to each plan in a county is based on performance of the measures listed above in the Algorithm column, and the capacity of the provider network in the county for each plan.

The performance bonus distribution pool is funded by a capitation withhold from the plans and funds the performance bonus. Criteria for earning bonus dollars include the measures listed above in the Performance Bonus column.

On measures that are part of Michigan Medicaid's performance recognition program, Medicaid Health Plans have performed well. In May 2015, CMS published a report that named Michigan as a high performing state on child healthcare measures, ranking 6th overall.¹⁰ Michigan Medicaid Health Plans are consistently named in the top National Committee for Quality Assurance (NCQA) Health Insurance Plan Rankings for Medicaid plans, including three Michigan plans in the top 12 for the 2014-2015 measurement year. The performance recognition program highlights metrics that measure our progress on key priority areas like Governor Snyder's Michigan Health and Wellness 4x4 Plan and other public health initiatives. As a result, compared to all other Medicaid Health Plans nationally, Michigan Medicaid Health Plans score:

- between the 50th and 75th percentile on all childhood immunizations, well-child visits, adult access to care, and cancer screening measures
- above the 75th percentile against all Medicaid plans on measuring body mass index (BMI) for adults and children
- above the 90th percentile for providing immunizations to adolescents

The design of the Michigan Medicaid performance recognition program is intended to reward plans for driving improvement in quality which can lead to better control of chronic diseases, which can lead to reduced visits to the emergency department as well as inpatient admissions. The metrics included in the performance recognition program are well-vetted and align with state and national priority areas. Michigan Medicaid will continue to evolve the program to best suit the needs of the population and the program as a whole.

Identify Private Sector Initiatives Used to Incent Individuals to Comply with Medical Advice

The private sector uses a variety of methods to incent individuals to maintain healthy behaviors. The most commonly utilized options are wellness programs, financial incentives, electronic monitoring tools, and counseling and medication management. Each option aims to provide the user with easy to use services that encourage identifying health risks, reducing the progression of a chronic condition(s), or participating in preventative health measures. As studies show these initiatives to be moderately to fairly successful with their users, private sector employers continue to explore additional types of incentives and options in this arena.

Wellness Programs

According to the RAND Corporation's 2013 Workplace Wellness Programs study, approximately half of U.S. employers offer wellness promotion initiatives. Additionally, many major insurers have begun incorporating wellness programs into their health insurance plans. These wellness programs often include:

- Screening activities to identify health risks (e.g., measurement of body weight)
- Preventive interventions to address health risks (e.g., nutrition counseling)
- Health promotion activities (e.g. healthy food options or on-site clinics).

¹⁰ Centers for Medicare and Medicaid Services (2015). The State of Children's Health Care Quality in Medicaid and CHIP: Who Are the Higher-Performing States? Retrieved from <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/child-core-set-hps-brief.pdf>.

While formal program impacts have been limited to date, participation is typically greatest in health screening or related activities, while take-up remains low in interventions identified based on screen results.

Financial Incentives

Financial incentives are common among workplace wellness programs. Rewards in the form of cash, reduced health insurance premiums, and gym discounts are among the most common ways that employers and/or health plans incent program participation and healthy behaviors.

Many insurers for private sector employers have implemented Value-Based Insurance Design (V-BID) programs in the last decade. These programs are intended to increase adherence to treatment and care guidelines by aligning patients' out-of-pocket costs with the value of health services. A notable example of this is Blue Cross Blue Shield of North Carolina's V-BID program, which began in 2008. The program tested improving medication adherence by eliminating generic medication copayments and reducing copayments for brand-name medications. The program's evaluation found that, in the initial two years of the program, it improved patient adherence to medications for diabetes, hypertension, hyperlipidemia, and congestive heart failure by 2.7 to 3.4 percent, when compared to others whose employers did not offer a similar program.

In a study published in the *New England Journal of Medicine* in 2011¹¹, researchers examined 5,855 Aetna members who had recently been hospitalized after suffering a heart attack and were subsequently prescribed preventive medications. Half of the participants in the study were required to pay the usual copay for their medications while the other half had their copay waived. The study found the compliance rate was 44 percent for patients who had their copay waived, compared to 38 percent for those required to pay the usual copay amount. The rate of hospital readmissions was also lower among the group not required to pay copays saving Aetna more than \$6,000 per member for this group.

Electronic Monitoring Tools

Electronic monitoring tools have emerged as a promising means to improve treatment adherence. Johnson and Johnson recently launched a new digital mobile health management tool, *MyHealthDiscovery*TM, in June 2015. The tool includes a health assessment designed using a predictive validity study to determine the questions that are most predictive of health-related behaviors and recommends manageable action steps based on the individual's responses to this assessment. It was also designed to aggregate results of members to allow health insurance payers to better manage population health and to guide interventions targeted to address health challenges of specific member groups.

Other digital tools have already been implemented successfully. According to a study published in the *Journal of the American Medical Informatics Association*, Kaiser Health System's online prescription drug refill tool was found to increase medication adherence for Kaiser Permanente's patients with Type 2 diabetes.¹² When the study began, individuals spent between 12 and 16 percent of the time without having the medication on hand, with variations across racial/ethnic groups. Upon switching to exclusively online refills, the time without medication was reduced by more than three percent, across all racial/ethnic groups.

Counseling and Medication Management

Many insurers offer counseling services, such as nurse advice lines, as part of their employer-sponsored coverage options. Nurse advice lines provide employees with access to nurses via phone to receive confidential health information and advice; services are often available 24 hours a day.

¹¹ Choudhry, N., et. al. Full Coverage for Preventive Medications after Myocardial Infarction.

¹² Lyles, C., et. al. Refilling medications through an online patient portal: consistent improvements in adherence across racial/ethnic groups.

In 2012, Walgreens presented research showing the effectiveness of pharmacist-led training and counseling in improving medication adherence. For the study, 4,500 diabetes patients who were newly prescribed self-injectable medications were trained by Walgreens pharmacists on appropriate injection technique, side effect management and the importance of adherence to therapy. After the initial training, the pharmacists completed a follow-up assessment at the patients' next refill. Results after the initial two year study period found that patients who received two counseling sessions with a pharmacist improved medication adherence by 24 percent, compared to a usual care control group.

The Boston Children's Hospital Community Asthma Initiative (CAI) was developed to help improve the health and quality of life of children with asthma and their families. The program incorporates nurse case management and home visits to assist the participating families in managing their child's asthma, medications, and triggers. Evaluation of this initiative found a significant reduction in hospital costs compared with the comparison community, as well as a return on investment of \$1.46 per \$1 spent.