MICHIGAN MEDICAID: RELATIVE COST EFFECTIVENESS OF ALTERNATIVE SERVICE DELIVERY SYSTEMS

FINAL REPORT

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UMBC
AN HONORS UNIVERSITY IN MARYLAND

CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

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EXECUTIVE SUMMARY

This report, completed to fulfill the requirements of Public Act No. 349 (2004), compares the costs involved in delivering health care services to Medicaid recipients under four alternative delivery systems:

- Capitated managed care under multiple managed care organizations (MCOs)
- Fee-for-service (FFS)
- Primary care case management (PCCM), a non-capitated form of managed care
- Capitated managed care under a single statewide MCO

As explained in detail in the full report, we conclude that capitated managed care under multiple MCOs will cost the state of Michigan significantly less in state funds in FY 2006 than any alternative delivery system. Based on Michigan's current program design, which includes an assessment fee to support the state's Quality Assurance Assessment Program (QAAP), this is true whether we assume no increase in managed care rates, as proposed in the Governor's FY 2006 budget, or assume the full 12.4 percent rate increase that is necessary to comply with the federal government's "actuarial soundness" standards.

Provided QAAP remains in place, we estimate that the state of Michigan would save between $28 million and $129 million in state funds in FY 2006 when capitated managed care is compared to all of the alternative delivery systems. The exact amount of savings that Michigan will achieve depends on whether the 12.4 percent rate increase is applied, and on which alternative delivery system is under consideration.

The full report, which provides detailed information on our assumptions and findings, follows.

BACKGROUND

Nationally, Medicaid spending has increased dramatically in recent years, from $205.7 billion to $275.5 billion between fiscal years 2000 and 2003, an average growth rate of 10.2 percent per year.[1] The reasons for the increases vary from state to state, but in general, the rise in per-recipient health care costs, though certainly significant, is less important than the overall increased caseload in Medicaid. Nationally, enrollment in Medicaid has grown by more than 30 percent since 2000.[2]

Michigan's Medicaid caseload has mirrored this national trend. It has grown from a little over 1 million in 2000 to over 1.4 million today. This is due to a number of factors that are not unique to Michigan, including a sluggish national economy, substitution of Medicaid coverage for private insurance particularly among children and dependents of workers, and the open-ended nature of the Medicaid entitlement.[3] Even though the Michigan Medicaid program has aggressively pursued cost containment strategies that have successfully held the growth of per-beneficiary spending to a level that compares favorably with the performance of commercial health insurers, caseload growth is primarily responsible for a total spending increase of $550 million for FY 2004.[4]

To address the increase in Medicaid spending, Public Act No. 349 (2004) requires the Michigan Department of Community Health (DCH) to evaluate alternative approaches to providing Medicaid physical health services to clients currently served by Medicaid MCOs through the Comprehensive Health Care Program (CHCP).

DCH retained the Center for Health Program Development and Management at the University of Maryland, Baltimore County (UMBC) to fulfill the requirements of Public Act No. 349.[5] As a result, this report addresses the elements in the Legislature's requirement that DCH estimate and compare the cost and assess the impact on providers and clients of each of four alternative systems for delivering physical health care services to Michigan's CHCP population:

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[1] Holahan, J. and Ghosh, A. "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* W5-52 (Jan. 26, 2005).

[2] Ibid.

[3] Strunk, B. and Reschovsky, J. "Trends in U.S. Health Insurance Coverage, 2001-2003, Tracking Report No. 9," Center for Studying Health Systems Change (August 2004), accessed at www.hschange.org/CONTENT/694.

[4] Michigan Department of Community Health, Modernizing Michigan Medicaid, p. 2 (Feb. 2005).

[5] An independent research organization, UMBC provides rate setting services for the state of Maryland's Medicaid program, and UMBC previously has contracted with the federal government and other states to provide technical assistance in Medicaid rate setting studies. UMBC provided these services as a subcontractor to Health Management Associates.

- Capitated managed care under multiple MCOs
- FFS
- PCCM
- Capitated managed care under a single statewide MCO

Before examining alternative delivery systems, however, it is useful to briefly explore the recent history of Michigan's Medicaid program in the context of the performance of other states' programs.

Michigan Physician Sponsor Plan

In 1982, Michigan implemented a mandatory enrollment PCCM program: the Physician Sponsor Plan (PSP). PSP was intended to improve Medicaid recipients' access to care and improve cost-effectiveness compared to the existing FFS delivery system. Under the authority of a federal §1915(b) waiver approved by the Health Care Financing Administration (HCFA) (which became the Centers for Medicare and Medicaid Services [CMS] in 2001), PSP required all non-exempt Medicaid-eligibles in both AFDC and Blind and Disabled eligibility categories[6] to enroll with a participating primary care provider (PCP) who would act as the recipient's physician-sponsor.[7] DCH paid these primary care providers/case managers (PCPs/CMs) a $3 per month per recipient case management fee to authorize delivery of most covered medical services,[8] maintain a 24-hour access system, and make appropriate referrals. Additionally, actual health care services delivered by either the PCP/CM or another provider were reimbursed on a FFS basis. A 1992 evaluation of the program's cost effectiveness found it had produced a 14.6 percent savings over expected FFS costs for the same populations, without reducing quality or access to care.[9]

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[6] "AFDC" or "TANF" and "SSI" or "ABD" are terms commonly used to refer to groups of Medicaid recipients whose Medicaid eligibility is either based on qualifying for the corresponding federal assistance program or on other, related eligibility factors. Recipients classified as "AFDC"/"TANF" or "SSI" do not necessarily qualify for Aid to Families with Dependent Children (AFDC), its successor program, Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI), or Aged, Blind, and Disabled (ABD) benefits. In this report, "AFDC" or "TANF" means all Medicaid-eligible families and children not exempt from mandatory program enrollment. The term "Blind and Disabled" (in lieu of "SSI" or "ABD") means all non-exempt recipients whose CHCP eligibility is based on aged, blind, or disabled Medicaid eligibility categories. This is for consistency with the Comprehensive Health Care Program's health plan contract, which provides for different capitation rate methodologies for "TANF" and "Blind and Disabled" eligibility categories.

[7] The Physician Sponsor Plan's eligibility rules excluded recipients who were: Medicare dual eligibles or QMBs; residing in nursing facilities or ICF-MRs; enrolled in another managed care program; participating in an HCBS waiver; or eligible for Medicaid based on a spend-down. As of June 30, 1996, PSP enrollment was 501,499 (451,349 TANF and 50,150 SSI). This represented about 44 percent of Michigan's total Medicaid population at that time.

[8] The PCP/CM's preauthorization was not required for emergency, dental, psychiatric (community mental health), ophthalmologic, obstetric, pharmacy, podiatry, nursing home, ICF/MR, durable medical equipment, transportation, chiropractic, immunization, STD, family planning, or school-based services.

[9] Health Management Associates, et al., "Evaluation of the Michigan Medicaid Program's Physician Sponsor Plan, FY 1988-1990," pp. 6, 26, 42 (February 1992).

Michigan Full-Risk MCOs: Comprehensive Health Care Program

In 1996, Michigan applied for approval of a new waiver under §1915(b) of the Social Security Act to operate the Comprehensive Health Care Program (CHCP), featuring comprehensive risk contracting with qualified MCOs. This waiver also included mandatory enrollment of program-eligible Medicaid recipients. HCFA approved Michigan's proposal in 1997, and subsequently approved a two-year waiver renewal in 2000. CMS approved a second two-year renewal in 2003. The current waiver expiration date is July 1, 2005, and a renewal request to operate the program beyond that date is pending at CMS. CHCP's initial implementation was in five counties. More counties were added as additional MCOs were allowed by DCH to participate. Today the program operates nearly statewide. Recipients choose between at least two full-risk health MCOs in 54 of Michigan's 83 counties. In the rest of the state, the breakdown is as follows. In seven counties with a single MCO, enrollment is voluntary; recipients may either enroll in an MCO or choose to access care through the FFS system. In four counties with a single MCO, automatic enrollment occurs unless the recipient affirmatively chooses FFS. In 15 rural counties with a single MCO, enrollment is mandatory. Finally, in three counties, MCO enrollment is not available.

Management Intensity in Managed Care

Before evaluating alternative approaches to providing Medicaid physical health services as directed by Public Act No. 349 (2004), it is important to understand the basic characteristics of the different health care delivery models under consideration. This section will focus on how variations in management intensity can affect cost-effectiveness in different managed care models. The next section will explain that the alternative delivery system models vary by their usage of capitation as a reimbursement methodology, which creates important differences in incentives.

Four categories of alternative health care delivery systems are discussed in this report. Among state Medicaid programs around the country, substantial variation in individual program designs can be found within these categories. The following descriptions outline characteristics common to all programs falling within each category:

- In a multiple MCO model, the MCOs contract with the state to provide a comprehensive package of services to enrollees in exchange for a prospective per-member-per-month (PMPM) payment. The monthly payment to MCOs remains the same regardless of the type or amount of services actually delivered. Because the MCOs are at risk for the cost of services delivered, they have a strong incentive to manage enrollees' utilization of services. The amount of the monthly capitation payments the state makes to participating MCOs is based on the estimated cost (risk) of providing covered services to specific categories of enrollees. Risk contracting creates a financial incentive for MCOs to manage enrollees' care efficiently and in a cost-effective manner. Each MCO enrollee is assigned to a PCP, who provides most preventive and primary care services, as well as referrals for specialty care.
- A FFS program is non-managed care. Providers have individual contracts with the state Medicaid program under which they directly bill the state as services are

delivered. The state's budget is less predictable, because the actual expenditures are determined by the volume and composition of services that are delivered. Moreover, providers do not have an incentive to control costs, because they are paid directly for each service. In a FFS system, the only way for a state to control costs is for the state to act directly as a utilization management entity, exercising oversight and scrutiny over providers' billing practices.

- In a PCCM program, the state contracts with primary care case managers to provide case management services (locating, referring, coordinating, and monitoring assigned beneficiaries' health care services) for a set, periodic case management fee. Traditionally, all non-case management services provided either by the primary care case manager (usually a primary care physician such as a pediatrician or family physician) or another provider would be delivered on a FFS basis. However, some PCCM programs involve partial-risk contracts under which the PCCM provides certain primary care services on a risk basis.
- A capitated MCO program with a single statewide MCO is a model that, at present, does not exist anywhere in the country. In theory, it would operate like a multiple capitated MCO system, with a key difference: only one MCO would be awarded a contract by the state. In this respect, this alternative delivery system would look much like a utility company in an era before deregulation: the state would negotiate rates with a single statewide entity. One goal of this design would be to reduce the overall administrative costs, because only one MCO is involved which might avoid duplicate administrative structures across MCOs. However, this model does not exist anywhere in the country for two fundamental reasons: first, the federal government is reluctant to authorize a monopoly that would force Medicaid beneficiaries (and providers) into dealing with a single MCO where no choice would exist, and second, states are reluctant to create a model where a single MCO would have such large bargaining power in negotiations -- which might be used both to drive up rates and to "take the state hostage" when a state attempts to exercise oversight authority. These concerns are one reason that most recent public policy decisions in other sectors have moved in the direction of deregulation – leading to more choice and more competition.

From one category of delivery system to another (e.g., from PCCM to MCO), and even from one individual program to another within the same category, there can be enormous variation in management intensity. The range of management intensity is not necessarily dependent on program type. A full-risk MCO program can be relatively "low-managed," and a non-risk PCCM can be relatively "high-managed." It all depends on the program design. That said, the intensity of a program's cost-management features tends to correlate with program type and the level of risk contracted.

High-managed care typically is associated with an MCO-type care delivery system, incorporating relatively intensive utilization management and other cost containment features. To avoid the wasteful or unnecessary provision of health care services, high-managed care imposes more prior authorization, referral, and other utilization requirements on providers and enrollees. High-managed care is characteristic of programs that deliver care through capitated, full-risk managed care entities and incorporate financial incentives to curb inappropriate utilization.

Low-managed care is characterized by relatively weak cost-containment features, and is usually associated with health care delivery systems other than MCOs. A low-managed care delivery system is traditionally non-risk or partial-risk, and has relatively less rigorous utilization controls. Many forms of commercial insurance utilize low-managed care (such as preferred provider organizations). These programs rely on differential patient cost-sharing provisions to encourage patients to be cost-effective. These cost sharing tools are not available in Medicaid. Since more potent utilization controls and cost-containment features are characteristic of high-managed care by definition, the fact that it is demonstrably more cost-effective than low-managed care is not surprising.

Capitation Rates

A crucial factor in establishing MCO managed care delivery costs is how much the state pays MCOs to provide Medicaid managed care services to their enrollees. An important variable in comparing MCO managed care cost-effectiveness to alternative delivery systems is whether MCO capitation rates remain static or increase.

Federal Medicaid rules require that payments to MCOs be actuarially sound. In simple terms, rates are considered to be "actuarially sound" when the rates take into account the predicted costs of delivering the covered benefits to the covered population. For Medicaid, a federal rule therefore requires that the state (or its contracted actuaries) certify to the federal government that the rates are actuarially sound. This mathematical calculation must be performed in accordance with generally accepted actuarial principles, and must be appropriate for the populations to be covered and the services to be furnished under the contract.[10]

It is the federal requirement of "actuarial soundness" that led to the large 12.4 percent rate increase initially proposed for FY 2006. This was not discretionary for Michigan. DCH's contracted actuarial firm, Milliman USA, independently calculated that Michigan must increase its rates by 12.4 percent in FY 2006 in order for those rates to meet the federal requirement of actuarial soundness. Perhaps ironically, this large potential rate increase is being used by some to criticize DCH's management of the managed care program, when in fact the reason for the 12.4 percent rate increase is the fact that DCH has paid *below* an actuarially sound rate for several years by forcing MCOs to bid for the privilege of participating in CHCP. While this has generated substantial savings for Michigan in prior years, it has led to a large shortfall that must be made up to achieve actuarially sound rates. In fact, even the 7.5 percent increase paid to MCOs in FY 2005 did not adequately address the extent of prior years' underpayments, leading to the large catch-up that Milliman's calculations required for FY 2006.

Governor Granholm's budget proposal for FY 2006 contains no rate increase for the MCOs. Under the "Modernizing Michigan Medicaid" reforms announced in February

[10] See 42 CFR §438.6(c).

2005, Governor Granholm's budget includes instructions to DCH that they pursue a federal waiver of the actuarial soundness requirement.

Because funding for the FY 2006 rate increase is uncertain, this report presents separate cost-effectiveness assessments with and without the FY 2006 12.4 percent rate increase. It should be noted, however, that the state's current goal of operating the program at a funding level below actuarially sound rates is problematic, for two major reasons. First, as discussed above, the federal Medicaid program requires that MCO payment rates be actuarially sound. Although the state plans to seek a waiver of the actuarial soundness requirement, federal approval of such a waiver may be unlikely, especially in time for the start of FY 2006. Second, the effect on participating MCOs of rates that are lower than what would be actuarially sound is problematic. Without adequate financial resources, MCOs' ability to deliver quality care may suffer, and the MCOs' financial solvency may suffer. It is likely that some MCOs would choose to leave the program. If the capacity of the remaining MCOs is insufficient to serve the population, clients' ability to access needed services may be compromised.

STATE COSTS UNDER ALTERNATIVE DELIVERY SYSTEMS

UMBC's estimated costs of each of the delivery systems identified by the Legislature for evaluation are discussed below.

1. The Baseline: Managed Care Organizations (MCOs)

Of the alternative delivery systems the Legislature identified for evaluation, the full-risk capitated MCO model represents the status quo as the model currently in place under Michigan's Comprehensive Health Care Program. The state may continue to provide Medicaid-funded physical health services through multiple MCOs under comprehensive-risk managed care contracts. As previously described, in an MCO model, the MCOs contract with the state to provide a comprehensive package of services to enrollees in exchange for a PMPM payment. The monthly payment to MCOs is fixed, based on the number and nature of the enrollees. Risk contracting creates a financial incentive for MCOs to manage enrollees' care efficiently and in a cost-effective manner. Clients are afforded an opportunity to select their MCO; those who fail to choose an MCO are subject to "automatic assignment." Typically, MCO enrollees must access care through providers affiliated with their MCO.

To present any cost estimates of alternative delivery systems, a baseline cost estimate under the existing MCO managed care program needs to be determined. After evaluating the available resources, it was concluded that the source instrument to be used in developing the baseline would be Milliman's "Capitation Rate Development – FY 2005 and FY 2006" report dated May 3, 2004. This report reflects the most current and accurate utilization and cost estimates available. Using the enclosures in the report as well as supplemental documentation provided by DCH and Milliman, UMBC developed a cost model. The baseline costs used in this model are the $166.8 million, as reported in Enclosure 4 of the May 2004 Milliman report, reflecting December 2003 enrollment applied to FY 2006 rates.

The MCO/baseline cost estimate summarizes cost components into projected claims and administrative costs. "Projected claims" are payments for medical services delivered by providers to enrollees. "Administrative costs" include the MCO's administrative functions, such as provider enrollment, enrollee services, quality monitoring programs, utilization review, and others.

State and federal funds are considered separately so that the impact of the premium assessment fee component can be incorporated and costs that are the state's responsibility can be isolated.

It is important to explain how the premium assessment fee operates. This fee, otherwise known as the quality assurance assessment program (QAAP), was enacted as a state law. Under QAAP, MCOs are assessed a fee of 6 percent on all of their non-Medicare premiums. The MCOs pay this fee to the state and, once paid, it becomes revenue to the

state. Therefore, this applies to the Medicaid program, and, because QAAP is not applicable to FFS, it results in higher costs to managed care.

However, QAAP is cost-effective for the state because it is an administrative cost for the MCOs that must be included in the rate setting calculations. Because those rates paid to the MCOs are shared by the federal and state governments, slightly more than half of the costs related to the QAAP assessment are borne by the federal government. Thus, the state treasury in effect receives the entire amount of the assessment fee paid by the MCOs as state revenue, but DCH is only obligated to reimburse the MCOs for slightly less than half of the cost of QAAP from state funds (the remainder are federal funds). In short, QAAP provides financial benefits to Michigan that are not available in alternative delivery systems that do not have a premium assessment fee, which include FFS and PCCM.

Although the Legislature's instruction to determine the estimated cost of each alternative delivery system does not specify *whose* costs, the most relevant are the state's. To evaluate whether an alternative delivery model is less expensive *to Michigan* than MCO managed care, the analysis should not be driven by total funds (federal and state), but rather by state funds only. Consequently, this report focuses on each option's impact on state funds. (An evaluation of alternative delivery models' effect on total funds is presented in Appendix A.)

The following is a series of comparisons of the financial impact on the state budget of delivering Medicaid services using the MCO/baseline model versus alternative delivery models. Two variables are incorporated into the MCO/baseline model:

- A 12.4 percent MCO rate increase that has been proposed for FY 2006 as necessary for actuarial soundness
- A 6 percent premium assessment fee under the Michigan Medicaid QAAP

This results in four versions of the MCO/baseline model for comparison with alternative delivery models. These variations of the MCO/baseline model, all measuring costs in state funds only, incorporate the following assumptions:

- MCO rates without the FY 2006 rate increase; with QAAP
- MCO rates without the FY 2006 rate increase; without QAAP
- MCO rates with a 12.4 percent increase for FY 2006; with QAAP
- MCO rates with a 12.4 percent increase for FY 2006; without QAAP

The state's cost of delivering care using each of the four variations of the multiple MCO/baseline cost estimate are compared with the alternative delivery systems:

- FFS
- PCCM
- A single statewide MCO

2. Fee-for-Service (FFS)

In a FFS delivery model, clients access care through any provider who has agreed to participate in the Medicaid program under a non-risk contract. There is no requirement to see a primary care provider first before accessing health care services through any Medicaid-participating provider. Providers bill the Medicaid program for each service as it is provided.

Using the December 2003 Michigan MCO managed care enrollment and MCO payment rates developed by Milliman for FY 2006 as the baseline costs, UMBC modeled several alternative cost scenarios to estimate the financial impact of moving this population into a FFS model. For a meaningful estimate of this impact, there are a number of significant factors that need to be evaluated, such as the following:

- Changes in pricing. Although MCO-specific pricing (provider payment) data was not available for this study, discussions with Milliman indicated that the unit costs used in its rate development data reflected equivalence to Medicaid FFS rates. Thus, we did not assume any change in pricing in the FFS simulation.
- Changes in utilization. The baseline (MCO) model for this study incorporated relatively rigorous utilization management processes that are common to MCOs. Moving to FFS would result in less management of utilization. As a result, UMBC's FFS estimates include higher rates of service use in most categories of service.
- Shifting administrative costs. Moving from MCO managed care to FFS will eliminate the costs associated with the administrative load component that is built into MCOs' capitation rates. That is, the FFS program will realize some savings due to the elimination of managed care administrative costs. However, a portion of this administrative load cost reduction will be offset by additional administrative costs the state will incur in operating a much larger FFS program.
- Elimination of the managed care premium assessment fee. Moving from MCO managed care to FFS will eliminate the application of Michigan's managed care premium assessment fee under QAAP. As explained above in the description of how QAAP operates, this results in a net loss to the state treasury. The resulting loss of some federal matching funds is incorporated into the overall FFS cost analysis.
- Changes in future trends. To evaluate the future trend (health care cost inflation) rate under FFS as compared to MCO managed care, the analysis incorporates data from eligibility groups that are as similar as possible.

The following analysis, based on modeling performed by UMBC, illustrates how the costs of care delivery to the same population under FFS would compare to the costs of Michigan's existing MCO program.

As previously mentioned, the MCO managed care baseline used in this study reflects the $166.8 million as reported in Enclosure 4 of the Milliman rate development package for FY 2006, annualized for the year. All costs presented in the analysis are based on December 2003 enrollment levels. By holding enrollment levels for the TANF (and Blind

and Disabled) populations constant throughout our analysis, the overall costs presented exclude the impact of case mix change (i.e., variations in the percentages of TANF and Blind and Disabled enrollees) attributable to these two populations. Projecting forward in time, the managed care rate of trend by type of population and type of service was applied from the midpoint of the base period to the midpoint of each payment period.

To estimate the FFS costs of this population in FY 2006, the MCO managed care model was modified to estimate the impact on services utilized under MCO managed care in FY 2005 to FFS non-managed care in 2006.

In general, utilization assumptions for managed care were increased to develop utilization estimates for most types of services delivered under FFS; that is, UMBC assumed that utilization of most services, in the absence of an MCO's utilization controls, will increase under FFS. An important exception is that utilization of physician services will *decrease* under FFS. This is partly due to an anticipated shift from physician office visits to hospital-based outpatient clinic services. Shifting to a FFS system also has a potential effect on quality of care: utilization of preventive care services (e.g., well-baby visits and immunizations) is likely to decrease under FFS because of the absence of patient monitoring provided under MCO managed care.

The FFS experience was evaluated by five main service categories: inpatient hospital, outpatient hospital, prescription drugs, physician, and other ancillary services. The individual FFS categories of services were applied to the weighted categories of services under MCO managed care to estimate an overall rate of trend. On a purely quantitative basis, the consolidated TANF FFS trend estimates were slightly lower than UMBC expected, and the Blind and Disabled trend estimates were slightly higher than expected. To project costs forward from FY 2006, the TANF FFS trend would be applied at an annual rate of two points above MCO managed care. For the Blind and Disabled category, the annual rate applied would be three points higher than MCO managed care. The result more closely corresponds to prevailing national trends.

MCO vs. FFS

As shown in Exhibit 1, state funds expended for years 2004 through 2006 for MCO managed care would be lower than the amounts would have been using a FFS delivery system. Exhibit 1 assumes no FY 2006 MCO rate increase, and also assumes that the MCO rates will be subject to the 6 percent premium assessment fee. Fee-for-service claims reflect higher utilization levels and higher state administrative costs under FFS.[11] Moreover, anticipated higher FFS trends (health care inflation) should cause future state FFS costs to increase more rapidly than state costs for MCO managed care.

Another factor in MCO managed care's cost-effectiveness relative to FFS is the QAAP premium assessment fee. The QAP program generates revenue for the state, which is partially paid by federal Medicaid matching funds. This favorable arrangement under the

[11] For the FFS model used to develop Exhibits 1-8, an additional state administrative cost load of 1.75 percent of projected claims expense was estimated.

existing QAAP premium assessment program, along with the lower trends associated with MCO managed care, make costs under the current MCO managed care program more favorable to the state budget than FFS. Exhibits 1 and 2 show the estimated costs under MCO managed care compared to FFS in state funds only using December 2003 enrollment.

Exhibit 1: Comparison of Estimated State Costs - MCO vs. FFS (Without FY 2006 MCO Rate Increase/With QAAP)

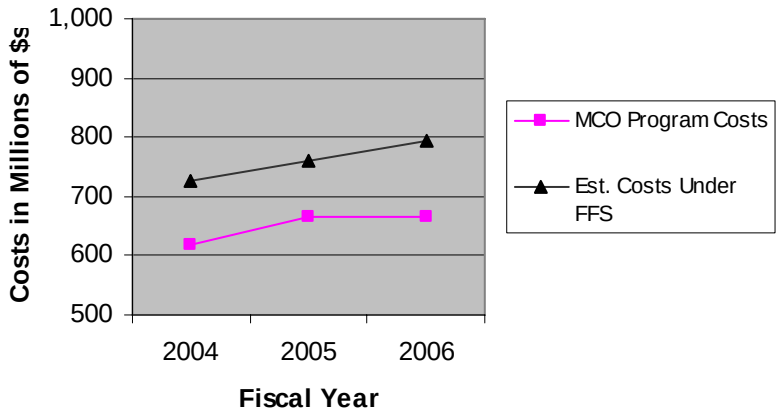


Exhibit 2: Comparison of Estimated State Costs - MCO vs. FFS, in Millions (Without FY 2006 MCO Rate Increase/With QAAP)

Fiscal Year	2004	2005	2006
MCO Program	$ 620	$ 666	$ 666
FFS	$ 727	$ 760	$ 795
Estimated Costs on a Cumulative Basis			
MCO Program	$ 620	$ 1,286	$ 1,952
FFS	$ 727	$ 1,487	$ 2,281
Difference	$ (107)	$ (201)	$ (330)

Exhibits 1 and 2 show that the state's costs for Medicaid service delivery using the MCO/baseline model (without the FY 2006 rate increase and with QAAP in place) are substantially lower than under a FFS delivery system. For the three-year period of FY 2004 through FY 2006, MCO managed care is estimated to generate a cumulative $330 million in savings to the state compared to FFS.

Exhibits 3 and 4 present another comparison of the MCO/baseline model to FFS with no FY 2006 MCO rate increase. The difference between this comparison and the one presented in Exhibits 1 and 2 is the removal of the QAAP premium assessment fee.

Exhibit 3: Comparison of Estimated State Costs - MCO vs. FFS (Without FY 2006 MCO Rate Increase/Without QAAP)

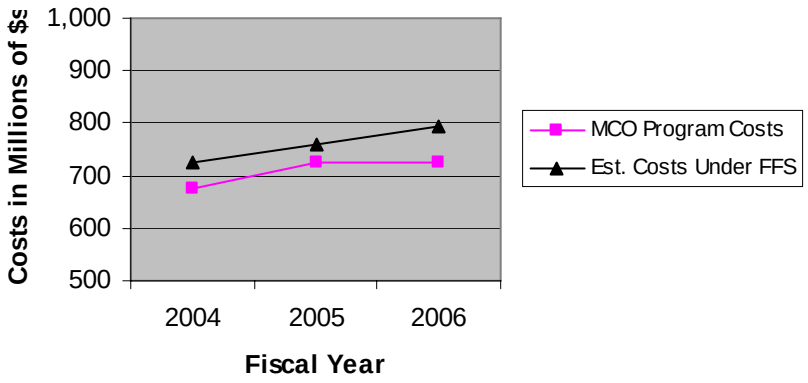


Exhibit 4: Comparison of Estimated State Costs - MCO vs. FFS, in Millions (Without FY 2006 MCO Rate Increase/Without QAAP)

Fiscal Year	2004	2005	2006
MCO Program	$ 676	$ 726	$ 726
FFS	$ 727	$ 760	$ 795
Estimated Costs on a Cumulative Basis			
MCO Program	$ 676	$ 1,402	$ 2,129
FFS	$ 727	$ 1,487	$ 2,281
Difference	$ (51)	$ (84)	$ (152)

Under the current system, MCOs pay a 6 percent QAAP premium assessment fee. As previously explained, QAAP is advantageous to Michigan. Thus, the absence of QAAP in this illustration results in lower savings for managed care. Assuming no FY 2006 rate increase and no QAAP premium assessment fee, the MCO model is expected to produce cumulative savings for the state (based on December 2003 enrollment) of over $150 million compared to FFS over three years. Although savings of this magnitude would be impressive, $150 million is less than half the expected savings when the premium assessment fee is considered. As shown in Exhibits 1 and 2, with QAAP in place, estimated cumulative savings in state funds from the MCO model (based on 2003 enrollment) would yield estimated savings for the same time period of around $330 million when compared to FFS.

In Exhibits 1 through 4, MCO capitation rates had not been adjusted for actuarial soundness. Exhibits 5 through 8 compare state costs under FFS with state costs under MCO managed care models with actuarially sound rates; specifically, 12.4 percent higher than those used in Exhibits 1 through 4.

As previously explained, Michigan's 7.5 percent rate increase in FY 2005 kept MCO payment rates below an actuarially sound level. A portion of the FY 2005 rate increase necessary for actuarial soundness was effectively postponed until FY 2006, resulting in the potential 12.4 percent increase in FY 2006. For the MCO model used in Exhibits 5 and 6, this $25 million in FY 2005 actuarial soundness "underpayments" are included – they represent a portion of the 12.4 percent the FY 2006 rate increase.

Exhibit 5: Comparison of Estimated State Costs - MCO vs. FFS (With FY 2006 MCO Rate Increase/With QAAP)

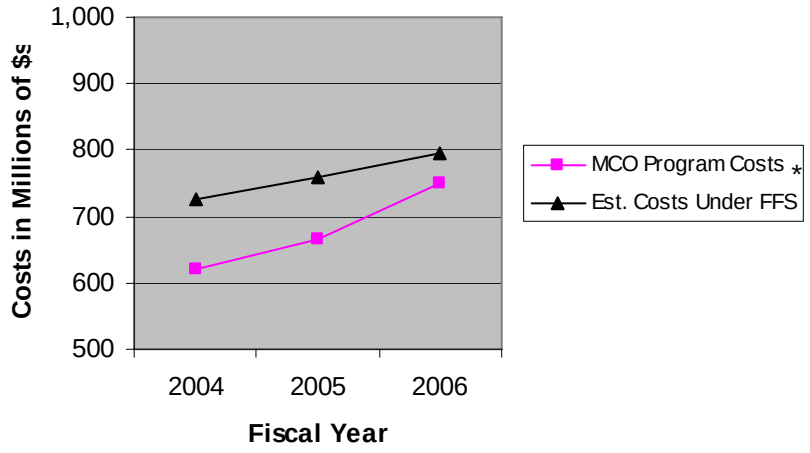


Exhibit 6: Comparison of Estimated State Costs - MCO vs. FFS, in Millions (With FY 2006 MCO Rate Increase/With QAAP)

Fiscal Year	2004	2005	2006
MCO Program *	$ 620	$ 666	$ 749
FFS	$ 727	$ 760	$ 795
Estimated Costs on a Cumulative Basis			
MCO Program	$ 620	$ 1,286	$ 2,035
FFS	$ 727	$ 1,487	$ 2,281
Difference	$ (107)	$ (201)	$ (247)

* In Exhibits 5 and 6, FY 2005 MCO costs exclude $25 million to maintain 7.5% budget cap. FY 2006 MCO costs include the $25 million.

In spite of the 12.4 percent rate increase, the MCO cost model's performance is considerably more cost-effective for the state than the FFS model. With QAAP in place, this MCO managed care model (using 2003 enrollment) saves a cumulative $247 million in state funds compared to FFS over three years.

Exhibits 7 and 8 mirror the analysis for Exhibits 5 and 6, except they change one key assumption: they assumed the elimination of QAAP. Because of the elimination of QAAP, a total of $27 million is shifted from the FY 2005 rate increase to the FY 2006 rate increase to achieve actuarial soundness over the two-year period.

Exhibit 7: Comparison of Estimated State Costs - MCO vs. FFS (With FY 2006 MCO Rate Increase/Without QAAP)

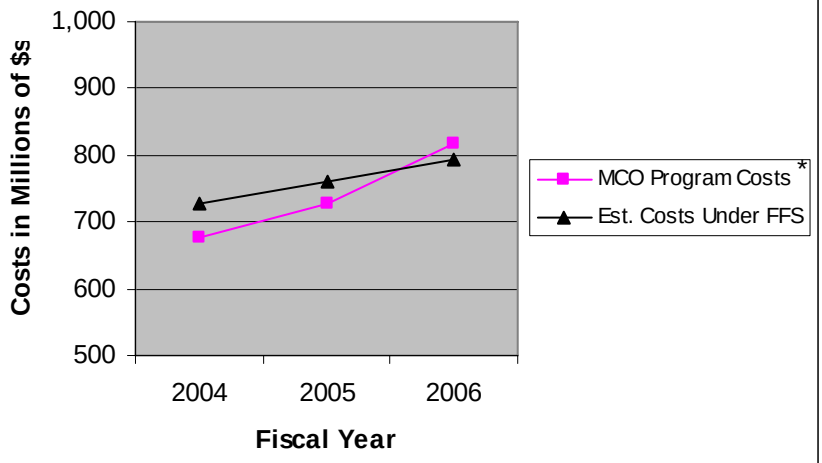


Exhibit 8: Comparison of Estimated State Costs - MCO vs. FFS, in Millions (With FY 2006 MCO Rate Increase/Without QAAP)

Fiscal Year	2004	2005	2006
MCO Program *	$ 676	$ 726	$ 817
FFS	$ 727	$ 760	$ 795
Estimated Costs on a Cumulative Basis			
MCO Program	$ 676	$ 1,402	$ 2,219
FFS	$ 727	$ 1,487	$ 2,281
Difference	$ (51)	$ (84)	$ (62)

* In Exhibits 7 and 8, 2005 MCO costs exclude $27 million to maintain the 7.5% budget cap. FY 2006 MCO costs include the $27 million.

Under these assumptions (full payment of the 12.4 percent rate increase; no QAAP program), the MCO model's cumulative savings in state funds for FY 2004 through FY 2006 are estimated at $62 million compared to FFS. Although the savings are less than they would be with QAAP in place (an estimated $247 million), the MCO model is clearly more cost-effective than the FFS model using any of the four sets of assumptions explored in Exhibits 1 through 8. The MCO model is more cost-effective than FFS

regardless of whether a 12.4 percent MCO rate increase is instituted for actuarial soundness or whether QAAP is considered.

Fee-for-Service Effect on Providers' Relationship to the Medicaid Program

Four key elements affect a provider's relationship to a health delivery system:

- Reimbursement rates
- Administrative burden
- Opportunity to participate
- Utilization review

When comparing alternative delivery systems to a multiple MCO delivery system, these elements will be compared.

Reimbursement Rates

In virtually all states' capitated Medicaid managed care programs, the MCOs pay providers at least as well, per unit of service, as Medicaid FFS. In certain services, such as specialty physician care, MCOs typically pay far better than Medicaid FFS. In many instances, this results in a larger aggregate pool of specialist providers in capitated managed care than in FFS, because some providers participate through MCOs when they would not accept Medicaid FFS rates.

Administrative Burden

A full-risk MCO delivery system requires providers to submit encounter data – information about services delivered to enrollees – to MCOs. This resembles the process of submitting a claim to Medicaid FFS, although a single provider may be required to submit data to different MCOs in different manners, thereby multiplying his or her burden. Providers must fulfill other MCO-related administrative requirements, as well, that exceed their burdens in Medicaid FFS, and these burdens also may differ from MCO to MCO. Many of these burdens, however, are intended to improve health status and health outcome reporting, which is virtually non-existent in FFS.

Opportunity to Participate

In FFS, any qualified provider who is willing to accept Medicaid's FFS rate schedule is allowed to participate. There is no screening function that limits providers. This is different from managed care, where an MCO may choose not to offer contracts to all providers, because it decides that it can achieve the best contractual arrangement with a provider by guaranteeing a certain volume of business. Moreover, an MCO may be more restrictive than FFS in the credentialing (contracting) standards it deploys. These factors may create winners and losers among providers; some providers may find themselves shut out of MCO contracting, whereas other providers find that they experience a guaranteed and steady flow of patients (which is not guaranteed in FFS). For example, because enrollees are assigned to PCPs, an MCO-contracted PCP may have a very dependable patient base. That patient base could erode for the PCPs if Michigan's Medicaid program shifts to a FFS system of care.

Utilization Review

An MCO delivery system exercises much more utilization review than FFS, to avoid unnecessary and inefficient care and stay within the fixed capitation payment. This level of scrutiny in capitated managed care occasionally frustrates providers, but it is directly related to the reason that capitated managed care is less expensive for Michigan than FFS. Providers tend to prefer FFS's relatively low level of utilization review, because FFS traditionally does not "second-guess" providers.

FFS Effect on Enrollees

Three key elements affect an enrollee's relationship to his or her delivery system:

- Choice of and access to providers
- Quality of care
- Ease of obtaining services

When comparing alternative delivery systems to a multiple MCO delivery system, these elements will be compared.

Choice of, and access to, providers

Under a FFS model, recipients may access services through any willing Medicaid provider without regard to MCO affiliation, and without a PCP's referral for specialty care services. The FFS network of providers may be insufficient, however, to provide adequate access to all covered services required by the Medicaid population. In the absence of conscious network building, significant gaps in the FFS provider pool can develop, particularly regarding providers of specialty and sub-specialty services, as well as in underserved areas. To the extent that providers are disinclined to participate in FFS Medicaid, the FFS model may provide less dependable services access than the MCO model. MCOs' responsibility to satisfy provider network adequacy requirements usually means active recruitment. This deliberate network building brings about improvement of provider networks that enhance enrollees' overall access to care.

Managed care can also be a positive force in recruiting non-Medicaid providers who participate in MCOs' commercial networks: establishing a relationship with the MCO may encourage a provider to participate in its Medicaid network. This converts a non-participating provider into a Medicaid-participating provider, improving access.

Quality of care

In virtually all studies on the subject, capitated managed care leads to better coordination of care and better health outcomes. In part this is due to an MCOs' emphasis on prevention (a cost-effective strategy), and in part this is due to the role of a PCP in coordinating a person's care. More specifically, in the full-risk MCO model, Medicaid recipients are assigned to a PCP who is responsible for their periodic and acute examinations, immunizations and other preventive services, medical record maintenance, referrals for specialty care services, and patient monitoring. This "medical

home" approach optimizes continuity of care and care coordination. MCOs are responsible for establishing and maintaining provider networks that adequately provide all covered primary and specialty care services that enrollees require. MCO network requirements promote better overall access to care.

Ease of Obtaining Services

Medicaid beneficiaries often state that they believe it will be easier, in certain narrow situations, to obtain services, because they can make their own arrangements to be seen quickly by any FFS participating Medicaid provider. However, in reality this is often harder in FFS, due to the non-participation of many Medicaid specialists. On the other hand, MCOs typically operate under access standards that require that enrollees be seen for certain conditions in a time-sensitive way (depending on whether the underlying condition is non-emergent).

3. Primary Care Case Management (PCCM)

The next alternative delivery system model for consideration is primary care case management. A PCCM system of care delivers covered services through contracted individual providers, group practices, and in some cases entities that employ or contract individual providers. Under a PCCM contract, PCPs/CMs are assigned responsibility for specific recipients, to whom they provide primary and preventive care services, refer and arrange for specialty care services, and coordinate care. Although PCPs/CMs traditionally have been physicians, some states' PCCM programs also contract with advanced practice nurses or physician assistants.

The costs and savings associated with any PCCM delivery system depends on how the program is structured. Medicaid PCCM programs currently in operation around the country vary widely from state to state. These variations include reimbursement methods, the makeup and intensity of state-run utilization management activities, and the populations enrolled in the program (e.g., Medicaid eligibility categories). Another important factor is the substantial variation from program to program of the level of risk assigned to the PCP/CM retained by the state Medicaid program.

Only one PCCM program feature appears to be universal: each recipient is assigned to a PCP/CM who is responsible for maintaining the recipient's medical records, coordinating care, and making appropriate referrals to other providers. In exchange for performing these administrative and medical management functions, the program pays the PCP/CM a nominal per-recipient case management fee, which is typically $2 to $4 PMPM.

PCCM programs can be categorized as "non-risk" or "partial-risk."

- Non-Risk PCCM Programs: Basic, non-risk Medicaid PCCM programs incorporate a case management fee as discussed above. In addition, PCPs/CMs are expected to provide primary and preventive care services to their assigned recipients on an FFS basis. These traditional PCCM programs are based on non-risk contracts. All covered medical services, whether delivered by the PCP/CM or by a referred specialist, are reimbursed through FFS Medicaid. In most states, the Medicaid agency retains responsibility for utilization management activities.[12] Non-risk PCCM programs include North Carolina Access, Georgia Better Care, and Michigan's former Medicaid PCCM program, the Physician Sponsor Plan. The PCCM programs in each of these states use non-risk contracts with PCPs/CMs that incorporate a per-recipient case management fee arrangement and FFS reimbursement for medical services.

- Partial-Risk PCCM Programs: Some programs use partial-risk contracts that require PCPs/CMs to provide some or all covered primary care services on a capitated basis. In this model, financial risk for assigned enrollees' inappropriate utilization of services creates a financial incentive for the PCP/CM to deliver preventive care and

[12] Michigan's earlier Physician Sponsor Plan included preauthorization as a PCP/CM responsibility covered by the case management fee.

information about how to access care appropriately. Oklahoma's SoonerCare PCCM program uses partial-risk contracts that incorporate three distinct reimbursement elements. First, SoonerCare pays the PCP/CM a per-recipient case management fee of $2 to $3 per month (variation is based on recipient's age, sex, and eligibility category). Second, capitated payments to the PCP/CM reimburse certain primary care services, including well-baby and other primary care visits, immunizations, and basic diagnostic lab services. Capitation rates range from $6.42 to $35.17 PMPM. The specific rate is a function of a recipient's individual risk factors (age, sex, and eligibility category). The capitation fee is not tied to services actually delivered; it remains the same regardless of utilization. All other covered medical services are reimbursed under FFS.

In other states, there is a great deal of variation in PCCM program designs. The following discussion of four states' PCCM programs, together with the data in Exhibit 9, illustrate the range of features and the variation in cost savings.

- Oklahoma: SoonerCare Plus (MCOs) and SoonerCare Choice (PCCMs) operated side-by-side with somewhat different benefit packages. As an incentive for MCO enrollment, the MCO benefit package was somewhat more generous than that offered under PCCM. Since the expiration of the MCO program's waiver authority in April 2004, Oklahoma's Medicaid managed care program has moved entirely to a partial-risk PCCM model with enrollment of around 360,000. Using available data, UMBC estimated savings (considering state funds only) of 3 percent per year in Oklahoma's PCCM program, relative to FFS. (The reasons for Oklahoma's decision to move from an MCO program to a PCCM program included the state's difficulty attracting and retaining participating MCOs, as well as obtaining a waiver extension.)

- North Carolina: This PCCM program covers 783,738 Medicaid recipients, distributed among the program's three tiers. The first tier, Carolina Access, is a basic PCCM model. In the remaining two tiers, Access II and III, PCPs/CMs receive an additional monthly case management fee for additional services. The program also incorporates state-contracted third party administrative entities responsible for developing and managing provider networks. These entities receive $2.50 PMPM to coordinate disease management, utilization review, and quality improvement across provider networks.

- Massachusetts: This state operates a PCCM program and a full-risk MCO program side-by-side. In the PCCM program, the PCP/CM is responsible for providing all primary and preventive care services, and for coordinating referrals for specialty care. Instead of a monthly case management fee, the PCP/CM receives a flat fee of $10 for every office visit provided to an enrolled recipient, in addition to FFS reimbursement of the specific medical services provided. This fee-per-visit feature provides no direct cost-containment incentive, nor is it meant to. It does encourage PCPs/CMs to bring members into care. A third-party contractor manages the provider network for the PCCM program and is responsible for developing provider profiles as an element of the PCCM program's quality improvement activities. Regulations

prohibiting mandatory MCO enrollment of disabled recipients have led to case mix variations between Massachusetts' PCCM and MCO programs.

- Georgia: Georgia Better Health Care (GBHC) is a traditional §1915(b) non-risk PCCM program with enrollment of about 840,000. PCPs/CMs receive a $3 PMPM case management fee. All covered medical services are reimbursed under FFS. Georgia plans to replace GBHC with a full-risk MCO program, scheduled for implementation in January 2006.

Exhibit 9: PCCM Programs – Other States[13]

State	Program Name	PCCM Enrollment	PCCM CM Fee (PMPM)	PCCM/CM Case Management Responsibility	PCCM Capitation Payment	PCCM Capitated Services	PCCM Savings
OK	SoonerCare	359,682 (69%) as of June 2004	$2-$3 adjusted for age, sex, eligibility group	Coordinate care	$6.42-35.17 adjusted for age, sex, eligibility group	PCP visits, immunizations, basic lab	3% (estimated) FY05 (state funds only; relative to MCO)
NC	Community Care - N.C. ACCESS, A-II, A-III HMO program	751,789 - 70% of Medicaid, 76% of managed care eligibles	Access: $1 to PCP/CM; II & III: $2.50 to PCP/CM; $2.50 to ASO	PCP/CM refers or provides primary care services (FFS) Access II & III use ASO for DM, UR, QI	None. All services FFS	None	1% for FY03 (state funds only; relative to FFS)
MA	Mass Health PCCM and MCO	321,525 (54%) PCCM; 270,509 (46%) MCO	$10 per visit	Coordinate referrals, manage care	None. All services FFS	None	Not available
GA	Georgia Better Health Care	840,630 (58% of total Medicaid)	$3	Coordinate care	None. All services FFS	None	5% (estimated) CY01-02 (relative to FFS)

[13] Refer to Appendix C for notes and source information.

Development of the PCCM Model

As shown in the examples above, the characteristics of PCCM programs can vary significantly. If Georgia's program is used to illustrate the cost difference between a PCCM program model and an MCO program, several additional cost components must be incorporated into the analysis. As a benchmark, UMBC estimated an additional state administrative cost load of 1.75 percent of projected claims expense for the FFS model used to develop Exhibits 1 through 8.

In 1993, when Georgia began moving from FFS into its current PCCM program, the state incurred additional administrative costs in connection with additional personnel, utilization review, and quality assurance review systems needed to operate the new care delivery system. To reflect these additional costs, the 1.75 percent administrative cost load estimate used in the FFS model was increased to 2.15 percent for the PCCM model, or an additional $5.5 million in FY 2006. Another GBHC-related cost to be considered is the $3 PMPM case management fee.

In information provided to CMS, Georgia projected savings of 7.4 percent compared to FFS for the GBHC program's upcoming waiver period (roughly CY 2003-04). This percentage reflected projected savings. Looking at the program's *actual* savings for the prior waiver period, UMBC estimated a savings rate of approximately 5 percent relative to FFS. This is the level of savings UMBC assumed in estimating savings for the PCCM model used for this report.

Comparing PCCM with Alternative Models

In evaluating the relative costs of providing care through different delivery models, all relevant cost variables associated with each model must be appropriately considered.

- FFS vs. PCCM: When comparing a PCCM model to a FFS alternative, the PCCM model will cost the state less if the level of savings from better care management is greater than the additional administrative costs the state incurs from operating a PCCM, plus the monthly per-person case management fee the state pays to the PCP/CM. In UMBC's modeling, the combined additional administrative load and case management fees associated with the PCCM model reflect about 2 percent of projected claims. Since estimated savings are higher at 5 percent, PCCM service delivery would be less expensive than FFS.

- MCO vs. PCCM: When comparing state PCCM costs to those associated with an MCO program, the PCCM model is not subject to the 6 percent premium assessment fee burden that is incurred under MCO managed care. As explained in more detail below, certain features of Medicaid financing make an MCO program less expensive to the state than a PCCM program.

State Costs under MCO and PCCM Models

As demonstrated in the comparison of state costs under MCO and FFS models (above), the favorable treatment to the state for QAAP provides a financial advantage for the existing MCO managed care program. Along with the lower trends for MCO managed care, this makes the costs of providing care under the current MCO managed care program much more favorable to the state budget in every year of the analysis. Exhibits 10 through 17 show the estimated costs in state funds (as influenced by rate and fee variables) under MCO managed care compared to a PCCM model, using December 2003 enrollment.

Exhibit 10: Comparison of Estimated State Costs - MCO vs. PCCM (Without FY 2006 MCO Rate Increase/With QAAP)

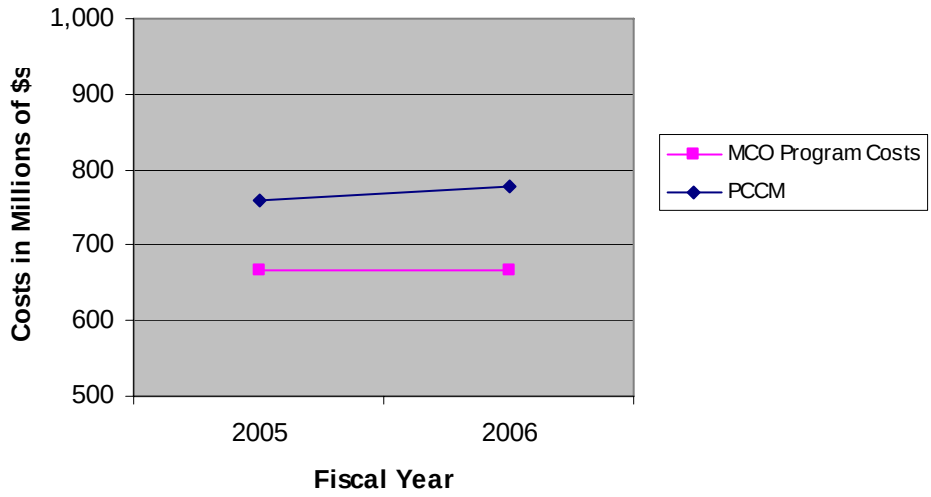


Exhibit 11: Comparison of Estimated State Costs - MCO vs. PCCM, in Millions (Without FY 2006 MCO Rate Increase/With QAAP)

Fiscal Year	2005	2006
MCO Program	$ 666	$ 666
PCCM	$ 760	$ 777
Estimated Costs on a Cumulative Basis		
MCO Program	$ 666	$ 1,332
FFS	$ 760	$ 1,536
Difference	$ (94)	$ (204)

The comparison in Exhibits 10 and 11 of the MCO managed care model incorporates no FY 2006 rate increase. The QAAP premium assessment fee is in place. With these assumptions, the MCO model produces estimated cumulative savings of $204 million (state funds only) compared to the PCCM model for the two-year period of FY 2005 and 2006 using December 2003 enrollment.

Exhibits 12 and 13 compare state costs under the PCCM model and under an MCO model that incorporates no FY 2006 rate increase. However, unlike Exhibits 10 and 11, 12 and 13 do not include the effect of the QAAP premium assessment fee.

Exhibit 12: Comparison of Estimated State Costs - MCO vs. PCCM (Without FY 2006 MCO Rate Increase/Without QAAP)

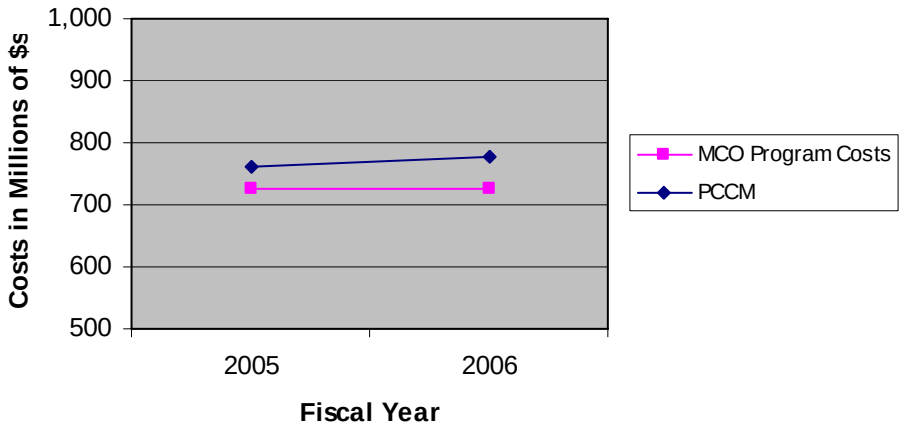


Exhibit 13: Comparison of Estimated State Costs - MCO vs. PCCM, in Millions (Without FY 2006 MCO Rate Increase/Without QAAP)

Fiscal Year	2005	2006
MCO Program	$ 726	$ 726
PCCM	$ 760	$ 777
Estimated Costs on a Cumulative Basis		
MCO Program	$ 726	$ 1,453
FFS	$ 760	$ 1,536
Difference	$ (33)	$ (83)

Exhibits 12 and 13 illustrate the significance of the QAAP premium assessment fee to the cost-effectiveness of the MCO managed care model to the state. As shown in Exhibits 10 and 11, the MCO managed care model without a rate increase saves the state an estimated $204 million over FY 2005-2006 when QAAP is included in the rates. When all variables remain constant except for the elimination of QAAP, Exhibits 12 and 13 show that the MCO model generates less than half the savings (an estimated $83 million) over the same two-year period.

Exhibits 14 and 15 use an MCO model that incorporates the 12.4 percent rate increase for FY 2006, so that capitation rates paid to MCOs are actuarially sound. The QAAP premium assessment fee is also considered for this scenario.

Exhibit 14: Comparison of Estimated State Costs - MCO vs. PCCM (With FY 2006 MCO Rate Increase/With QAAP)

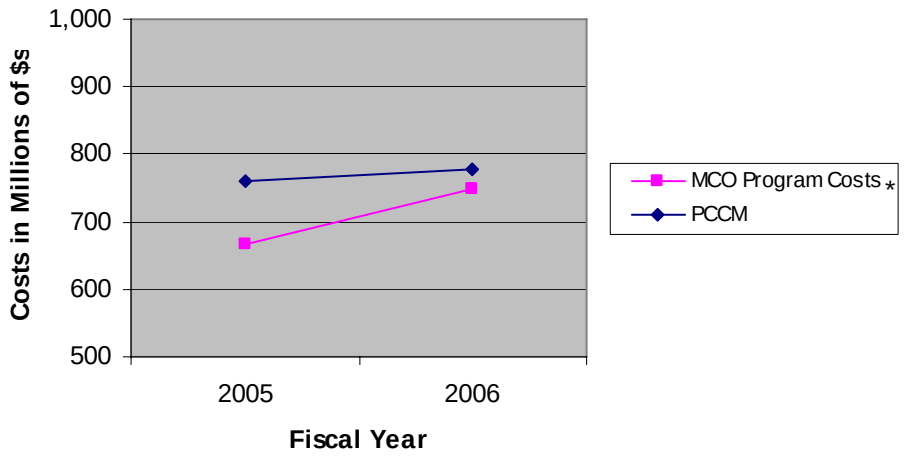


Exhibit 15: Comparison of Estimated State Costs - MCO vs. PCCM, in Millions (With FY 2006 MCO Rate Increase/With QAAP)

Fiscal Year	2005	2006
MCO Program *	$ 666	$ 749
PCCM	$ 760	$ 777
Estimated Costs on a Cumulative Basis		
MCO Program	$ 666	$ 1,415
FFS	$ 760	$ 1,536
Difference	$ (94)	$ (122)

* 2005 MCO costs exclude $25 million to maintain 7.5% budget cap. 2006 MCO costs include the $25 million.

As displayed in Exhibits 14 and 15, the expected cumulative savings in state funds using the actuarially sound MCO model as compared to the PCCM model is estimated at $144 million (using December 2003 enrollment) for FY 2005-2006 when the premium assessment fee is considered.

Exhibits 16 and 17 compare state costs using an actuarially sound MCO managed care model (with a 12.4 percent rate increase for FY 2006) compared to state costs using a PCCM model, when the effect of QAAP is not considered.

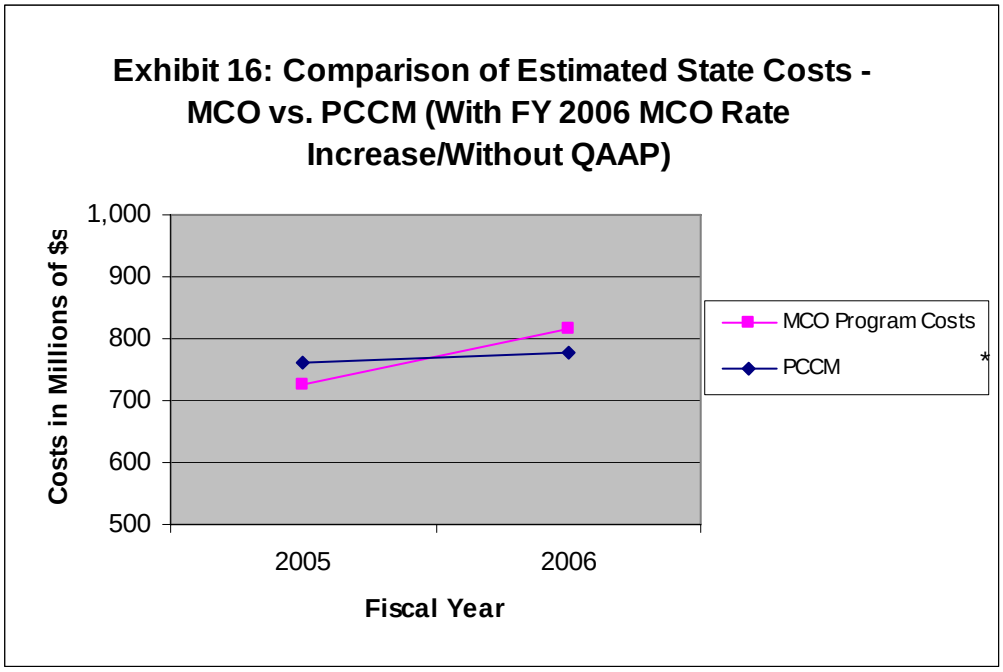


Exhibit 17: Comparison of Estimated State Costs - MCO vs. PCCM, in Millions (With FY 2006 MCO Rate Increase/ Without QAAP)

Fiscal Year	2005	2006
MCO Program *	$ 726	$ 817
PCCM	$ 760	$ 777
Estimated Costs on a Cumulative Basis		
MCO Program	$ 726	$ 1,543
FFS	$ 760	$ 1,536
Difference	$ (33)	$ 7

* 2005 MCO costs exclude $27 million to maintain 7.5% budget cap. 2006 MCO costs include the $27 million.

Exhibits 16 and 17 illustrate the effect on state Medicaid costs when the QAAP premium assessment fee is removed from consideration, comparing an actuarially sound MCO model with the PCCM model. The MCO model's performance is more cost-effective in FY 2005, but the 12.4 percent rate increase (necessary in part to address FY 2005 underpayments) raised costs enough to make the MCO model less cost-effective in the second year. Over the two-year period of FY 2005 to FY 2006, the PCCM model is cumulatively more cost-effective in state funds than the MCO model by a relatively small margin (an estimated $7 million). Going forward from 2006, it would be expected that the PCCM model would cost more than the MCO model under this scenario since lower medical expense trends would be realized under the MCO program. Thus, any potential savings in PCCM would be short-lived.

Exhibits 16 and 17 represent the fourth set of comparisons illustrating the state's relative costs of delivering covered Medicaid services through MCO managed care or PCCM delivery models. This is the only comparison in which the PCCM model's performance, in terms of state funds, is more cost-effective. It should be noted that the MCO model's performance in the second year (FY 2006) is affected by the aggregate effect of a "catch-up" rate increase and the theoretical absence of the advantages the state accrues due to QAAP. Under each of the other scenarios presented, the state's costs are expected to be substantially lower under the MCO managed care model than they would be under a PCCM model.

PCCM Transition - Effect on Providers

The four elements previously described again will be compared.

Reimbursement Rates

As previously mentioned, in virtually all states' capitated Medicaid managed care programs, the MCOs pay providers at least as well, per unit of service, as Medicaid FFS. In certain services, such as specialty physician care, MCOs typically pay far better than Medicaid FFS. Because for specialists a PCCM program pays at the Medicaid FFS schedule, per unit of service, a PCCM program offers the same disadvantages as FFS. On the other hand, for a PCP, the PCCM program may be better than FFS, since participating PCPs will receive a monthly case management fee from the state for each beneficiary assigned to that PCP.

Administrative Burden

A capitated MCO delivery system may impose the highest level of administrative burden on providers – and a great degree of this burden relates to quality assurance activities and reports. FFS results in the lowest level of administrative burden on providers, and is one reason that many providers prefer FFS. The burdens in a PCCM program typically fall somewhere in the middle. PCPs have heightened duties in a PCCM system (when compared to FFS) because of their role as primary care case managers. In addition, specialists have higher administrative burdens in a PCCM system (again, when compared to FFS), because they generally are not permitted to render care – and get reimbursed – absent a referral from a PCP. This is more onerous than FFS, when specialists may see a patient based merely upon the patient's self-referral. Moreover, for

both primary care and specialty physicians – and for other provider types such as hospitals and pharmacies – both FFS and PCCM are less burdensome due to the generally lower level of utilization review.

Despite those points, however, an important adjustment that PCPs (as well as other providers transitioning into a PCCM program) would have to make is the absence of an MCO's organizational support. For example, MCOs are required to provide adequate access to appropriate care for enrollees with special health care needs. One way in which MCOs address this is by identifying (in enrollment data transmitted to MCOs) enrollees with special health care needs. MCOs are responsible for including in their provider networks all types of ancillary, institutional, and specialty care providers that their enrollees with special needs require. Under a PCCM delivery system, a PCP has only the state Medicaid provider network to draw upon when making specialty care referrals. As discussed above (in connection with the effect on providers and enrollees of transitioning to a FFS delivery system), the state Medicaid provider network may not be as complete as —and may not provide a comparable level of care access to— an MCO's provider network. This is because MCOs have to develop and maintain provider networks that comply with their programs' network adequacy and accessibility requirements. A network that meets such requirements requires conscious, deliberate network-building efforts. MCOs have the organizational capacity to do this, but PCCM delivery systems do not. The absence of this degree of MCO organizational support could frustrate many PCPs working within a PCCM model.

Opportunity to Participate

In PCCM, as in FFS, any qualified provider who is willing to accept Medicaid's FFS rate schedule is allowed to participate. There is a key exception to this general rule: the state may limit who is allowed to act as a PCP, because the state generally will want to assign beneficiaries to PCPs in an efficient way, cognizant of caseload efficiencies. There is no screening function that limits providers. As in FFS, this is different from capitated managed care, where an MCO may decide that it can achieve the best contractual arrangement with a provider by guaranteeing a certain volume of business.

Utilization Review

While a PCCM delivery system generally involves substantially less utilization review than an MCO system, it has more utilization review than pure FFS since certain services require a PCP's referral before they may be authorized. An MCO delivery system exercises much more utilization review than either PCCM or FFS, to avoid unnecessary and inefficient care. This level of scrutiny is directly related to the reason that we estimate that capitated managed care generates savings when compared to a PCCM or FFS system.

Transition to PCCM - Effect on Enrollees:

When comparing alternative delivery systems to a multiple MCO delivery system, these elements will be compared.

Choice of, and access to, providers

In a PCCM system, beneficiaries would have the right to choose providers, although once assigned to a PCP the beneficiary then cannot shop around with other PCPs – the beneficiary would be obligated to work through his or her PCP to access specialty care. With respect to other provider types, however, such as hospitals and pharmacies, a beneficiary could seek services from any provider that participates in Medicaid FFS. Again, this could be a far narrower pool of providers than a beneficiary may have access to under capitated managed care, where MCOs often recruit providers who otherwise shun Medicaid. That is, MCOs' responsibility to satisfy provider network adequacy requirements usually means active recruitment. This deliberate network building brings about improvement of provider networks that enhance enrollees' overall access to care.

Quality of care

Quality of care improves under a PCCM program, when compared to FFS. This is directly related to the PCP's role as a medical home for the beneficiaries assigned to the PCP's care. However, quality of care still is not as good as capitated managed care, which brings a great deal more scrutiny and accountability to measures such as immunization rates, well-child check-ups, prenatal care, periodic physicals, etc.

Ease of Obtaining Services

A PCCM program resembles a FFS program in making services available to beneficiaries, with one advantage: the state will assure that the beneficiary is assigned to a PCP, so the beneficiary will not have to search for a PCP willing to provide services. Beyond that, however, the beneficiary still must seek out willing providers on his or her own, limited by the pool of providers willing to participate in Medicaid and accept Medicaid FFS rates. Access to care, particularly specialty care, may be compromised under a PCCM model (when compared to an MCO system) because it provides no entity that is responsible for recruiting providers to participate in an adequate network. In view of the North Carolina programs already discussed, it appears that provider network management can be successful within a PCCM framework. However, the network features of the North Carolina PCCM model are not typical of PCCM programs in general.

An MCO's organizational capacity is also relevant when assessing how MCO enrollees are affected when shifting to a PCCM system. MCOs provide enrollees numerous benefits that are not available under a PCCM model. For example, MCOs provide easily available and understandable information about how to access care. Some MCOs provide additional benefits not required by the program either as an enrollment incentive or because providing the service is viewed as cost-effective for the MCO. MCOs also provide health education programs and outreach activities that promote preventive services and healthy lifestyles. Because MCOs are accountable for meeting performance standards, there are strong financial incentives for MCOs to encourage enrollees to receive regular checkups, screenings, and other preventive services. Some MCOs even provide tangible rewards to enrollees for healthy behavior (such as receiving diagnostic

screening). Preventive services are a demonstrably cost-effective means of reducing overall health care costs. MCO managed care is generally considered superior to other care delivery models in terms of the number of enrollees who receive preventive services, and also with respect to access to care.

4. Single Statewide MCO

Delivering Medicaid services through a single statewide MCO does not appear to be a viable option. Practical considerations include the fact that no current plan is both capable and willing to participate in CHCP on a statewide basis. Consequently, any efforts by DCH to identify a qualified plan to serve as the single statewide Medicaid MCO will likely be met with difficulty. Moreover, assuming that a willing and qualified plan could be found, the program's sole plan would have an inordinately powerful bargaining position in contract negotiations. Under these circumstances, it is doubtful that the state would be able to contract with the plan at a reasonable rate. The state would be under great pressure to agree to unjustifiably high payment rates in order to avoid losing its sole contractor.

In addition to the practical considerations, when Medicaid recipients are subject to mandatory enrollment in a managed care plan, federal regulations authorized by the Balanced Budget Act of 1997 (BBA) require that they have a choice between at least two MCOs. The only current exception is that, subject to certain conditions, mandatory enrollment in a single plan may be permitted in rural areas. "Rural areas" is defined as anywhere outside of "urban areas." "Urban areas" are defined as being within a Metropolitan Statistical Area (MSA) as determined by the federal Office of Management and Budget. Because Michigan has 15 MSAs, the rural exception cannot be used to authorize mandatory enrollment into a single statewide plan.[14]

Nationally, very few states operate a mandatory enrollment single-plan area. In these few cases, the program covers only limited benefits (e.g., Washington) or a limited population (e.g., Oregon). There are no comprehensive single-plan programs currently operating on a statewide basis in any state in the country. Of state Medicaid managed care programs that operate a single-plan area, all but one are authorized under the BBA rural exception. Hawaii's §1115 waiver program, for example, has two or more participating MCOs on four islands, and uses the BBA rural exception for two more rural islands that have only one participating plan each. Only one state operates a single-plan program under authorization other than the BBA rural exception: the Kentucky Partnership Plan uses a single plan for Louisville and surrounding areas. Authority for this single-plan area was under §1115 of the Social Security Act. Since CMS originally approved Kentucky's program in 1993 (before the BBA instituted a generally applicable choice requirement that is virtually un-waivable), the program's approval predated the BBA's choice doctrine, which went into effect in 1997. Today, BBA and 42 CFR §438.52 preclude approval of any new mandatory enrollment single-plan areas unless the rural exception applies.

Currently there are 26 Michigan counties with only one CHCP-participating plan, and three counties with no participating plan. Michigan has relied on the rural exception to maintain mandatory enrollment in 15 rural counties where the single contracting plan has

[14]Section 1932(a)(3)(b) of the Social Security Act and 42 CFR §438.52 states the choice of MCOs rule and the exception for rural areas, which are areas not within a Metropolitan Statistical Area (MSA). MSAs are listed in OMB Bulletin No. 05-02 Appendix, pp. 118-19.

adequate capacity and systems to serve the county's entire managed care-eligible Medicaid population. In the 11 single-plan counties where the rural exception does not apply, recipients can choose between MCO enrollment and accessing care through FFS Medicaid.

Transition to Single Statewide MCO - Effect on Providers:

When comparing alternative delivery systems to a multiple MCO delivery system, these elements again will be compared.

Reimbursement Rates

It is difficult to project how well providers might be reimbursed by a single statewide MCO. On the one hand, providers may have limited bargaining power, should they seriously want to (or need to) participate in Medicaid. Some providers who depend on Medicaid beneficiaries – perhaps urban hospitals and pediatricians are good examples, given their Medicaid caseloads – may be asked to accept very low rates. On the other hand, should providers themselves form loose bargaining coalitions, they may be able to extract high reimbursement rates from a single MCO that needs to build a provider network.

Administrative Burden

Working with a single entity may simplify providers' lives, by reducing duplicate administrative processes such as credentialing and provider training. Yet, if the states contracts with a single MCO that has a hostile or inefficient administration, it could greatly frustrate and alienate providers. Again, this would depend a great deal on the specific processes of the singe MCO that might be awarded such a contract.

Opportunity to Participate

A single MCO environment would create a make-or-break scenario for providers – they could participate only if they secure a contract with that one MCO. Otherwise, they would be precluded from serving Medicaid beneficiaries enrolled in the MCO. This would create a very highly charged provider-contracting environment.

Utilization Review

Much like the administrative burden discussion, with a single statewide MCO a provider would be subjected to only one set of utilization review criteria. If these criteria are fair and easy to understand and execute, they may lead to provider satisfaction when compared to a situation with multiple MCOs, each of which has its own set of rules. Alternatively, however, if the single MCO's criteria are unfair or difficult to understand and executed, it could lead to a great deal of provider discord.

Transition to Single Statewide MCO - Effect on Enrollees:

When comparing alternative delivery systems to a multiple MCO delivery system, these same three elements will be compared.

Choice of providers

A single statewide MCO would present enrollees with the lowest degree of choice – they only could choose from among the providers offered by that single MCO. This presents less choice than a multiple MCO system – where the provider networks may vary from MCO to MCO but more providers would be available in aggregate.

Quality of care

It is hard to assess how quality of care would compare in a single MCO system. Perhaps quality might improve, since the state would be able to focus its monitoring and oversight activities on a single entity, which could develop clinical standards that would affect all enrollees. Yet, the opposite also might be true: that the state would have less influence, if the single MCO thought it could exert leverage over the state – in the form of monopoly power – to avoid accountability.

Ease of Obtaining Services

The ease with which beneficiaries could access services would depend entirely on the factors mentioned above: the breadth of the network, the single MCO's access standards, and the state's ability to exercise oversight authority. These factors are difficult to predict for a system that does not exist anywhere in the country.

CONCLUSION

A capitated managed care program, involving multiple MCOs, is the most cost effective delivery system for Michigan. It also incorporates many public health benefits that are not usually found in less intensively managed program types. An MCO's capacity to deliver the program's benefit package to its enrolled population is dependent on developing, maintaining, and monitoring a comprehensive provider network large and varied enough to adequately serve its enrollees' needs. Such a network is an essential adjunct to an MCO "medical home" provided by an enrollee's PCP. Because of the PCP's connection to an established provider network of specialty and ancillary care providers, that enrollee has better access to care and better coordination of care than is typically found under a FFS or PCCM model.

Historically, Michigan established MCO payment rates through a competitive bidding process. In response to new federal actuarial soundness rules adopted by CMS under the Balanced Budget Act, the Department of Community Health retained the services of a national actuarial firm to develop actuarially sound MCO payment rates over a two-year period: FY 2005 and 2006. The capitation rate increase developed for FY 2005 was capped at 7.5 percent. That limitation led to a major aspect of the fiscal dilemma the state now faces: the total FY 2006 rate increase includes a residual "catch-up" rate component from FY 2005 that was excluded from that year's rate increase. The expected FY 2006 rate increase includes not only the deferred FY 2005 rate component and the full FY 2006 rate component, but it includes all other adjustments necessary to achieve the federal requirement of actuarial soundness.

In considering the alternatives to a capitated multiple MCO system such as CHCP, several options were evaluated. Whether the state develops a less intense form of managed care, such as a PCCM model, or returns to a traditional FFS model, the overall levels of services utilization will increase over time. Thus, more services will be used. In addition, trends (inflation) observed for the FFS and PCCM models will also increase over time, compared to the multiple MCO system of managed care. Overall, these increases make the alternative systems more expensive, in spite of the fact that they might have lower administrative costs.

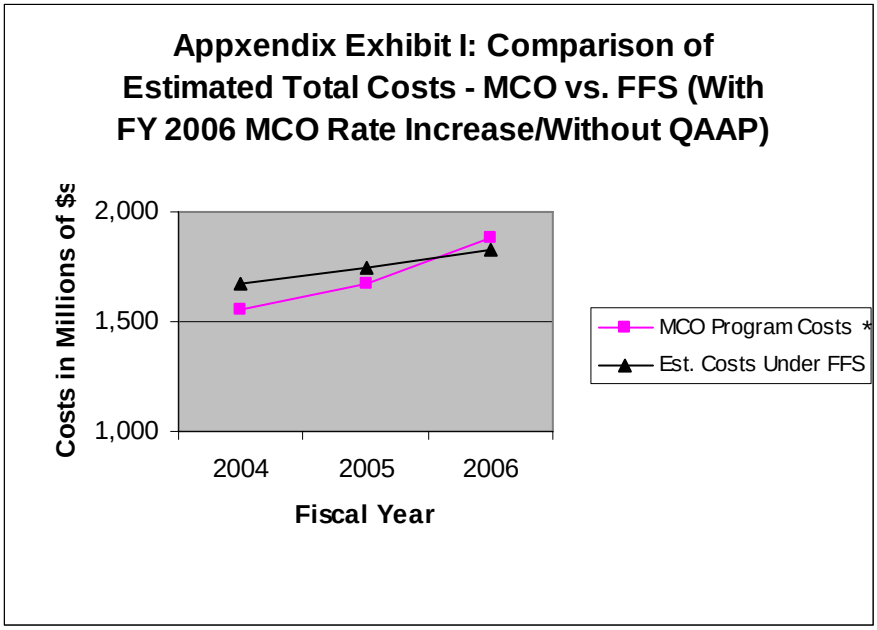
Any change by a state Medicaid program from one service delivery model to another will produce financial costs that are difficult to quantify. There will be other effects as well, on both recipients and providers. [[Transition between programs can be expected to disrupt continuity of care as recipients shift from one program to another and, for many recipients, from their established PCP to new providers. Recipients who do have to change providers inevitably will experience some level of confusion in attempting to access care under the new program. Recipients' uncertainty as to how and where to access needed care can delay or deny its delivery to the very vulnerable population Michigan's Comprehensive Health Care Program serves.

Appendix A

Comparison of Estimated Costs in Total Funds Under Alternative Delivery Systems

MCO vs. FFS - Total Funds (Including FY 2006 MCO Rate Increase and Without QAAP Premium Assessment Fee)

Appendix Exhibits 1 and 2 show the estimated total (federal and state) costs under MCO managed care compared to the FFS model using December 2003 enrollment. Assumptions include a 12.4 percent FY 2006 MCO rate increase, and exclude QAAP.



Appendix Exhibit 2: Comparison of Estimated Total Costs - MCO vs. FFS, in Millions (With FY 2006 MCO Rate Increase/Without QAAP)

Fiscal Year	2004	2005	2006
MCO Program *	$ 1,557	$ 1,674	$ 1,882
FFS	$ 1,670	$ 1,746	$ 1,826
Estimated Costs on a Cumulative Basis			
MCO Program	$ 1,557	$ 3,231	$ 5,112
FFS	$ 1,670	$ 3,416	$ 5,242
Difference	$ (113)	$ (186)	$ (130)

* 2005 MCO total costs exclude $62 million to maintain 7.5% budget cap. 2006 MCO total costs include the $62 million.

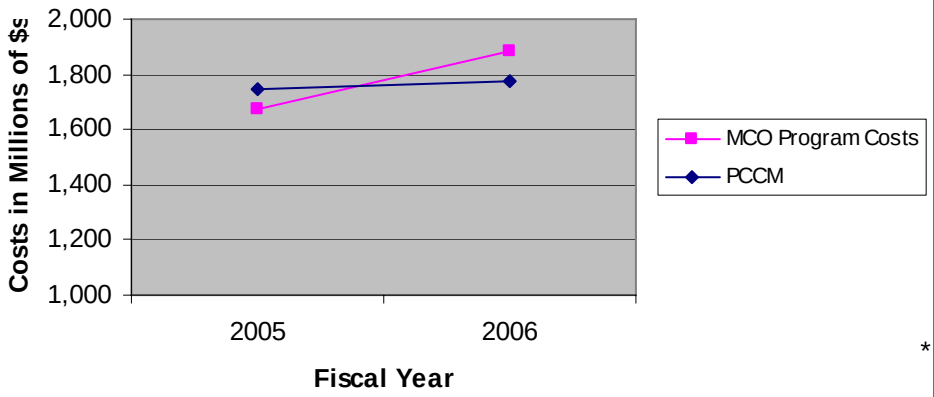
Under the scenario presented in Appendix Exhibits 1 and 2, in which MCOs are paid actuarially sound rates but excluding the effect of QAAP, estimates of total savings (based on 2003 enrollment) show the MCO model as more cost-effective in the first two years, with FFS somewhat more cost-effective in FY 2006. (Note that in this scenario,

FY 2006 would be the implementation year for a rate increase reflecting not only the current rate year but also a portion of the rate increase needed in the previous year that was postponed because it exceeded the budget cap.) This scenario also shows cumulative total costs for the three years as less under MCO managed care than under a FFS delivery model.

MCO vs. PCCM – Total Funds (Including FY 2006 MCO Rate Increase without QAAP Premium Assessment Fee)

Appendix Exhibits 3 and 4 compare total (federal and state) costs under the PCCM model to those under the MCO model, applying a FY 2006 rate increase, excluding the QAAP premium assessment fee, and based on 2003 enrollment.

Appendix Exhibit 3: Comparison of Estimated Total Costs - MCO vs. PCCM (With FY 2006 MCO Rate Increase/Without QAAP)



Appendix Exhibit 4: Comparison of Estimated Total Costs - MCO vs. PCCM, in Millions (With FY 2006 MCO Rate Increase/Without QAAP)

Fiscal Year	2005	2006
MCO Program *	$ 1,674	$ 1,882
PCCM	$ 1,746	$ 1,779
Estimated Costs on a Cumulative Basis		
MCO Program	$ 1,674	$ 3,555
FFS	$ 1,746	$ 3,524
Difference	$ (72)	$ 31

* 2005 MCO costs exclude $62 million needed to maintain 7.5% budget cap. 2006 MCO costs include the $62 million.

Under the scenario presented in Appendix Exhibits 3 and 4, MCO total costs are estimated to be lower than PCCM total costs in the first year, but higher in the second year, due to the effect of the FY 2006 rate increase.

Appendix B

Technical Appendix: Assumptions Incorporated into Alternative Delivery Models

This report's analyses are based on cost models for alternative delivery systems developed by UMBC. In the interests of providing a full explanation of how UMBC arrived at its conclusions, what follows are lists of the assumptions built into each of the alternative care delivery models considered in this report.

MCO Managed Care Model

- 2006 total base costs: Milliman Enclosure 4 (adjusted for 2005 budget impact)
- Projected average annual rate of trend (FY07 – FY10): 4.7% [15]
- MCO administrative component of rate: same as 2005 MCO rates
- Additional state administrative costs: $0

Fee-for-Service Model

- Projected average annual rate of trend (FY07-FY10): 7.3%
- MCO administrative component of rate: $0
- Additional state administrative costs: 1.75% of projected claims
- Managed care deterioration applied: 13%

PCCM Model

- Projected average annual rate of trend (FY07-FY10): 6.3%
- MCO administrative component of rate: $0
- Additional state administrative costs: 2.15% of projected claims
- Managed care deterioration applied: 8%
- Case management fee: $3 PMPM

[15] Although UMBC did not include any specific references in the report to expected performance of the various delivery models in these future years, the report does include general observations about their expected performance over the long term.

Appendix C

Notes and Sources for Exhibit 9 Data: PCCM Programs - Other States

Oklahoma: After operating PCCM and MCO programs side-by-side for a number of years, Oklahoma terminated the MCO program in January 2004. MCO enrollees were transferred into the PCCM program by April 2004. Data for columns 5-7 were drawn from Oklahoma Health Care Authority web pages: http://www.ohca.state.ok.us/ (2005 Physician Contract, OHCA 2004 Annual Report). For column 8, UMBC estimated FY05 savings based on FY04 experience.

North Carolina: Enrollment data are for June 2003 and exclude the state's Medicaid MCO program that is operated only in Charlotte and the surrounding county. North Carolina's PCCM program grew through a phased expansion developed in stages: Carolina Access, Access II, and Access III. In 1993, the case management fee paid by Carolina Access was lowered to $1.00 PMPM to encourage expansion of the program's Access II and III components. (Medicaid in North Carolina Annual Report 2003, at: http://www.dhhs.state.nc.us/dma/2003report/03MedicaidAnnualReport-chap1.pdf).

The PCP/CM responsibilities reimbursed by the case management fee do not include any medical services. These are provided either by the PCP/CM or a referred provider on a FFS basis (Basic Medicaid Billing Guide, Feb. 2005, at: http://www.dhhs.state.nc.us/dma/basicmed/February2005/esection4Jan2005.pdf).
North Carolina provided the information (per "Community Care At a Glance" Fact Sheet January 2005) that according to a recent Mercer Human Resource Consulting Group actuarial study, program savings due to Access II and III were $60 million for FY 03, which coverts to 1% compared to fee for service.

Massachusetts: MassHealth 1115 Demonstration Project Annual Report SFY2003. http://www.mass.gov/Eeohhs2/docs/masshealth/research/1115_2003-demoar.pdf.

Georgia: Enrollment data for Georgia was by reference to CMS' Medicaid Managed Care Plan Level Data by state (June 30, 2003) Medicaid Managed Care Program Summary http://www.cms.hhs.gov/medicaid/managedcare/er03net.pdf. Savings were estimated based on information included in CMS' Georgia Better Health Care Fact Sheet at: http://www.cms.hhs.gov/medicaid/1915b/ga03fs.asp.