GERALD R. FORD SCHOOL OF PUBLIC POLICY
SCIENCE, TECHNOLOGY, AND PUBLIC POLICY
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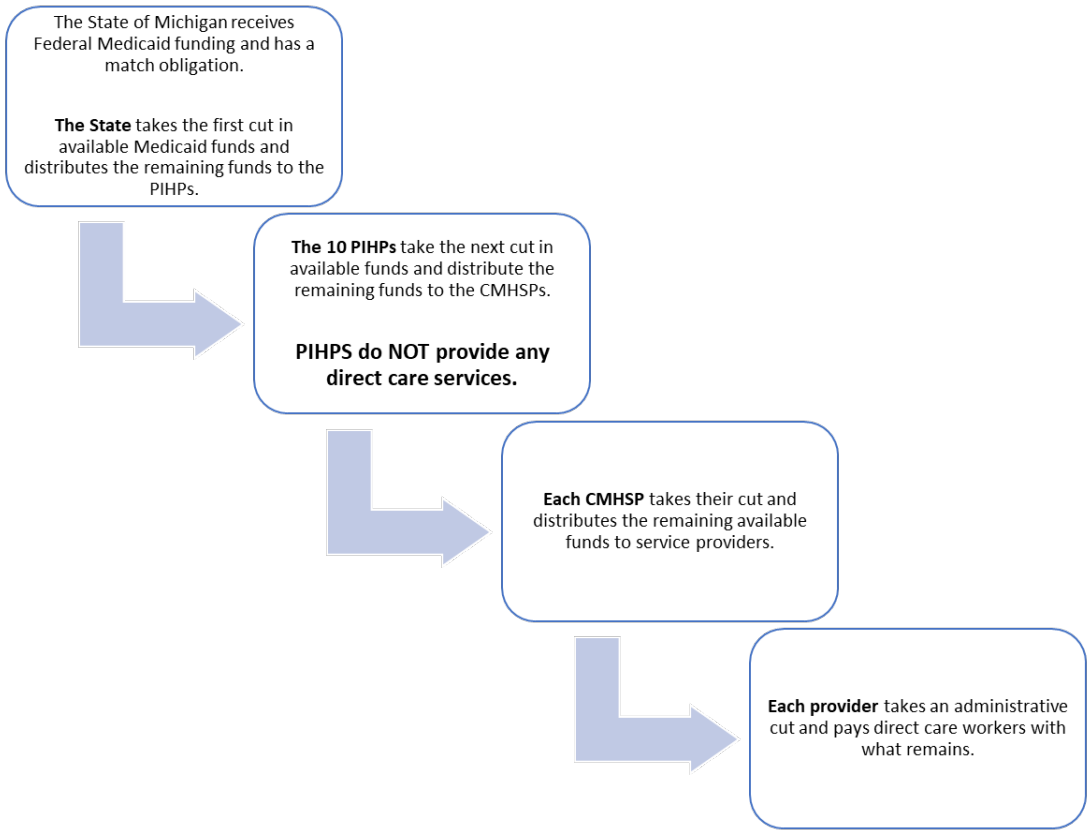
Reduce Unnecessary Administrative Costs in Order to Direct More Money to Direct Care Workers and Services

Key Issue: There is a significant amount of waste regarding Medicaid spending at the **Prepaid Inpatient Health Plan** (PIHP) and Community Mental Health Services Program (CMHSP) levels in the state of Michigan. This loss leads to fewer dollars being available for direct care workers and essential services.

Key Areas of Concern: The number of agencies that Medicaid funds must filter through that are related to intellectual/developmental disabilities (I/DD), mental health (MH), and substance use disorder (SUD) services **causes significant losses and inefficiencies**. Moreover, the State of Michigan/Department of Health and Human Services has very little oversight over PIHPs and CMHSPs. As a result, **the organizational structure that oversees the appropriation of Medicaid funds creates a fundamental conflict of interest** wherein the PIHP administrative body overseeing CMHSPs is composed of CMHSP directors.

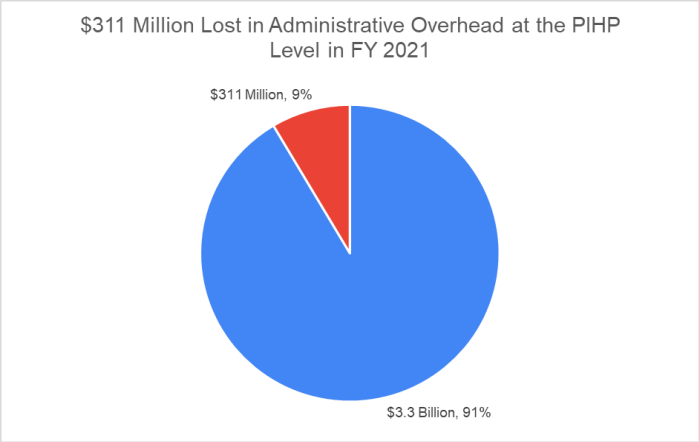
The current organizational structure is as follows:

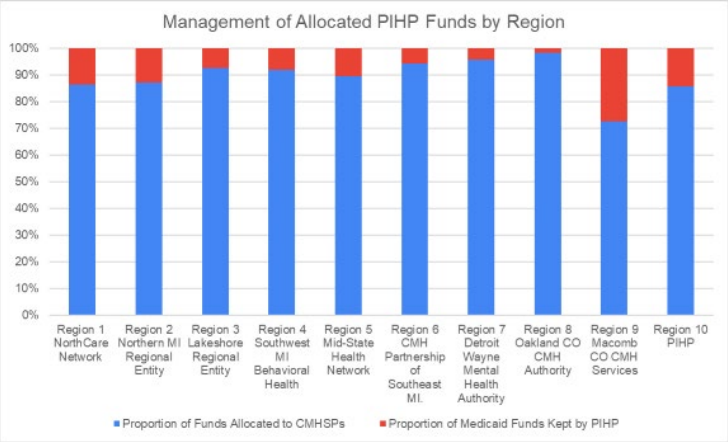


Examining Administrative Waste at the PIHP Level

PIHPs provide NO direct care services yet take 9% of the available Medicaid funds to use for administrative overhead, **amounting to $311 million in fiscal year 2021**.[1]

As of 2020, there were roughly 165,000 direct care workers in Michigan. Roughly $1,885 more could have been allocated to each worker in 2020 if these overhead costs were given to workers instead.[2]





In fiscal year 2021, Michiganders with intellectual/developmental disabilities, mental illness, and substance use disorders lost $311 million in services because Medicaid funds were wasted on administrative overhead by PIHPs.[3]

Proposal: The State of Michigan should adopt a third-party, administrative services organization (ASO) model to administer Medicaid services, similar to the one adopted in the state of Connecticut. In doing so, PIHPs will be eliminated from the appropriations process altogether, and CMHSPs will remain only as providers, thereby eliminating a conflict of interest.

ASO Model Overview: This model adopts a fee-for-service approach wherein a state's Department of Health and Human Services (DHHS) enters into contracts with ASOs for different service types (e.g., medical, behavioral health, living support, etc.). A certain percentage of administrative payments to the ASO is withheld by DHHS until the end of the fiscal year and is only fully transferred if the ASO is able to "demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures."[4]

Traditional Medicaid & ASO Model Comparison:

Topic	Current, Managed Care Service Model	ASO, Fee-For-Service Model
General Treatment Process	An individual is referred (by a school, doctor, vocational rehabilitation services, etc.) or is self-referred to a local CMHSP. The CMHSP screens individuals and determines what services they are eligible for. The individual is limited to providers within their local CMHSP's network.	An individual may go directly to an ASO where their level of care needs are assessed. The ASO determines the appropriate budget required for assistance. The patient, given their budget, **may choose any provider in the state to work with.**
Payment Structure	**Capitated Rate:** The state's Medicaid agency assigns Managed Care Organizations (i.e., PIHPs) **a monthly fixed rate budget** based on the number of people in the region that are eligible for Medicaid in a month regardless of how many services the CMHSP provides in the month. All direct care services and CMHSP staffing/overhead come from the same budget, leading to a **conflict of interest** when it determines individual budgets for services for people with I/DD, MI, and/or SUD services. Rates for services vary by CMHSP and by region.	**Fee-For-Service:** The state's Medicaid agency directly reimburses claims—subject to ASO's determination of an individual's annual budget—submitted by providers. The ASO has no stake in the determination of one's budget. **The budget is devised based solely on an individual's needs**, acting as a firewall between the authorization and implementation of services. Rates for services can be either standardized across the entire state or by region.

Determination of Direct Care Workers' Hourly Wage	Determined by the local CMHSP. Salaries are drawn directly from the CMHSP's budget, creating an incentive to keep wages as low as possible. The current, all-inclusive maximum rate is $18.36 per hour ($2 of which were a temporary COVID-19 premium) as of 2020 for Region 6.[5]	Determined by the state's actuarial firm. Example: Milliman calculated an all-inclusive hourly rate of $37.40 per hour (H2015—Community Living Supports) for fiscal year 2023.[6]
Assumption of Risk	The Managed Care Organization (PIHP/CMHSP) assumes some financial risk, while some risk frequently filters back to the State.	The state's Medicaid agency assumes financial risk.
Oversight	Each Managed Care Organization (PIHP/CMHSP) "determines its own coverage, utilization management, provider network, provider payments," and recipients rights services.[7]	The state's Medicaid agency controls provider payment schedules statewide and has control over standardized coverage and utilization management.[8] The ASO also provides recipient rights services.

Advantages of the ASO model:

1. By eliminating the numerous bureaucratic layers that Medicaid funds must go through, allocation of funds becomes more cost effective.
    a. **Taxpayers' dollars are used more efficiently** as Medicaid funds are now able to go directly to providers rather than being filtered through multiple agencies.
        i. For FY 2023, Connecticut's Medicaid administrative costs (3.8% of total Medicaid expenditures) were substantially lower than that of managed care states' averages (9.4% of total Medicaid expenditures).[9]
    b. More money is available **to pay direct care workers higher wages, helping to address the ongoing workforce shortage**.[10]
    c. There is **better protection for individuals** receiving services.

2. Individuals will have greater control over self-determination/self-direction and greater freedom to choose the providers they work with.

3. The ASO acts as a firewall between the state, the CMHSPs, and providers. Providers and ASO will now contract directly with the state.

[1] "Report For Section 904 Community Mental Health Service Programs Demographic And Cost Data Fy 2021," State of Michigan Department of Health & Human Services, May 2022, https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Budget-and-Finance/Legislative-Reports-FY22/09-19-2022/Section904-1_PA87of2021.pdf?rev=82b7882d1fda49d88052349805e82258.

[2] Abdullah Hashsham, Abigail Lindsay, and Nancy Baum, "Supporting direct care workers in Michigan," Center for Health & Research Transformation, Accessed April 14, 2025, https://chrt.org/wp-content/uploads/2024/06/DCW_LegislativeBrief_-CHRT-final.pdf.

[3] "Report For Section 904."

[4] "A Précis of the Connecticut Medicaid Program," Connecticut Department of Social Services, Accessed April 14, 2025, https://portal.ct.gov/-/media/departments-and-agencies/dss/medicaid-hospital-reimbursement/precis_of_ct_medicaid_program.pdf.

[5] Kate Massey, "L 20-42", Michigan Department of Health and Human Services, July 30, 2020, https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder14/Folder3/Folder114/Folder2/Folder214/Folder1/Folder314/L_20-42.pdf?rev=0ed017f95ca74af98676bee9dc003a40&hash=4A4AD59EC2D612E9411CC40B12F6E386.

[6] Jeremy A. Cunningham et al., "Behavioral Health Comparison Rate Development – SFY 2023," State of Michigan Department of Health and Human Services, Milliman Client Report, July 20, 2022, https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Reporting-Requirements/BH_Comparison_Rate_Development_Report_SFY_2023.pdf.

[7] "Overview of Connecticut Medicaid," Connecticut Department of Social Services, Accessed April 14, 2025, https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2023/interim/230831_mctf_03_WOOLSTON_2023%2008%20%20Idaho%20Medicaid%20presentation.pdf.

[8] "Overview of Connecticut Medicaid."

[9] "Medicaid Landscape Analysis," Connecticut Department of Social Services, Last revised December 2024, https://portal.ct.gov/dsshome/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf.

[10] "Michigan's Direct Care Workforce, Living Wage and Turnover Cost Analysis," Center for Health Care Strategies, August 2021, https://www.chcs.org/media/Michigans-Direct-Care-Workforce-Living-Wage-and-Turnover-Cost-Analysis.pdf.