



Michigan Association of Health Plans

Presentation of Michigan Association of Health Plans Senate Subcommittee on Department of Community Health Appropriations

March 16, 2011

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Richard B. Murdock
*Michigan Association of
Health Plans*

Good afternoon. My name is Rick Murdock and I am the Executive Director of the Michigan Association of Health Plans. Members of our association participate in the Medicaid Managed Care Program through a competitive bid process for the awarding of contracts. Medicaid Health Plans are currently responsible for the delivery of comprehensive health services for nearly 1.3 million Medicaid beneficiaries.

We understand very well that Michigan's structural deficit must be addressed for the FY 12/FY 13 budget development. We assume the structural deficit—including support for Medicaid--will be partially addressed through:

- Reform through administrative consolidations and efficiencies;
- Redirection of existing resources to those programs demonstrating value and outcomes; and
- Reductions and program eliminations.

We also understand and will be supporting the proposal for changing the restricted fund from the current HMO use tax to a paid claims tax in order to generate the same amount of special use revenue and continue to save the general fund. We will be addressing this more specifically at next week's hearing.

MAHP believes the following principles can be used to guide the changes necessary to transition Michigan's Medicaid program through the next year(s):

- Enroll current beneficiaries into managed care rather than reducing optional benefits;

- Focus on ways to integrate benefits and create savings rather than reducing provider reimbursement;
- Identify ways to streamline and consolidate state agency bureaucracy, eliminate regulatory redundancy, and focus on contract performance; and
- Promote those administrative rules and Medicaid policies that make fiscal sense to Michigan and not focus on revenue neutrality.

The Administration has emphasized that a “results” oriented budget will be in order—that is, programs must demonstrate a return of value in order to deserve continued support. This requires the use of measurable objectives (contract performance standards) and audited data. Medicaid Health Plans are held accountable to the performance standards of the State Medicaid contract and continue to provide the highest level of service and noted by the annual rankings of the U. S. News and World Report where Michigan had 12 of the top 50 ranked Medicaid plans in the United States last year.

Minimally, **\$4.5 billion in total savings** has been realized due to Medicaid Managed Care between FY 00 and FY 10 or nearly **\$400 million each year**. The savings (compared to fee-for-service) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state in exchange for actuarially sound funding. The record over the past years is clear. It is far more efficient and cost-effective to use the managed care system than traditional fee for service. MAHP and members support the increased enrollment of Medicaid beneficiaries into managed care. In all instances of managed care enrollment the core principles provide for a “medical home”, state accountability from a single organization, audited performance standards, and cost-savings to the State.

During this most critical year for determining the policy and funding of Medicaid, it is more fundamental than ever that Michigan’s decisions are built upon facts, performance and demonstrated outcomes—these are successful building block of Medicaid managed care.

RECOMMENDATIONS

1. Medicaid Enrollment in Managed Care.

New Populations and programs should be included under the Managed Care Program and as necessary specific rate structure recognizing the actuarial costs:

- Dual-Eligible Population and begin working with overall long term care options
- MI CHILD Enrollment into Medicaid Managed Care
- Children’s Special Health Care Services (mandatory enrollment)
- Complete and monitor the enrollment of Foster care Children
- Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.

2. Medicaid Eligibility (Accelerate enrollment into Managed Care)

- Develop Eligibility Access Points:
 - Outstationed Workers in hospitals and similar settings
 - Application Assistance
 - Automation
- Consider Express Lane Eligibility (ELE) for children.
- Evaluate the feasibility of use of “pre-populated” redetermination forms and/or a simplified redetermination form for those subject to the “long form’ and Pre-populated forms to simplified redetermination.
- Study the option to delink Medicaid application from other human services program applications and start planning now for a faster and user-friendly system for determining Medicaid eligibility to go into effect in 2014 with the Insurance Exchange.

3. Administrative Savings, Third Party Liability (TPL), Fraud/Abuse

- Consolidate the current multi-agency state responsibility for oversight of Medicaid Contract into a central office and focus on health outcomes using common metrics and objectives and audited performance requirements.
- Streamline unnecessary administrative costs by reducing or eliminating paper requirements in lieu of electronic documents and web-based information sites, requiring the use of deemed compliance by virtue of national accreditation such as NCQA, and changing the perspective to a “regulation by exception”—that is focus on contractors who are not meeting standards established in the contract.
- Increase third party collections by fully complying with the federal requirements and provision of access to third party carrier information for Medicaid health plans.

- Support efforts for improved fraud and abuse coordination and support the concept of enabling legislation to create the Medicaid Inspector General Office and focus collaboration efforts through Medicaid policy and new contract provisions regarding reducing “waste” in our health system that will benefit all payers, including Medicaid.

4. Actuarially Soundness

- Administrative costs related to the proposed paid claims tax must be included in the development of actuarial rates for FY 12.
- Costs related to the support by Medicaid Health Plans for their participation in the Multi-Payer Collaborative for Patient Centered Medical Homes must be supported in the development of actuarial rates for FY 12.

5. Provider Reimbursement

It is a cruel hoax to provide coverage for Medicaid beneficiaries and then to have it denied due to lack of access to providers. It is widely recognized that one of the major drivers of provider access is the level of reimbursement. It is inconceivable to envision the expansion of Medicaid eligibility (under federal reform) that will bring nearly another half-million Michigan citizens into Medicaid and not significantly address the low-Medicaid reimbursement rates. In fact, Federal reform requires Medicaid to pay at Medicare levels for primary care physicians beginning in 2013 with the federal government paying for the increase in the first two years. If the Legislature does not enact the replacement for the current HMO use tax with the Paid Claims Tax, then the only other alternative is to reduce Medicaid spending by \$1.2 billion in order to realize GF savings. These significant reductions will most likely take place in provider reimbursement cuts.

Summary

MAHP continues to appreciate the support of the Senate Subcommittee for the Medicaid program and services. Our basic recommendations for your consideration are:

1. Realize cost savings by moving additional populations into managed care.
2. Improve eligibility and accelerate enrollment into managed care
3. Administrative Savings
4. Actuarial Soundness for Medicaid Health Plan Rates

5. Protect Provider Reimbursement Rates

Staff of the MAHP and members will continue to work with committee members on key budget detail issues and we will be happy to follow up on any of the issues raised today or other related issues on health care reform.