



MICHIGAN ASSOCIATION
OF HEALTH PLANS | 2010

Performance, Value, Outcomes: Medicaid Managed Care: Part of the Solution For Health Care Reform

FY 2010 – 2011

EXECUTIVE SUMMARY

The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

Medicaid White Paper: FY 11

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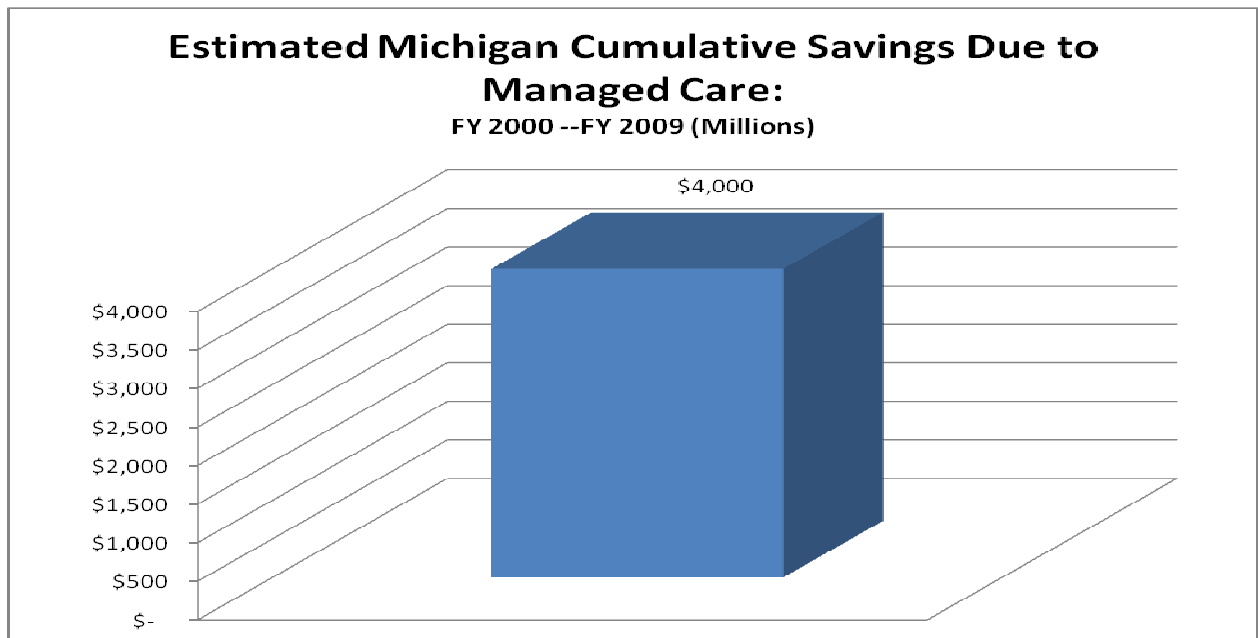
EXECUTIVE SUMMARY

During 2009 the MAHP Board of Directors adopted principles for overall health care reform. These principles were reaffirmed for 2010. MAHP believes it is no longer possible to view the reform of the Medicaid program separate from the reform of overall health care. Similarly, those who advocate for federal and state reform must include a vision of the future of Medicaid. Without this broader perspective, it is not possible to realize many of the administrative savings proposed for Medicaid nor understand how expanding Medicaid coverage will achieve objectives in health care reform.

The expectation of MAHP is that overall health care reform—including Medicaid reform) will reflect the following elements:

- Improved Access to Affordable choices for all citizens
- Protection of the safety net (Medicaid and MICHild)
- Linking payment to quality and performance outcomes.
- Cost containment that addresses overuse /underuse/misuse of health care resources
- Transparency in pricing and provider rates
- Personal accountability and wellness as part of a “value based benefit design” model
- Standardization and efficiency through technology

The Michigan Association of Health Plans annually develops a Medicaid White Paper that includes recommendations for sustaining and improving the Michigan Medicaid program. 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 and the successful building block of Medicaid managed care.

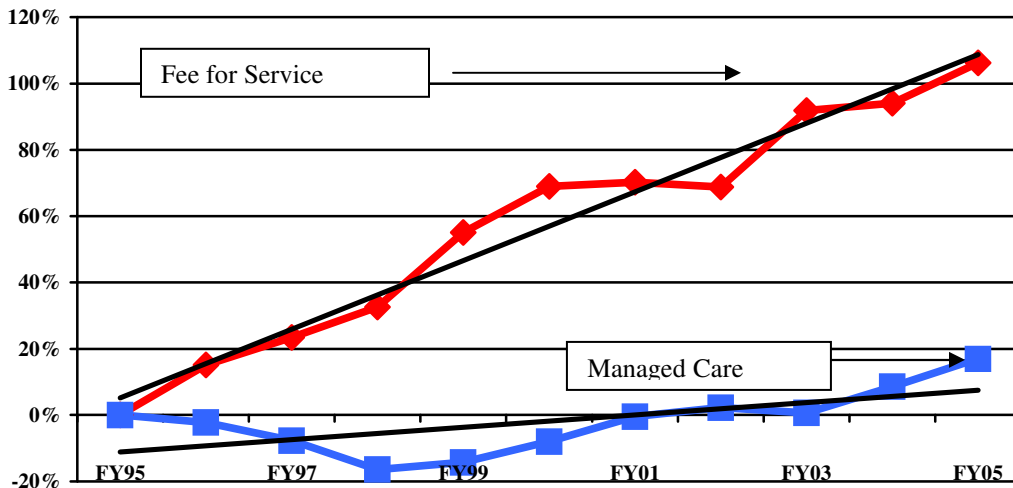


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The demonstrated and audited outcomes of the Medicaid managed care program are its strongest features. Policy makers, administrators and the public expect (and receive) value from the Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. The most obvious strength is cost savings as noted above.

The above graph indicates an estimated **\$4.0 billion in total savings** compared to Medicaid alternatives between FY 00 and FY 09 or between **\$350 and \$400 million each year**. This return on investment enabled both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas. As noted elsewhere in this White Paper, these cost savings are accompanied by increasing improvements in health status measures for children and adults that are determined by audited record review, and greater access to needed health care services documented by provider file contract information retained by the state. *Continuing to invest in Medicaid managed care will continue to provide these results for Michigan.*

Projected Trends in Medicaid Costs for Medicaid Fee for Services and Managed Care and Actual Growth: FY 95 – FY 05



(Source: MDCH Presentation to House Health Policy Committee, February 2007)

Without a managed care program, Michigan would be relying on a fee-for-service base of operations with inherent inefficiencies and inability to manage the health care needs of the state's most vulnerable population. The savings in managed care are illustrated above and illustrate this point far better than any other description the value that Medicaid managed care has provided and can continue to offer for the State of Michigan.

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The savings (compared to fee-for-service) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care. MAHP believes the value of Medicaid managed care in terms of accountability, access, and cost effectiveness is now well established. An objective of this White Paper is to provide a “road map” for Michigan policy makers that will deliver cost savings and reform necessary to position Michigan’s Medicaid program for the future.

Conclusion

All commentators recognize that Michigan’s fiscal status requires a new way of thinking, including how we approach Medicaid. We can all agree that it is far preferable to agree upon a reform solution that will maintain eligibility and support essential networks of providers than to cut either eligibility or reimbursement or both. Failure to implement such a solution will have far reaching impact throughout the health care system and will affect the overall cost of health care for everyone. The legislative and administrative challenge is to not only identify the “path” for cost effective care, but make the administrative and operational decisions to make it happen. *From the perspective of MAHP, the undisputable key facts are:*

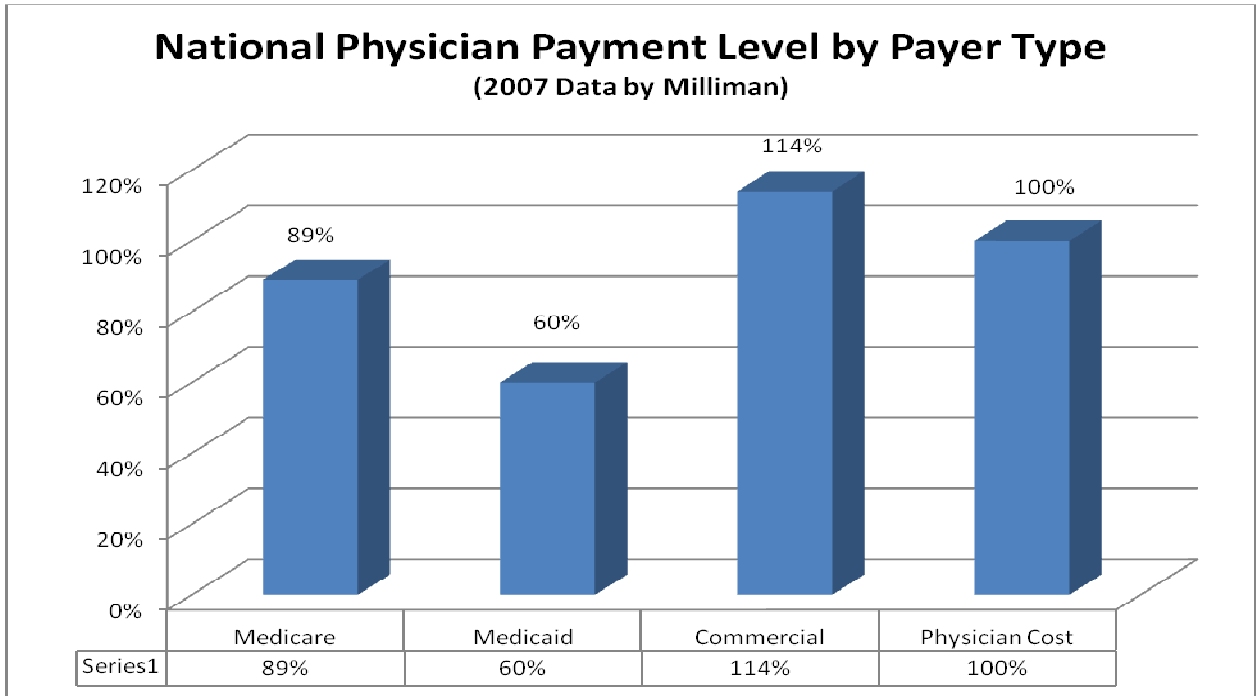
- Both the Legislature and Administration continue to rely on Medicaid managed care to deliver services to nearly 1.2 million Michigan citizens. Most other states are now just moving toward the comprehensive managed care approach that Michigan has implemented for a number of years. To retreat from this position would not only cost the state hundreds of millions to cover health care obligations in a fee-for-service environment — but would lose accountability, care coordination and preventive health services currently being provided to Michigan’s most vulnerable population. In this reform environment, the real question is why we are not doing more managed care in Medicaid.
- While 2/3 of the eligible Medicaid population is enrolled in managed care, **3/4 of the cost of Medicaid still resides with the remaining fee-for-service Medicaid population not enrolled in managed care.** MAHP believes that the state can extend the value, already documented by managed care, through further expansion and/or the application of managed care principles with other Medicaid eligible population or programs administered by MDCH.
- Continuing to reduce provider reimbursement increases **cost shifting** to commercial carriers—that issue combined with **uncompensated care** for the uninsured has pushed additional commercial premium costs over \$1000 for families and nearly \$400 for individuals and is growing.
- Failure to adequately support Medicaid risks the unraveling of essential health care for all Michigan citizens, as if a physician closes his or her office, they are no longer there for anyone and if a hospital closes a unit, service, or program, it is no longer available regardless of payer status.

MAHP FY 11 MEDICAID RECOMMENDATIONS

1. Increase Provider Reimbursement to Medicare Reimbursement levels.

Increasing provider reimbursement is one of the most critical issues facing Medicaid. However, all interested parties should be aware of the burden that we pay now and will pay more in the future for failure to address this issue. It is undisputable that Medicaid pays among the least of all insurers for services rendered to beneficiaries. The difference between the cost of the service and the actual Medicaid payment is a cost that is paid by other customers and those individuals paying out of pocket. This is commonly referred as a cost-shift to commercial payers.

The most recent national analysis of this “cost-shifting” was produced in a 2008 report by Milliman and compared payment level between Medicare, Medicaid and Commercial payers. Nationally, this cost shift results in more than \$88 billion dollars in premium payments by Commercial payers than would otherwise be necessary if public payers (such as Medicaid) paid equivalent rates.



The Michigan Health and Hospital Association estimates that the 2008 burden of cost-shifting by Medicaid and Medicare was more than \$1 billion. Similarly, people without health insurance often delay or defer care until it reaches an acute or emergent condition. Care provided at that time is expensive and totally preventable is

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access to affordable insurance was available. The cost of care provided to the uninsured is referred to as uncompensated care. Nationally it is estimated by Families USA that \$116 billion dollars of care was provided and not paid for by the uninsured. This cost is “paid” through a “hidden tax” or higher premiums for commercial payers.

The simple fact is low Medicaid payments lead to cost-shifting and commercial premiums absorb the cost. Similarly increased care to the uninsured results in provider costs that are absorbed by higher commercial premiums. This creates a cycle—more cost-shifting, more uncompensated care, higher commercial premiums, more uninsured and Medicaid, and the cycle continues.

By understanding these dynamics, it makes both good public policy and economic sense to protect the provider base and increase Medicaid reimbursement. By increasing payments to Medicare level, Michigan will realize a positive economic impact for businesses through less exposure to uncompensated costs and cost-shifting. More importantly, all citizens will realize the benefit of a payment rate that will support practicing physicians and providers in Michigan. Details on the amount of the increase necessary and funding are outlined under recommendation 4 below.

2. Promote Cost Savings and Improve Access by Retaining and Expanding Eligibility through Medicaid Managed Care in Michigan.

2.1. Transition beneficiaries currently served under traditional fee for service to Medicaid Managed Care, and save between \$20 to \$115 million through improved management and collection of use tax revenue. Beneficiaries affected would include:

- Foster Care Children (required under current year budget boilerplate)
- Children with Special Health Care Needs (under a risk sharing model with MDCH and on voluntary enrollment basis)
- Dual Eligible Beneficiaries (Medicare/Medicaid) with Special Needs Plans certified by CMS along with the continuum of Long Term Care Services support services
- Other potential excluded or voluntary populations, including ABW or county health plans.

This proposal makes sense under a policy and reform environment. Managed care provides Michigan with the accountable and high performance expected of a health care system. Cost effective care is provided with the incentives to provide the care in the most appropriate and low cost setting. Generally, a move from Medicaid fee-for-service to managed care will provide a modest savings of 3-5% simply due to the introduction of coordination, disease management and evidence base practice guidelines. Further savings may be assumed if the program design includes more intensive use of managed care tools, including prior authorizations. This will permit the Medicaid program to continue to provide services at current level and for current eligible populations.

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Combined, it is estimated that the general fund savings possible from the movement of currently enrolled Medicaid beneficiaries to managed care identified in the recommendation above is nearly \$20 million. Further, the potential savings from combining the continuum of long term care services is another \$95 million by exposing existing costs to the use tax that Medicaid Health Plans are obligated to pay.

2.2 Save \$7 million to \$10 million and increase eligibility in MICHILD by contracting with Medicaid Health Plans. This change will:

- Redirect \$7-\$10 million in savings and revenue to provide state match to increase MICHILD eligibility to 300% as permitted under reauthorization.
- Eliminate the annual \$3-5 million in additional MDCH costs associated with cost settlement agreement with BCBSM (and eliminate the reported \$15 million in losses otherwise absorbed by BCBSM that will improve their overall margins).
- Increase State revenue by nearly \$4-5 million for supporting Michigan's Medicaid programs as a result of MICHILD premiums being covered under the State's Use tax law (not possible now).
- Improve and document performance consistent with the proven record of Michigan's Medicaid Health Plans.
- Provide continuity of care for children and adolescents and their families
- Capitalize on Medicaid outreach efforts to reach those children eligible but yet enrolled in MICHILD

The federal reauthorization of the Child Health Insurance Program, MICHILD in Michigan, permits increasing the eligibility level. It is possible through implementation of the recommendations above to raise enough new revenue to provide the necessary state match for MICHILD and increase eligibility to 300% of poverty. This is a key recommendation by many advocates and coupled with the recommendation for increasing overall provider reimbursement to Medicare levels addresses many of the concerns identified in prior years.

2.3. Expand coverage of Medicaid to 133% of poverty and reduce the number of uninsured in Michigan (similar to that recommended in federal reform). Key considerations of these recommendations are:

- Using Medicaid Health Plans as delivery system to leverage additional state and federal dollars for Medicaid;
- Federal matching funds would cover 65-70% of increase in costs;
- No new general fund dollars would be required for the state match;
- State match would come from existing provider taxes, redirection of savings from programs currently funded with 100% GF, and new earmarked revenue from health care providers;
- All providers would be reimbursed at no less than Medicare levels; and
- Develop mechanism to address increasing caseloads to automate enrollment and eligibility issues.

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Under federal reform proposals, Medicaid expansion was an agreed upon element. States would have the option of early expansion through Medicaid State Plan amendments. Absent federal reform, Michigan will have to seek a federal waiver to accomplish this objective. However the impact to Michigan is significant and as many as 600,000 additional citizens—currently without coverage may be eligible under Medicaid.

As identified earlier in this paper, reducing the number of uninsured will also reduce the amount of uncompensated care that is provided by Michigan's hospitals and other providers and reduce the exposure of covering uncompensated care cost by commercial premium payers (Michigan's businesses and individual subscribers). This recommendation is consistent with that recommended by all advocates for health reform and can be supported through a package of existing and potential funding sources that do not rely on any new general fund support. This package will be discussed in more detail below under the final recommendation by MAHP.

2.4. Continued implementation of the Actuarial Soundness Medicaid policy for Medicaid Health Plans.

Federal rules outline the requirements for actuarial soundness. Michigan has adopted Medicaid policy that conforms to the federal rules and is the process used by the Medicaid Actuary in the development of capitation rates each year. Within the parameters of actuarial soundness, the Michigan Association of Health Plans supports the ongoing initiatives for funding of supplemental access payments to hospitals, adolescent programs and public entities through enhanced rates paid to Medicaid Health Plans. These payments assure access and generate additional state use tax revenue that supplants general fund for support in Medicaid which will help expand coverage and provider reimbursement in Michigan.

3. Improve Medicaid Efficiency/Reduce Fraud and Abuse

3.1. Medicaid (including Medicaid Health Plans) must reduce the administrative costs in health care and emphasize the use of Healthcare Technology that is in alignment with the overall health care industry and the standards recognized under Federal Law, including the following activities:

- Administrative Simplification Processes by Health Plans and Providers;
- Standardize billing formats consistent with transition to the HIPAA required 5010 transaction codes by 2012;
- Universal referral forms (when and where necessary);
- Standardized and provide electronic credentialing and primary source verification;
- Standardized electronic billing and attachments, claims status, and eligibility verification; and
- Standardized reporting of accepted and rejected encounter records received in the MDCH data warehouse.

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MAHP and member health plans continue to work hard in reducing administrative costs where ever possible and identify ways for our managed care industry (not just Medicaid but all products) to improve efficiencies. The bulleted items above are just examples of the work underway to improve the overall delivery of health care and align with the incentives and program objectives for health care technology, and federal HIPAA rules. The MAHP continues to develop standard or “Master Agreements” with different vendors to assist all health plans in reaching these objectives.

3.2. Efforts to **improve Medicaid Fraud and Abuse efforts**, including the Medicaid Inspector General Legislation, should result in the consolidation of existing programs and coordination with other programs—and not duplication of existing oversight.

Ongoing efforts to improve the Michigan program for Fraud and Abuse are supported by MAHP, including the intent established by the proposed State Medicaid Inspector General Legislation. It is important for Michigan to take the prudent steps in consolidating the fraud/abuse programs, but must do so in a manner that does not add costs to the Medicaid program. Currently, the fraud and abuse program duplicates many of the existing regulatory oversight activities of other units of state government and does not implement any obvious coordination of activities. MAHP welcomes the legislative and administrative attention to this program and believes significant improvements; including cost savings can be achieved. It is also important for the Fraud/Abuse program to be transparent in its operation, capitalize on technology rather than manual reviews, and be consistent with federal fraud/abuse guidelines and requirements.

Finally the Fraud/Abuse program must be sensitive to the many system and operational changes facing Medicaid. These changes have and are likely to continue to create inappropriate enrollment changes, retroactive enrollment decisions, and related problems. Without understanding the entire Medicaid eligibility and enrollment program, many of these current and future state system programs may appear to be seen as inappropriate actions by contractors, including Medicaid health plans.

3.3. The Legislature should continue to **support boilerplate** adopted in FY 10 budget that emphasizes improved administrative savings, and should include language to permit Medicaid Health Plans to provide outreach activities to Medicaid members due for eligibility re-determination.

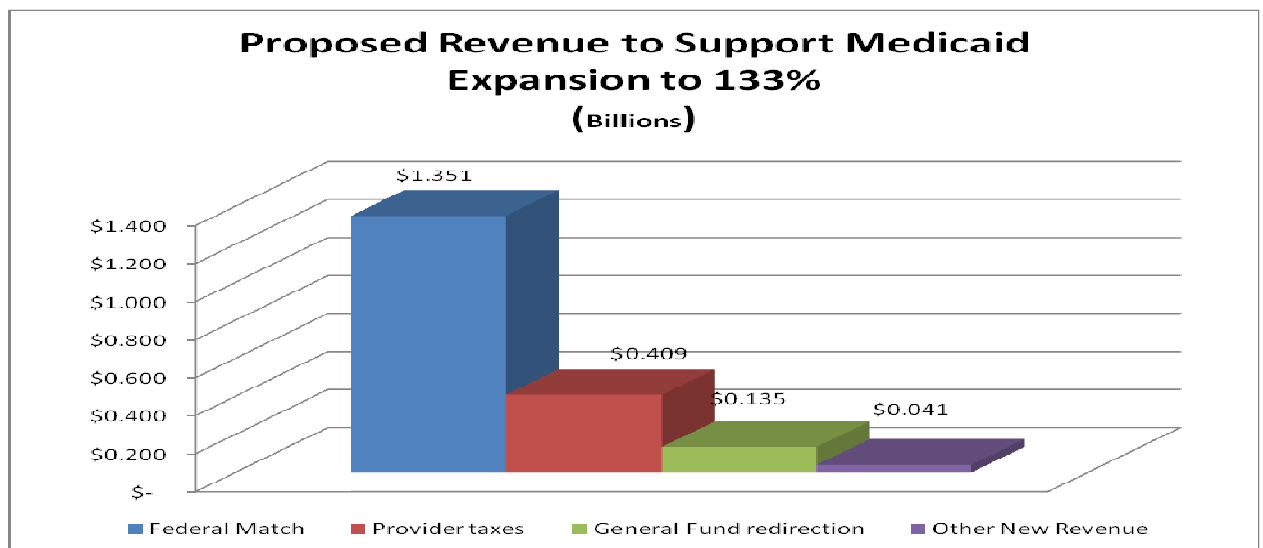
4. Dedicate Resources for Medicaid Without Adding New General Fund

Michigan’s Medicaid health plans are making concerted efforts to streamline their operations and reduce administrative costs. These initiatives include business process improvement efforts, streamlined administrative procedures, alliance and group purchasing initiatives, and provider contracting initiatives, including preferential contracting with high quality, lower cost providers.

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Moreover, the Medicaid health plans have invested millions of dollars in order to meet the increasing standards required under the state's contract. Michigan's Medicaid health plans look forward to this continued partnership with the State of Michigan to provide access to high quality medical services for Michigan Medicaid enrollees. The recommendations under this White Paper promote significant policy changes for Medicaid that will appear to confront the reality of Michigan's economy—however, unless such changes are made now, the entire Medicaid program will begin to unravel in ways that will create permanent harm to providers, systems of care, and ultimate services that Michigan citizens depend upon regardless of source of payment. MAHP historically will provide recommended solutions to such issues, and this is no exception.

An approach that simply reduces payments is the wrong solution. MAHP also realizes that it is not realistic to assume any new general fund solution—and therefore, the health care community will need to agree to support the recommendations above and finance those solutions as suggested in the following. In gross funding terms, it will take an estimated \$1.9 billion to increase Medicaid eligibility to 133%. Federal support would provide nearly \$1.4 billion of this amount based on current and projected matching rates over the next three years. The remaining obligations for state match would come from provider taxes, general fund redirection and recognition of new state revenue. The chart below illustrates this funding proposal.



The list of recommendations to implement the funding proposal include:

- 4.1. Move existing and new beneficiary populations (Existing Medicaid Fee For Service or New Enrollment) into Medicaid Health Plans to realize increased revenue from the State's Use Tax as well as that generated from existing provider taxes—this revenue is a substitute for general fund and will generate federal match.

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- 4.2. Continued support through managed care for supplemental payments for hospitals, adolescent center programs and services, and dedicated public entities that provide essential access to critical services and settings for Medicaid beneficiaries enrolled in Medicaid Plans. This generates additional federal match and increased State use tax revenue.
- 4.3. As expansion of new eligibility is implemented, redirect newly available general fund dollars (previously used to support programs at 100% state funding) to support the expansion population in Medicaid.
- 4.4. Inclusion of new revenue related to expansion in Medicaid spending. Research is now showing that for every \$10 million in new Medicaid spending, a minimum of \$10.8 million will be realized in salary gains with the attending increase in new tax revenue; and
- 4.5. Consider modest paid claims surcharge, if necessary for support and if not otherwise pre-empted by federal reform.
- 4.6. Expand the number of providers, including physicians, in Michigan who contribute through a provider tax mechanism in recognition that Medicaid will soon represent ¼ of the state's population.

Part of this overall recommended MAHP package is the support for increased provider reimbursement. It is estimated that it will take over \$970 million dollars to increase rates to Medicare level at the proposed expanded Medicaid eligibility of 133%. This amount can be raised though a new health provider tax including physicians to provide the state match amount, the rest of the expense covered by federal matching revenue.

Conclusion

In order to adequately fund Medicaid services as outlined in these recommendations, the MAHP supports the package of approaches listed above as establishing a sound base of dedicated revenue (not one time funding or reliance on enhanced federal funds). This package will provide support for:

- a. Expanding Medicaid eligibility
- b. Reducing Michigan's uninsured and thereby reduce uncompensated care costs
- c. Increasing reimbursement to Michigan's Medicaid providers and thereby reduce cost shifting to commercial premiums

These steps will represent fundamental shifts in policy and help sustain Medicaid as a critical component of state health policy for Michigan's future without increasing general fund support.