Michigan Senate Appropriations Committee
Health and Human Services Subcommittee

Tuesday, February 9, 2016

Hearing on
Healthy Michigan Plan Waiver and MI Health Account Implementation

Good afternoon Mr. Chairman and members. My name is Rick Murdock and I am Executive Director of the Michigan Association of Health Plans. Our association represents all but one of the contracted Medicaid Health Plans that currently serve nearly 1.7 million Michigan citizens and which is a combination of traditional Medicaid, MI CHILD, Children's Special Health Care Services, and the Healthy Michigan Program. I am pleased to be here to offer a few comments regarding the 2nd Waiver for the Healthy Michigan Program and some perspective of the MI Health Account Implementation.

As you know MAHP was very supportive of the development and enactment of the Healthy Michigan Act—and supported the development of both Waiver I and Waiver II. Our objective in doing so was to take advantage of the expansion initiative (Healthy Michigan Program) and insert the various reforms and incentives for various parties, (consumers, providers, and health plans) and performance requirements that will provide the necessary accountability to taxpayers.

We understand that it would have been far easier, as some states have, to simply accept expansion and not create the state's "imprint" on implementation. But we supported the more accountable route of HB 4714 which became the Healthy Michigan Act which is intended to not only affect the Healthy Michigan Population but also the entire Medicaid program. A review of our testimony and various materials on advocacy during the development of this legislation reveals a consistent set of objectives that were embodied in the final legislation. The challenge then—as always—is in the implementation.

While most of our commentary today will be on incentives and the MI Health Account Implementation, we do not want to lose sight of the 2nd Waiver approval and related terms and conditions to which the MDHHS has conferred agreement in a letter to CMS on January 15th. MAHP supported the development and submission of the waiver request and was pleased by the ultimate agreement of approval by CMS. Continued health care coverage for nearly 600,000 Michigan citizens is the result and that alone cannot be overstated. Without the continuation of the program, the quest for improving value for taxpayers would have been lost.

Because of the waiver requirements of the Healthy Michigan Act (Waiver I & II), CMS and the MDHHS negotiated a set of "terms and conditions" that governs the implementation, reporting, public input process, and evaluation. How those terms and conditions are implemented will now dictate the success of this program.

Incentives

Inherent in managed care is a tension between providers and health plans and with consumers and health plans. There is a belief that requiring more uniformity will mitigate much of this tension. We can accept that view when:

- A uniform requirement to create targeted incentives areas is adopted; or
- A uniform set of metrics are developed to measure success; or
- A uniform provision for individualized consumer incentives.

However, when the objective of uniformity extends to "**how**" each health plan will implement an incentive program, as an example, that approach erodes the ability of health plans to be creative and innovative—and reduces their ability to compete. We believe the end product then is a move toward "average" rather than the higher standards we are accustomed to achieving.

I wanted to take a moment to outline this concern as this is the context under which we react to various proposed incentives initiatives of MDHHS as they conduct the contract administration of the Medicaid plans which now incorporate the provisions of the Healthy Michigan Act. To be sure, our concerns should never be seen as opposing the need to implement provisions of the act—but as a view of how best to achieve implementation. We also fully appreciate that it is within the terms and conditions that much of the detail of implementation (how it will be done and reported) is spelled out and how much uniformity is prescribed.

I believe we all have the same objective of implementing a program that will provide the use of clear incentives for providers and consumers as required under Healthy Michigan Act. Incentives for consumers is related to behavioral and health status change and a commitment to take responsibility. Types of incentives include gift cards and payment obligation reductions. The provider incentive is related to managing and communicating these changes and their incentive is mostly payment related.

The incentive for health plans (capitation withhold) is intended to measure health plan success and in the aggregate overall program success. Health Plans are incented in several ways. First to earn back the withhold of capitation payments, they must demonstrate that the consumer and provider incentives are working, that consumer payments are taking place, and that the overall results in such areas of Emergency Department use, Ambulatory services, re-admissions, and generic drug use are moving in positive directions. Secondly, many of these features are built into the automatic enrollment algorithm that governs the assignment of health plans for those who do not make a voluntary choice. Finally, the MDHHS is the responsible entity for implementation and its reports to both the Michigan legislature and to CMS is largely based on the performance and reporting of health plans.

2nd Waiver Approval Terms and Conditions

As discussed above, the 2nd waiver terms and conditions will now drive how effective the implementation of incentives will be. The terms and conditions are many, but a few do stand out:

28—addresses cost sharing and contributions for individuals above 100% FPL and who enroll, after April 1, 2018 in the Healthy Michigan Plan.
#29—addresses cost sharing and contributions for individuals above 100% FPL and who, after April 1, 2018, choose to enroll in the Marketplace Option.
#31—addresses contributions accounts and payment infrastructure operational protocols
#45—addresses the Marketplace option choice
#47—addresses the Marketplace option access to wrap around services

There are many more, but it will be the details behind these terms/conditions that will affect our health plans implementation of MI Health Account, enrollment into

the Marketplace and the impact on our members who are on the Exchange and the role of DIFS in these decisions. We look forward to working with MDHHS on the new protocols and standards and hope the lessons learned from the first full year can guide us into the future.

MI Health Accounts

Given the time lag built into the Healthy Michigan Program for beginning the development and distribution of MI Health Accounts, we are just coming off the first year of reporting. The MI Health Accounts are at integral part of Healthy Michigan Program. It is through this mechanism that consumer will become more acquainted with their payment responsibilities and total cost of the health care they experience. Several comments need to be made at this point.

First, while this is nominally a health plan requirement—and ultimately part of the health plan incentive related to withhold, the development of the reporting requirements and the selection of the vendor that each plan will use including payment to the vendor, was a state decision due to a need to have a common report format and messaging to consumers. As a result, health plans do not have full autonomy in managing this vendor contract—and yet under the terms of both Healthy Michigan Act and the new Medicaid contract, are responsible. Over the past several months, and numerous meetings with the MDHHS and the vendor, the operational issues have largely been resolved and reporting is now timely.

Secondly, similar to the rest of Medicaid, there is no penalty for failure to pay. This was acknowledged in both waiver terms and conditions and was not a feature sought by MDHHS in its waiver request. The Healthy Michigan Act included a recommendation to consider this issue and use the monthly premium process in MI CHILD as a model. This program has a penalty for failure to pay, including suspension of eligibility. Those reviewing the MI Health Reports should keep this factor in mind.

Lastly, unlike the rest of Medicaid, the collection of co-payments and contributions under the Healthy Michigan Act are assumed to be collected by the Health Plan and not the provider. Therefore, the opportunity to collect payment at point of service was lost. This payment collection function is also performed by the "common vendor" who produces, and distributes the quarterly MI Health Accounts. The health plan capitation rates assume at least 50% collection of these payments and the current collection rate averages about 32.6% of total obligations

(through December of 2015). The most recent report also indicates that about 30% of beneficiaries are making payment. Finally, the consumer incentives are being implemented according to the Act. These includes a 50% reduction in copay once the beneficiary reached 2% of the income; a reduction of 50% in contributions if they complete an Health Risk Assessment attested by a Provider; and receipt of a gift card (value of $50 dollars). All of these assume a beneficiary agreement to maintain a healthy behavior.

Savings and Value

Aside from simply being good healthy policy to provide coverage for as many citizens as possible, the value to taxpayers will continue to be realized by the requirements of the Healthy Michigan Program and its reach into all of Medicaid.

We know that as a state Michigan can improve our overall rate of emergency Department visits. The most recent reporting in Medicaid indicates an overall rate of 73 ED visits per 1000 beneficiaries. If this rate were to be reduced to the national average of 66/1000 then a savings of about $13.42 pmpm would be realized. Another example is to reduce the Hospital admission rate to the national average; this would create a savings of $40.97 pmpm. A final example may be in reducing the number of prescriptions to the national average as not only is pharmacy products becoming more expensive, the utilization (number of scripts) are higher in Michigan than the national average. A change of this nature would save about $28.45 pmpm. As expected, these are included in the performance measure for Health Plans and we expect to show improvement.

The one savings that was the focus of many during the development of Healthy Michigan is the expected reduction in hospital uncompensated care costs. There are now a convergence of a number of national studies that are documenting significant savings in uncompensated care related to expansion of Medicaid. These savings range from a national average of 26% reduction in uncompensated care costs (reported by CMS) to a Robert Wood Johnson (2015) report looking at individual states, including Michigan and reports from state hospital associations that indicate a reduction of between 46 and 59% in uncompensated costs. Finally, a recent (2015) study from Northwestern University, suggest that each uninsured person is associated with $900 in uncompensated care costs. We know this is the focus of the evaluation underway in Michigan and all of this data and research findings suggest that significant savings to Medicaid should be the outcome.

A final measure of value for taxpayers is to compare the premium in the insurance exchange to that of the Healthy Michigan Act. It would make no sense to operate the Healthy Michigan Program at an expense more than that offered in the Exchange. A comparison of rates of Healthy Michigan to the 2nd lowest Silver rate (used to calculate tax credits in the Exchange) in 2015 indicated that Healthy Michigan was at least 30% less expensive. From a taxpayer point of view, Healthy Michigan remains a value as those who are 100-138% of FPL will likely have their premium subsidized by tax credits and state payments for wrap around services.

Recommendations

1. We applaud the attention to these issues and the objective of full transparency of implementation. Without approval of the Waiver, the demonstration that Michigan began with the Healthy Michigan Act would have stopped.

2. We encourage the MDHHS to provide more timely provision of standards, protocol, metrics prior to implementation, in order for health plans to not only respond but to set up their systems to implement—some may require re-contracting with providers as example.

3. We encourage the MDHHS to assure that the alignment of the algorithm and performance measures are consistent with overall policy goals—sometimes it appears that we are off on a tangent due to additional standards.

4. The state of Michigan, working with Michigan Health plans and others need to negotiate for flexibility on terms/conditions where possible, such as the incentive protocol (Term # 31) and consider other models for incentives.

5. All parties involved in the Healthy Michigan Program need to continue a dialogue with the legislature on cost savings and future opportunities for efficiencies that were articulated in the Act, including movement of long term care beneficiaries into a managed care environment.