Presentation to Michigan Legislators

A Start on What You Need to Know About Medicaid in Michigan

January 29, 2019

By
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Topics

- History
- State/Federal Relationship
- Financing
- Covered Lives
- Covered Services
- Service Delivery Systems
- Future – Federal Reform

History

Medicare and Medicaid Passed In 1965

History

- Medicaid replaced Kerr-Mills as federal health program for low income citizens
- Optional for states
  - Michigan was the 25th state to adopt Medicaid in October, 1966
  - Arizona last to adopt in 1982

History

Law Promised Mainstream Healthcare

42 CFR §447.204 Encouragement of provider participation.

The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

State/Federal Relationship

- Choices for states within parameters
- Regulations and State Plan voluminous
- Components of State Plan
- Core Principles
- Waivers
- Federal Financial Participation

State/Federal Relationship

Nature of State Choices and Volume of Laws/Regulations

- State choices include covered services (with some required), reimbursement methods, fee schedules, and many, many more
- Regulations are complex and 700 pages; also other laws and guidance documents; staff need to know substantial part of Medicare regulations which are even more voluminous
- Michigan State Plan is 1,364 pages

State/Federal Relationship

State Plan Components

- Who is eligible?
- What services are covered?
- Who provides services?
- Organization of service delivery system
- Reimbursement methods and rates
- No two state Medicaid programs are identical

State/Federal Relationship

Core Principles

- Comparability of Services – Requires that benefits be consistent for all eligibility groups, geographic areas, and any other factor
- Statewideness – Requires that the service delivery system be consistent throughout the entire state
- Freedom of Choice – Prohibits states from limiting choice of providers

Federal Waivers

Different types of waivers

- 1915s (b, c, or b/c combo)
- 1115
- TEFRA
- 1902e(14)(A)
- 1332?

What are the rules for approval?

State/Federal Relationship

Federal Financial Participation

- Traditional program - %age based on state per capita income
- Floor is 50% and ceiling is 83%
- 57% rough national average; Michigan 64.45% in 2019
- Healthy Michigan is 93% in 2019 and 90% in all future years
- Most administration is 50% but some is 90% or 75% while family planning services are 90%

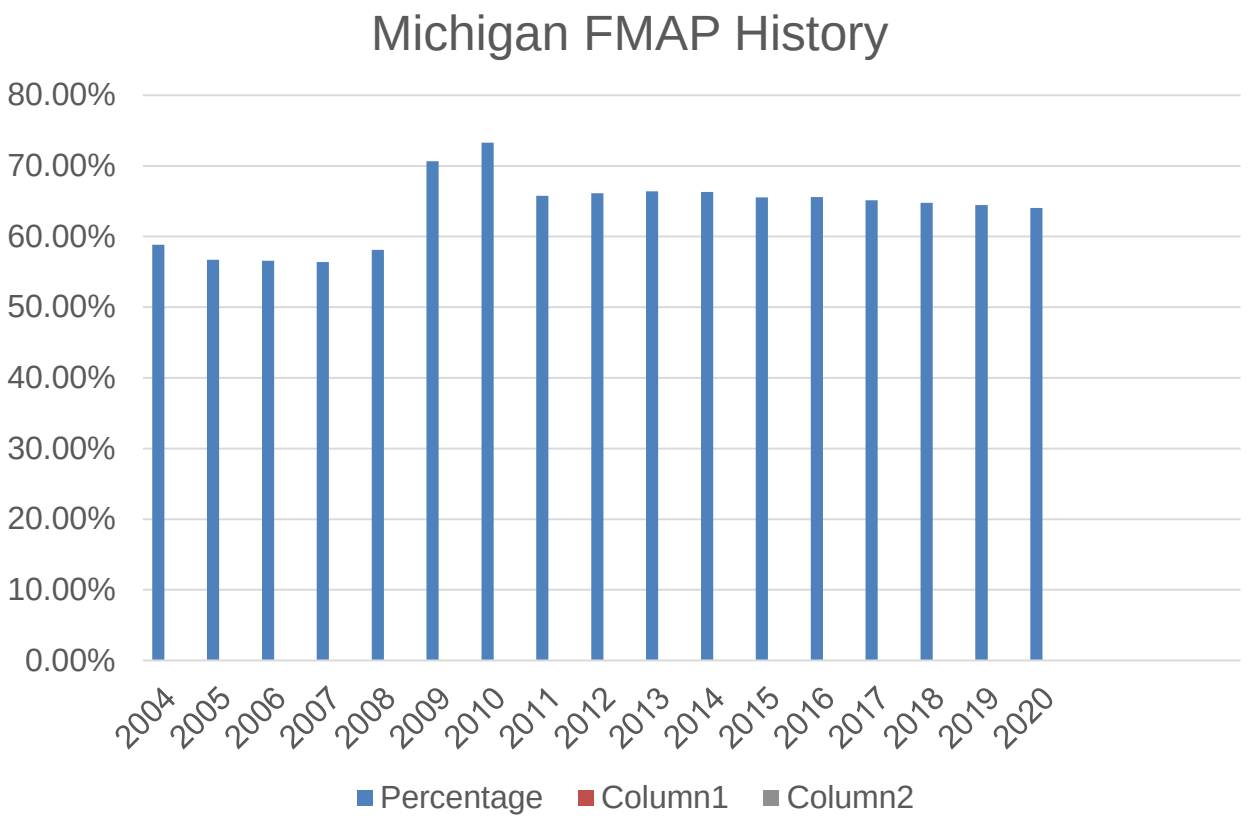
State/Federal Relationship

Federal Financing for Newly Eligible Beneficiaries in Michigan

Year	FMAP
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 on	90%

43

State/Federal Relationship



Financing

- Spending by fund source
- Special financing
- Cost savings options
- Context – health spending trends
- Administration

Financing

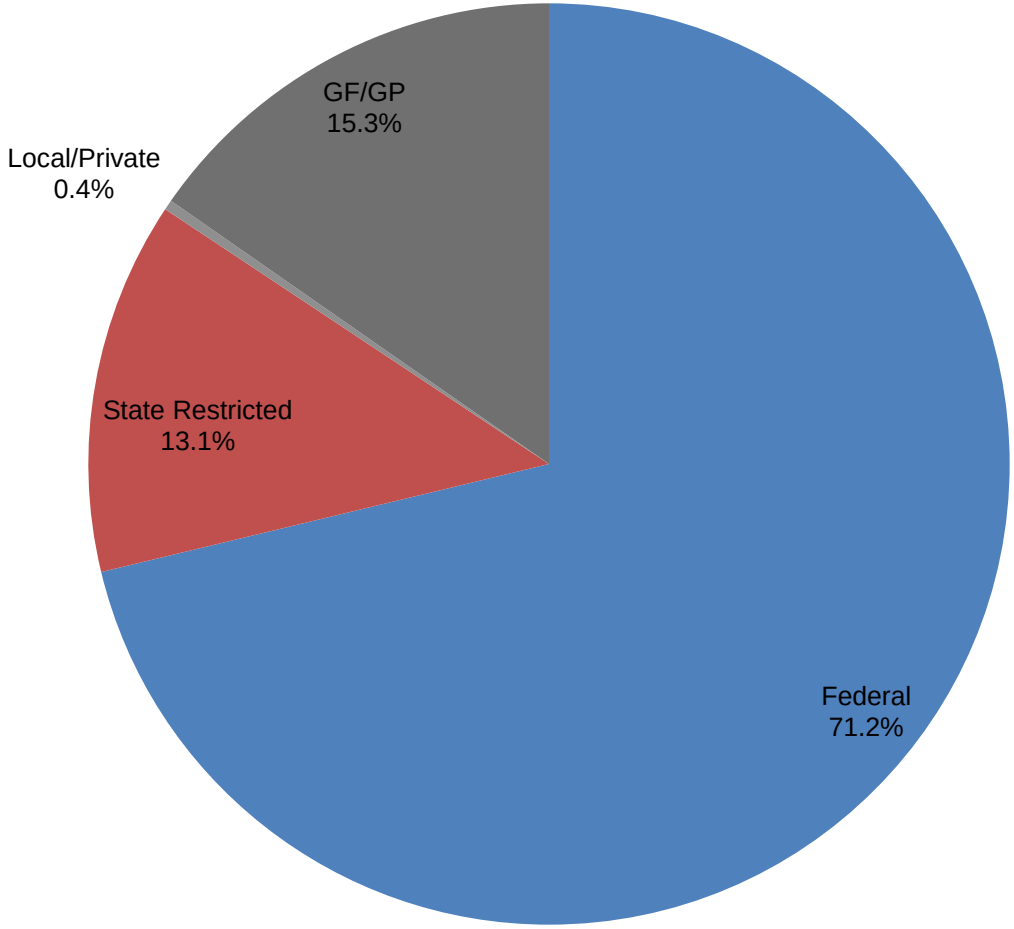
Michigan Medicaid $s by Fund Source

In $'000s for FY19

Federal	$12,620,598.2
Restricted	$2,320,365.9
Local/Pr	$62,445.0
GF/GP	$2,714,204.0
Total	$17,717,613.1

Financing

Medicaid Appropriation Revenue Sources

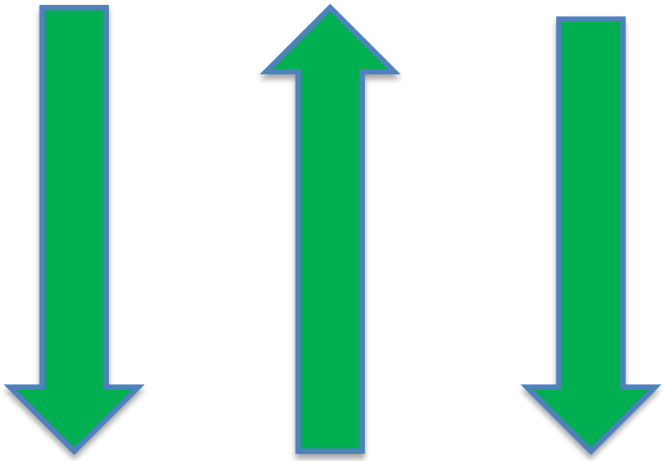


Financing

Intergovernmental Transfers (IGTs)

HURLEY HOSPITAL

Hurley sends $5M



Hurley sends back $10M

STATE OF MICHIGAN

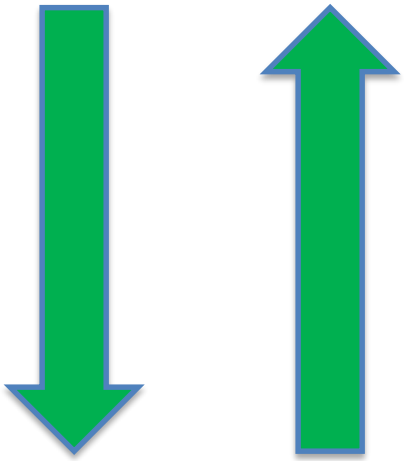
SOM pays Hurley $15M

Financing

Provider Taxes

LICENSED MI HOSPITALS

Hospitals pay $1B in taxes



Hospitals benefit differentially; winners and losers

STATE OF MICHIGAN

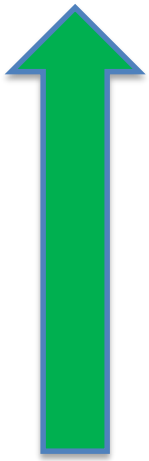
SOM pays uses tax to pay out $2.8B, over $2B to and over $800M to other providers

Financing

Certified Public Expenditures (CPEs)

PUBLIC ENTITIES (E.G., LHDs, SCHOOLS)

Public entity bills Medicaid for covered services



Auditors "certify" that public entity is funded with legal matching revenue source

STATE OF MICHIGAN

SOM pays public entity the federal share for public entity costs that exceed Medicaid payments

Financing

General Observations – Special Financing

- Each method has an elaborate set of rules
- These rules have evolved over the years
- A dynamic process: states invent legal approaches to financing; federal government implements new rules to curb practices it doesn't like; states invent more sophisticated methods; and so on
- Disproportionate Share payments are a great example
- Some rules have been institutionalized; best example is the federal cap on provider taxes at 6% (or 5.5%)
- Overarching principle – there must be a legitimate Medicaid payment

Cost Savings Options

- Traditional Approaches
- Fraud, Waste, and Abuse
- More Innovative Types – Cost Effectiveness
- Short Term Versus Longer Term Perspective

Financing

Traditional Approaches to Cost Saving

- Cut reimbursement rates
- Cut optional services (e.g., adult dental)
- Narrow eligibility levels
- All are problematic in some way
  - rate reductions impact provider participation, access, and uncomp care
  - cutting services leads to more services in inappropriate settings (e.g., EDs)
  - eligibility no longer in play with ACA

Financing

Fraud, Waste, and Abuse

- Define terms – what are we talking about?
- Media and other sources that paint a very grim picture; FBI estimates health care fraud for all payers between 3 and 10% of over $2 trillion
- Medicaid improper payments around 10%
- Health care waste estimated at 30% or more
- Actual fraud found is small fraction of estimates
- Most large providers are heavily audited and there are many federal and state agencies working to prevent and detect fraud

Financing

Fraud, Waste, and Abuse

- The Medicaid “improper payment rate” has hovered around 10% in recent years
- This does not mean that these payments were fraudulent
- Most often it is documentation or process issues that are identified as problematic
- As CMS implements new, more rigorous standards, states and their providers need time to adjust
- An example is requiring that the referring provider be enrolled and identified on the claim

Financing

Innovative Approaches

- Improving cost effectiveness is key
- Michigan Medicaid has the following as a sample of what is already in place:

- Volume purchase programs: incontinence supplies, eyeglasses, and hearing aids
- Medical health homes for individuals with chronic health conditions to reduce ED/IPH
- Require full term deliveries unless medically necessary
- MCOs required to increase Value Based Purchasing

Financing

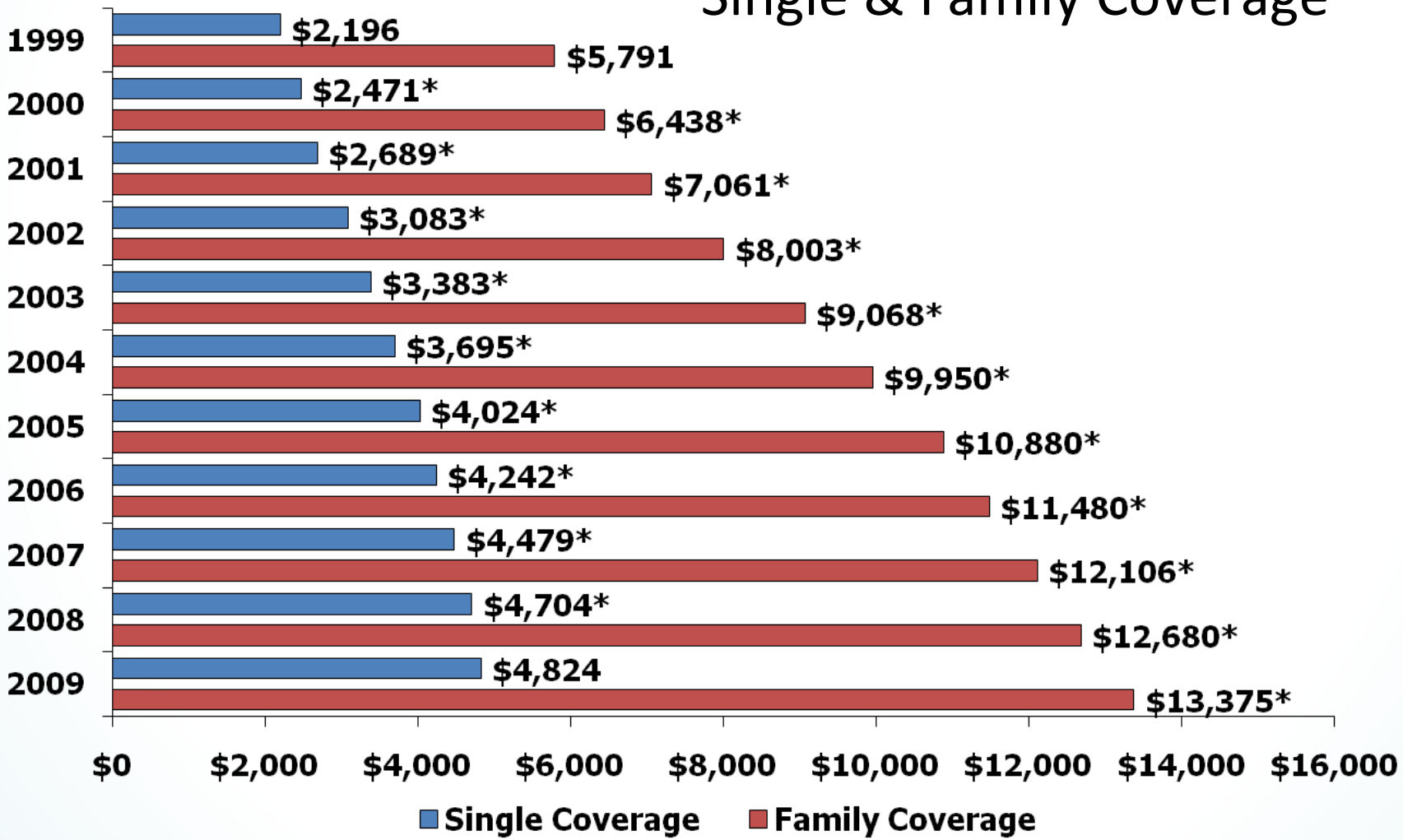
Short Term Versus Long Term

- Healthcare is complicated
- Many service delivery transformations take time (i.e., years) to get results
- Often learning from an initiative calls for modifications rather than ending it
- Both public and private sectors have pressures toward short term payoff (e.g., 2 year terms)
- Challenge to pursue sound policy when the environment works in opposition

Financing

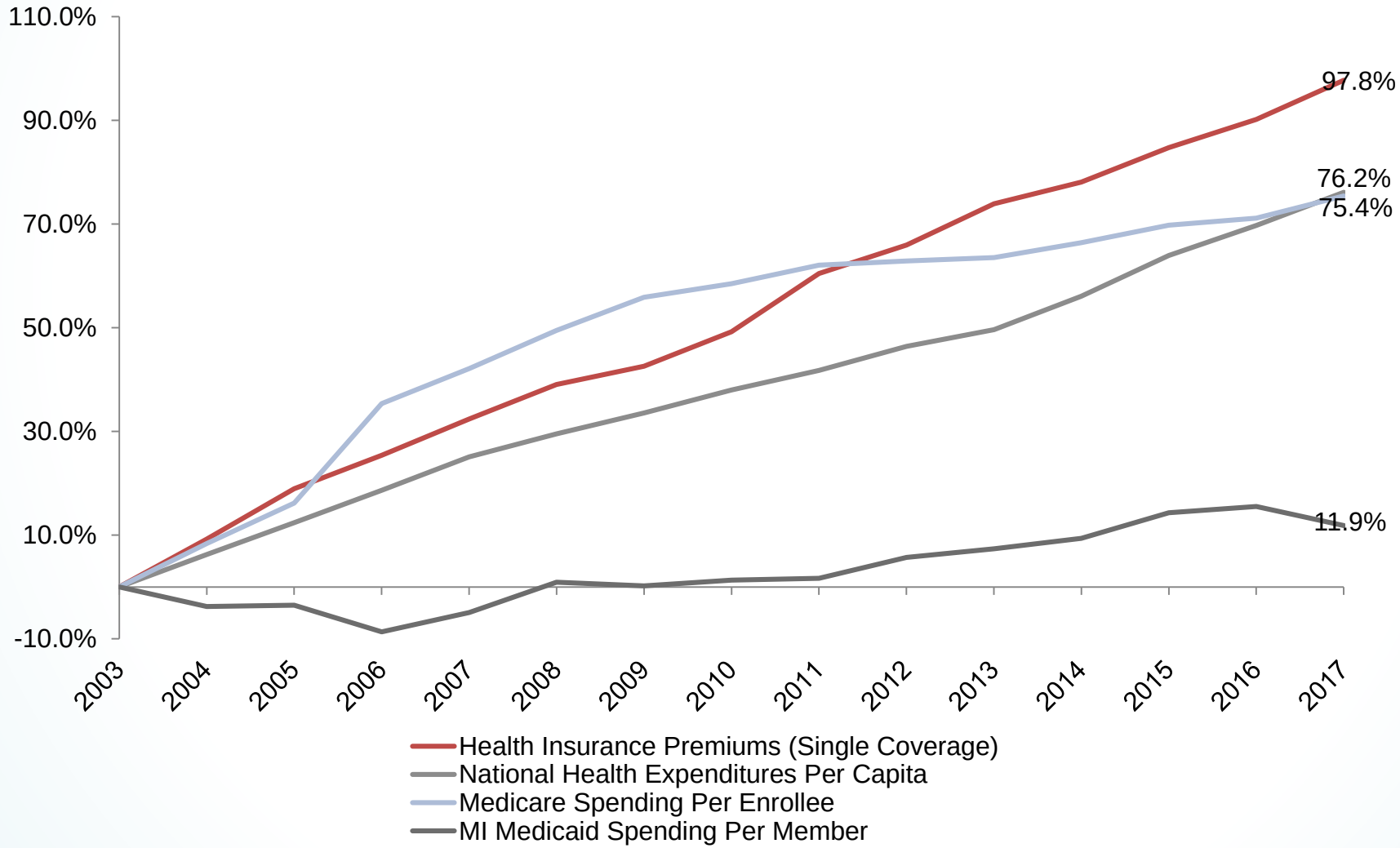
Context

Average Annual Premiums for Single & Family Coverage



Financing

Context – Health Spending Trends



Financing

Context – Health Spending Trends

- National health expenditures (NHE) have grown from $27.2 billion in 1960 to $3.49 trillion
- Over that same time period, NHEs have grown from 5% of GDP to 17.9%
- Under current law, national health spending is projected to grow at an average rate of 5.5% per year for 2017-26 and to reach $5.7 trillion
- On average, other wealthy countries spend about half as much per person on healthcare
- Medicaid is inescapably a part of all of this

Financing

Administration

- Cost is about 1.1% excluding eligibility
- Most functions are to control expenditures
- Prior authorization, third party liability, audit and financial settlement, and claims processing are examples
- Contractors can perform some functions but require oversight
- The Medicaid agency must manage MCOs
- Sound administration produces an accountable system

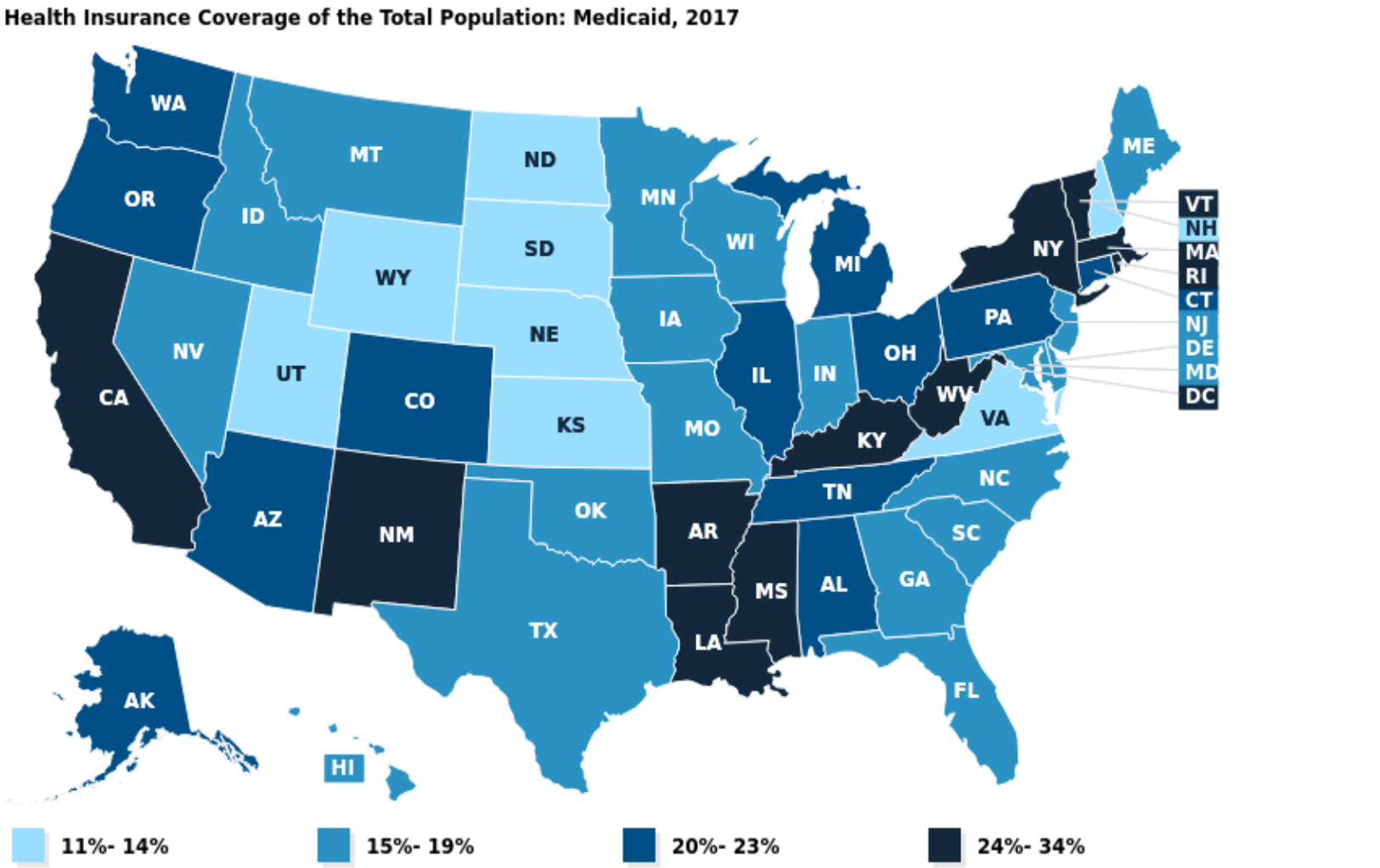
Covered Lives

How Many?

Total Enrollees	2,541,789
Non-Qualifying Spenddowns	41,375
Partial Eligibles	43,782
Total Full Benefit Enrollees	2,456,632

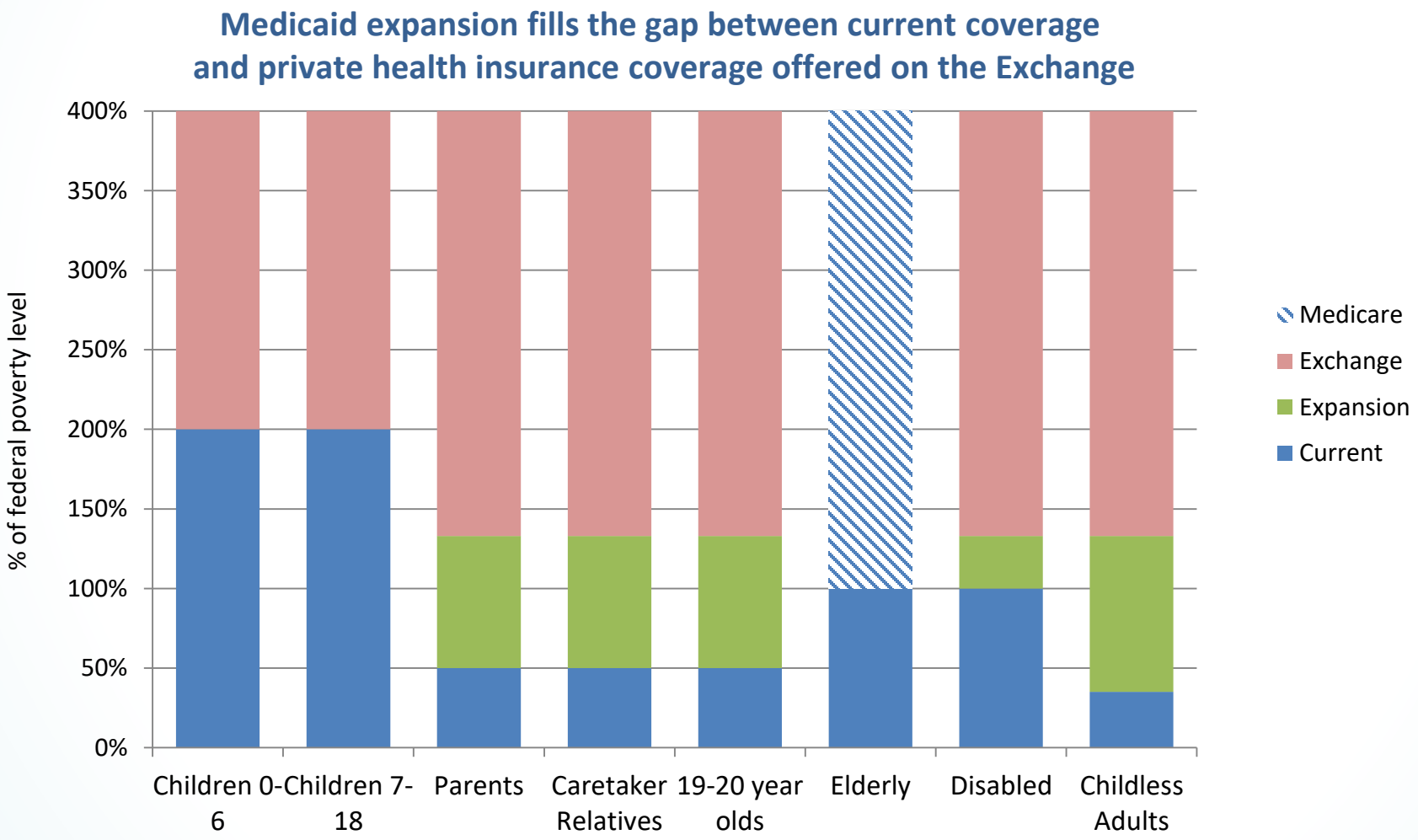
Covered Lives

How Many?



Covered Lives

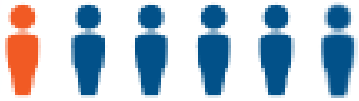
Who Are They?



Covered Lives

Who Are They?

In MI, Medicaid covers:



1 in 6 adults <65

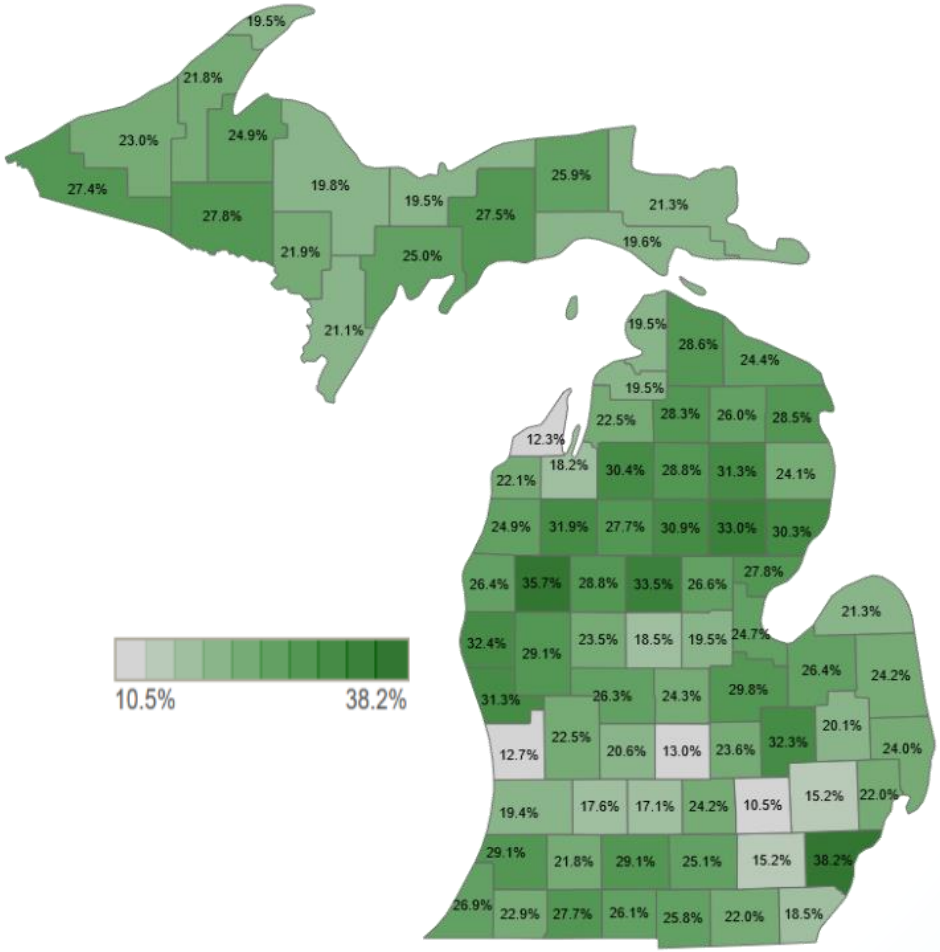
1 in 2 low-income individuals

2 in 5 children

3 in 5 nursing home residents

1 in 2 people with disabilities

Graphic from: Kaiser Family Foundation

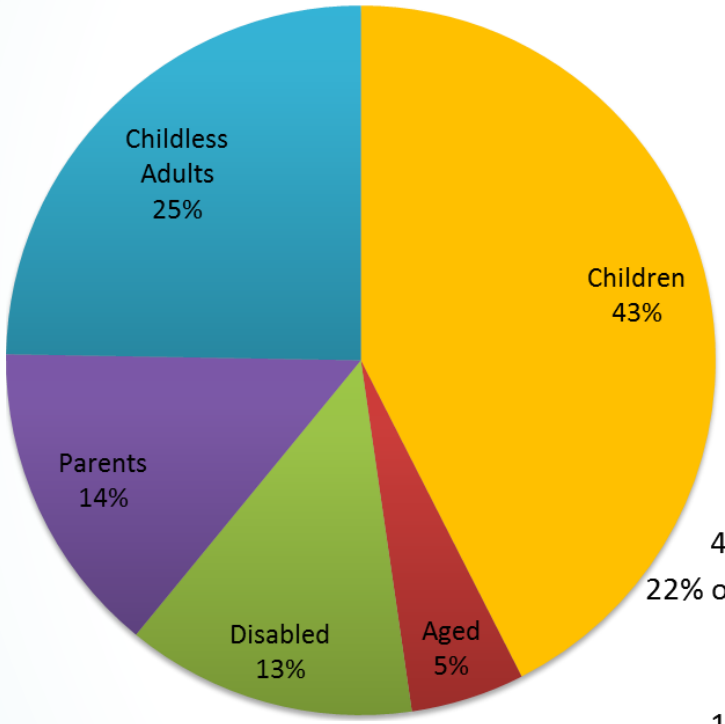


Graphic from: Michigan Health & Hospital Association

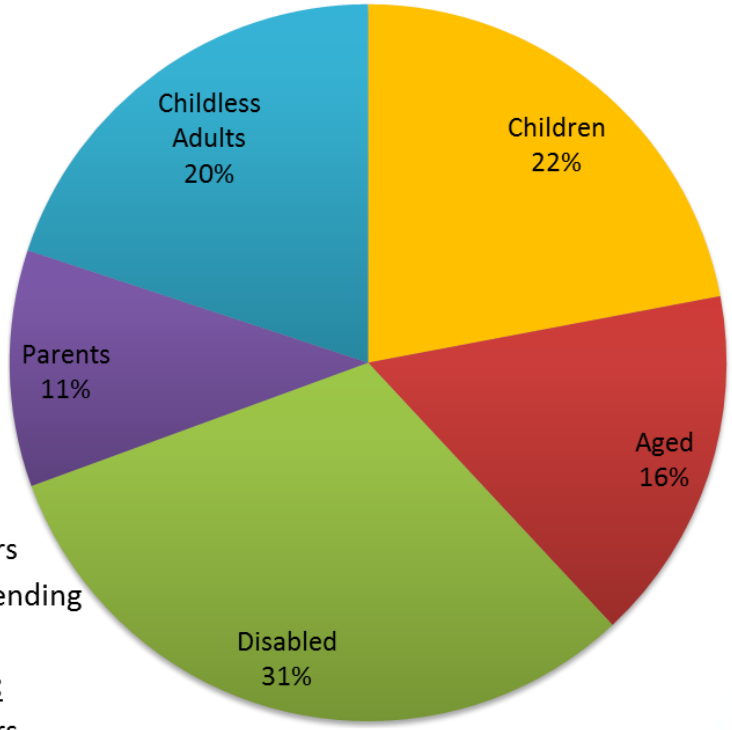
Covered Lives

Who Are They?

Consumers



Costs



Children:
43% of the consumers
22% of total Medicaid spending

Aged and Disabled:
18% of the consumers
47% of total Medicaid spending

Covered Lives

Who Are They?

- Michigan Medicaid has roughly 2.5 million enrollees
- They are not all the same; hence they don't all respond the same way
- This is true even within eligibility category
- Please don't assume there is "a solution" for the entire population, or even some segment
- Medicaid also has a disproportionate number of specific needs such 47% of newborn deliveries

Covered Lives

Why So Many?

	Federal Poverty Line			
Family Size	**100%**	**138%**	**150%**	**200%**
1	$12,140	$16,753	$18,210	$24,280
2	$16,460	$22,715	$24,690	$32,920
3	$20,780	$28,676	$31,170	$41,560
4	$25,100	$34,638	$37,650	$50,200
5	$29,420	$40,600	$44,130	$58,840
6	$33,740	$46,561	$50,610	$67,480

Covered Lives

Why So Many?

- In Michigan, 29% of the population is under 200% of the federal poverty line
- The national average is 28%
- Milliman Medical Index shows total employer and employee health costs combined for an average of $28,166 last year for family coverage
- Median household income was $61,372

Covered Services

Mandatory	Optional
• Hospital • Physician • Lab and X-ray • Nurse midwife • Certified nurse practitioner • Nursing facility • FQHC • Family planning • EPSDT • Home health • Ambulance • Non-emergency medical transportation	• Prescription drugs • Most mental health • Physical & occupational therapy • Optometry • Eyeglasses • Dental • Private duty nursing • Hearing • Chiropractic • Podiatry services • Home-based LTC • Hospice • DME & medical supplies • Orthotics and prosthetics • Oxygen

Covered Services

A Few Thoughts

- The designation of mandatory and optional services harkens back to 1965; the list has never been updated
- Including the full range of optional services is described by some as “Cadillac coverage”
- This has some truth but the reality is that it makes sense to have an appropriate provider available to meet health needs
- A dentist should treat oral health problems otherwise some end up in the Emergency Department at a far higher cost per encounter

Service Delivery Systems

Major Types

- Historically the U.S. system has been operated on a **fee-for-service (FFS)** basis; this means that a provider bills for each service that they render
- FFS has been associated with “freedom of choice” which is a foundational principle in Medicaid
- **Managed care** (primarily through HMOs) organizes the controls service delivery
- Managed care connects beneficiaries to primary care and other providers when appropriate; it also works to assure cost effective care
- Newer forms like **ACOs** attempt to bring providers (especially physicians) into value-based payments

The Future – Federal Reform

Basic Bargain With States

Fewer Dollars

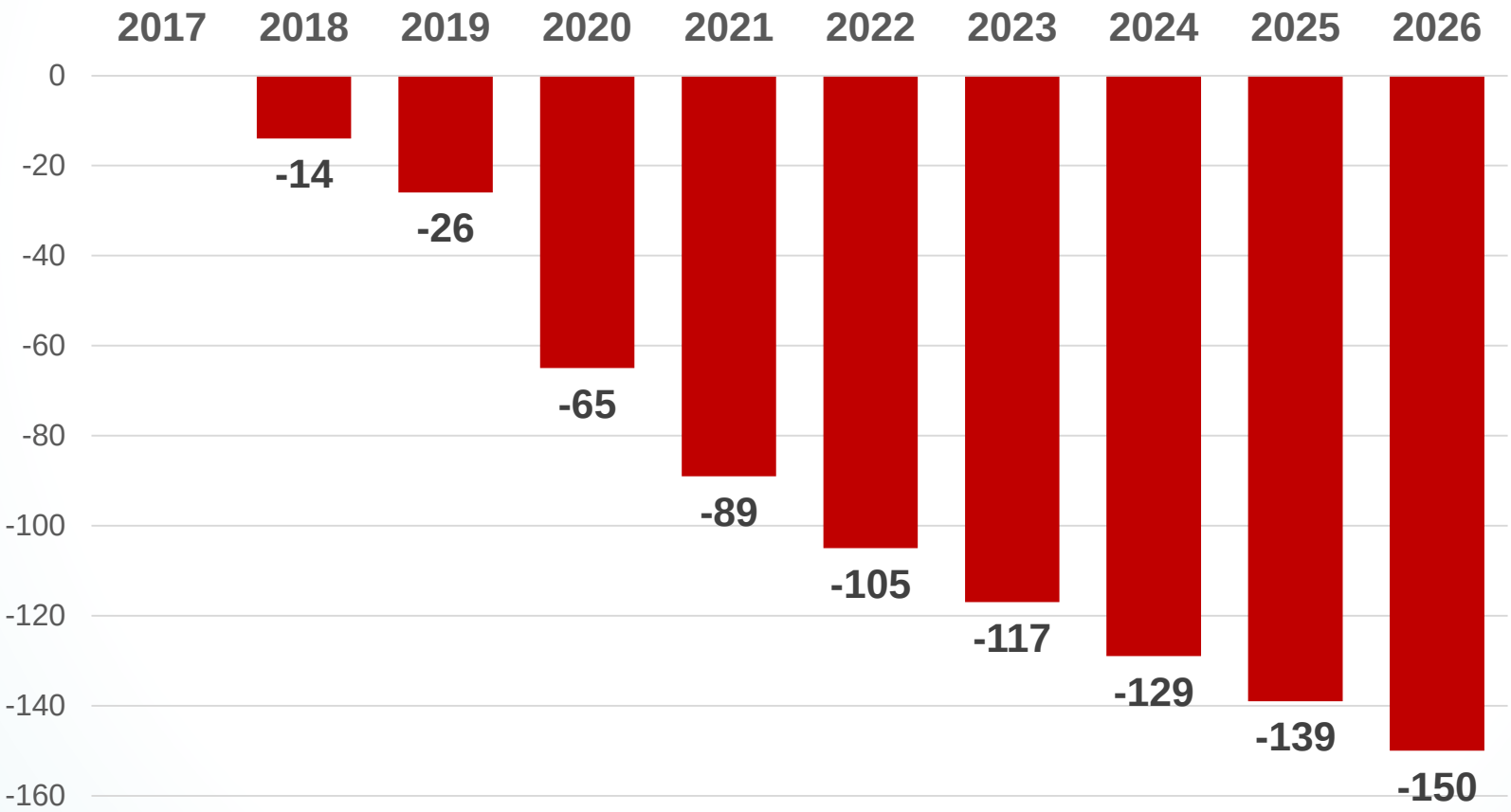
For

More Flexibility

The Future – Federal Reform

AHCA *Dollar* Cuts in Federal Medicaid Payments to States, 2017 - 2026

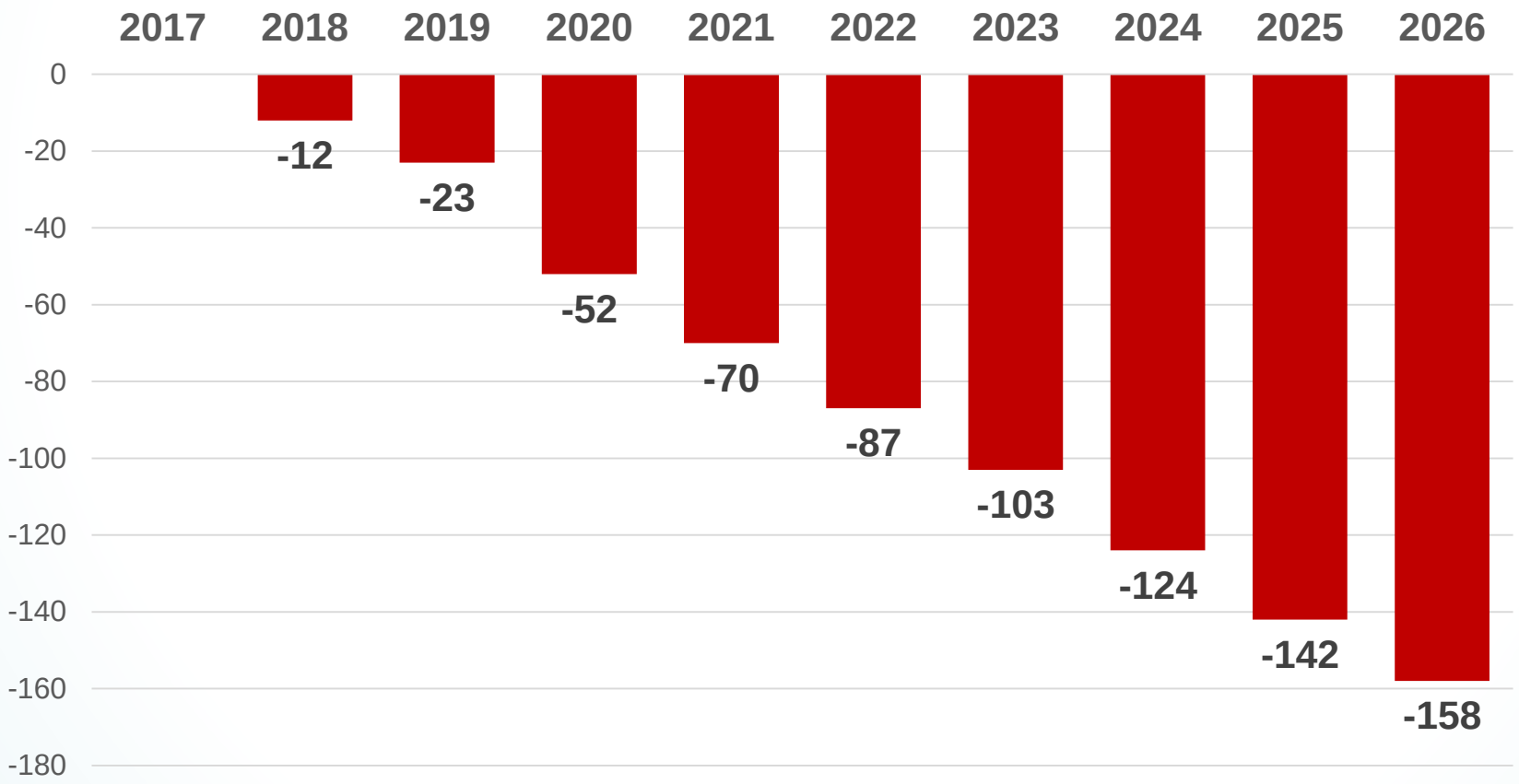
$ Billions per Year



The Future – Federal Reform

BCRA *Dollar* Cuts in Federal Medicaid Payments to States, 2017 - 2026

$ Billions per Year



Medicaid Overview