October 13, 2011

Medicaid Health Plans of America

Senator Patty Murray
448 Russell Senate Office Building
Washington, DC 20510

Dear Senator Murray,

As you and your colleagues on the Joint Select Committee on Deficit Reduction work to find savings to address the debt and deficit, Medicaid Health Plans of America (MHPA) would like to offer two policy proposals that would improve the Medicaid program and yield significant savings.

Coordinating Care for the Dual Eligibles

There are an estimated 9 million "dual eligibles" in the U.S. today. These individuals qualify for both Medicare and Medicaid. Dual eligibles account for only 16 percent of Medicare enrollees but 27 percent of Medicare outlays. They comprise 15 percent of Medicaid enrollees but more than 39 percent of Medicaid spending. The disparate benefits of the two programs – Medicare covers acute health care services and prescription drugs and Medicaid covers long-term care services and supports, as well as Medicare premiums and copays – need to be managed in order to make care more cost-effective.

MHPA believes that better integrating and coordinating care for individuals in these two programs will lead to better health outcomes and provide significant savings to the state and federal governments. A report we commissioned by the Lewin Group in 2008 found the potential of $148 billion in federal savings over ten years by enrolling all dual eligibles into capitated Medicaid health plans. The President's National Commission on Fiscal Responsibility and Reform also recommended Medicaid managed care as a more cost-effective means for delivering health services to these disabled and elderly beneficiaries.

MHPA supports giving states the option to passively enroll dual eligibles into a universal coordinated care program. States could either directly administer the program or contract with CMS for the program to be operated under Medicare. In both cases, states, the federal government, and health plans could enter into three-way capitation contracts.

Individual beneficiaries would have the opportunity to "opt-out" if they so choose for 60 days, after which they would remain in the plan without any eligibility redetermination occurring until the end of the enrollment period. Through this mechanism, individual beneficiaries would maintain the "freedom of choice" to choose not to participate in a coordinated care plan. However, individuals could also be incentivized to participate by either being charged modest

cost-sharing for remaining in the FFS system or by receiving additional benefits such as long-term services and supports not otherwise available under a state's Medicaid program if they enroll in a coordinated care plan. Plans would also be able to offer non-nominal incentives such as coupons for over-the-counter drugs to encourage enrollees' participation in care management activities or to reward desired behaviors (e.g., getting screening tests). We believe this approach would offer the proper incentives for individuals to stay enrolled and actively participate in the universal coordinated care program.

The coordinated care option administered by states would allow for Medicare and Medicaid financing to be integrated in two ways. Under one approach the Medicare program would provide an aggregate payment to states based on actuarial projections that take into account underlying demographic and risk characteristics of the dual eligible population. This funding would be blended with Medicaid financing into a single capitated payment to a Medicaid managed care plan. The actuarial value of the Medicaid component would be based on the historical cost of Medicaid state plan services and Medicare cost sharing. Alternatively, states would contract with existing Medicare Specials Needs Plans (SNPs) to provide Medicaid-covered services and cost sharing through a single capitated payment using the same methodology. Either way, combined payments would reflect anticipated savings achieved through a fully integrated program and states would be allowed to retain a portion of any realized savings to encourage their participation.

Under the coordinated care option administered by Medicare, health plans would bid against benchmarks based upon counties' Medicare FFS costs, similar to the way plans currently bid for Medicare Advantage. Payments would be risk-adjusted to reflect the severity of enrolled dual eligibles. Plans would be at risk to manage enrollees' costs within the capitated payment, but would also share savings equally with the federal government and states for bids below the benchmark. Up to three different benefit packages would be offered that include Medicare Parts A, B, and D, Medicaid-covered cost sharing, and varied Medicaid benefit packages, giving states a choice of optional Medicaid service plans to meet the needs of their dual eligible population. However, eligibility requirements would be standardized across participating states. States choosing this option would make residual payments to the federal government based on the actuarial value of the Medicaid benefit package they choose and Medicaid-covered cost sharing, adjusted for inflation.

States could pursue an integrated option through a standard State Plan Amendment rather than a waiver process, but would be required to make a three-year commitment to either approach. Unlike previous initiatives, these state options would provide an opportunity for truly efficient administration of Medicare and Medicaid benefits under streamlined rules and integrated financing that would maximize coordination of care. Consumer protections would be retained, but Medicare and Medicaid quality standards, reporting requirements, and grievance and appeals processes would be aligned across both programs to avoid unnecessary duplication. For example the Medicare Advantage star rating measures could be used as a starting point for developing a

set of quality metrics, so long as they are tailored to meet the special needs of the dual eligible population and include functional status measures for individuals at risk of institutionalization and recipients of long-term services and supports.

The Centers for Medicare and Medicaid would retain authority to monitor compliance, would be responsible for setting and enforcing standards for actuarially sound payment rates for health plans and calculating savings under the state-administered option, and would administer benchmarks and the bid process, as well as determine shared savings, under the Medicare option. States choosing to directly administer a fully integrated program would have the flexibility to set provider network requirements, utilize performance incentives for health plans, and implement program integrity measures, but would also be required to standardize the provision of eligibility data to plans.

Exempt Medicaid and CHIP Premium Revenue from the Annual Insurer Fee

The Patient Protection and Affordable Care Act places an $8 billion annual fee on the health insurance industry in 2014, which gradually increases to $14.3 billion in 2018. The fee applies to commercial, Medicare, Medicaid and CHIP health risk revenues.

Applying the fee in Medicaid and CHIP taxes the benefits of our poorest citizens and raises costs to states and the federal government because of the federal actuarial soundness requirement governing the payment of health plans that participate in the Medicaid and CHIP programs. The actuarial soundness requirement requires states to pay Medicaid and CHIP health plans adequately based on their medical costs, administrative costs, taxes and fees. Because more than half of every dollar spent on Medicaid is federally funded, the tax will also be passed along to the federal government and is essentially the federal government taxing itself. We are commissioning a study from a respected national actuarial firm to analyze the cost of the fee to states and the federal government, which we should have available in the next month and will share with you. We believe the impact of the fee to be a significant cost to the federal government over time.

MHPA recommends amending PPACA to exempt all Medicaid and CHIP premium revenue when assessing the fee.

We thank you for your attention to these matters which we believe would improve the Medicaid and Medicare programs while providing billions in savings to the federal government.

Sincerely,

Thomas L. Johnson
President and CEO