



MHPA Health Reform Recommendations

Approved June 3, 2009

Every American should have health coverage that includes an organized system of care. Covering the uninsured will undoubtedly require public and private sector solutions, including an expansion of Medicaid. However, experience shows us that the care coordination available in fee-for-service Medicaid is inadequate to ensure quality outcomes and the best use of taxpayer funds.

Medicaid health plans have been leaders in utilizing medical home models to provide a regular source of primary, preventative, and specialty care and in implementing disease management techniques to improve the health of individuals with chronic conditions. We believe Medicaid health plans are well-prepared to help address the most immediate challenges in expanding coverage and implementing delivery system reform. We bring these recommendations to the health reform efforts and stand ready to assist in being part of the solution.

Recommendation #1: Expand Medicaid eligibility for all Americans up to 150% of poverty while maintaining current categorical eligibility pathways.

States, in partnership with health plans, have experience in identifying and enrolling low-income uninsured Americans eligible for Medicaid and SCHIP. This population is often the hardest to reach because they may not have access to employer coverage or cannot afford private health insurance in the individual commercial market, but also may not fit into one of Medicaid's eligibility categories. Approximately one-half of the uninsured are considered low-income. To cover a significant number of uninsured Americans, expand eligibility to 150% of the Federal Poverty Limit and encourage states to contract with Medicaid health plans to provide a comprehensive set of fully-integrated, coordinated benefits including pharmacy, dental, and behavioral health care.

Recommendation #2: Require CMS enforcement of actuarial soundness requirement.

Federal law requires states to provide Medicaid health plans with prepaid payments that are actuarially sound, yet states use a variety of rate-setting methods that are often influenced by state budgetary factors. While the Secretary of HHS, through CMS, is required to certify that state rates are actuarially sound, enforcement of this requirement through the CMS regional offices has been inconsistent. Congress can ensure the federal-state partnership remains strong through enforcement of actuarially sound payment rates.

Recommendation #3: Extend the Medicaid Prescription Drug Rebate Program to pharmacy benefits provided through Medicaid managed care organizations.

Because states only capture rebates on pharmaceuticals provided in fee-for-service Medicaid, states are increasingly carving out pharmacy benefits from Medicaid managed care plans, disrupting coordination of care for beneficiaries and discouraging quality care.

The Medicaid Prescription Drug Rebate Program should be extended to pharmaceuticals provided to individuals receiving pharmacy benefits through Medicaid health plans. Enactment of this policy would bring large new revenue to states and the federal government to finance health reform and cover the uninsured.¹

Recommendation #4: Add an automatic countercyclical trigger mechanism to the FMAP formula to increase the federal share in economic downturns.

Congress should update the matching formula to more adequately account for Medicaid's countercyclical nature. State Medicaid rolls increase during downturns in the economy when more people lose their jobs, yet state budgets are ill-prepared to handle increased enrollment during these tough times. Increased federal matches should include state maintenance-of-effort requirements for Medicaid eligibility, benefits and provider reimbursement.

Recommendation #5: Create a system that covers all kids regardless of income.

No child in America should be without health coverage. We support a mandate that all kids have coverage. We also support the current SCHIP reauthorization which allows states to cover kids to 300% of poverty as a foundation to ensuring all kids have access to coverage.

Recommendation #6: Allow a state option for mandatory managed care enrollment programs for all populations.

To improve care coordination for low-income and special needs populations, states should be able to more easily gain approval from the federal government to require enrollment in a managed care plan for all Medicaid populations. Enrollees should have a choice of competing plans when two or more plans exist in the market. States should be given the ability to implement such programs through State Plan Amendment instead of the more burdensome waiver process.

Recommendation #7: Craft a national strategy on long-term care.

Medicaid pays almost 50% of the nation's post-acute and long-term care costs, and such costs account for about 35% of total Medicaid spending.² Projected growth in long-term care costs in the current Medicaid program—due to the dramatic increase in projected growth in the population of senior citizens—is not sustainable. Any comprehensive health reform bill should include a section on long-term care. We support efforts to increase access to home and community-based services to improve quality of life and choices for people with disabilities. Medicaid health plans are uniquely positioned to serve the elderly and disabled populations by coordinating benefits and support services.

Recommendation #8: Integrate the Medicaid and Medicare programs for the dual-eligibles by enrolling them into managed care.

Medicare and Medicaid benefits for the dual-eligible population should be better integrated to provide for the seamless provision of health care services from the individual's perspective. The clinical and eligibility characteristics of the dually eligible population are exceptionally well-matched to the strengths

¹ The Congressional Budget Office has scored this provision at \$11.0 billion in revenue to the federal government in FY2010-FY2019. Congressional Budget Office, Option 75, Budget Options, Volume 1: Health Care: December 2008.

² American Health Care Association. A Plan for Long-Term and Post-Acute Care Financing and Coverage Reform. March 2009.

of a fully integrated care program operated by at-risk health plans. Large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting.³ Policymakers should permit states to enroll all dual eligibles into a coordinated care setting with one plan for Medicare and Medicaid services, and permit states to share with the federal government in the net savings that otherwise accrue entirely to the Medicare program in the early years.

Recommendation #9: Improve Medicaid and SCHIP data collection at CMS on quality, outcomes, and cost for fee-for-service Medicaid and Medicaid managed care.

CMS should develop reporting measures on care coordination, quality and outcomes in Medicaid and be required to collect the data on such measures in a central location and to make the data publicly available. Likewise, CMS should collect and evaluate quality measures for Medicaid enrollees that are not Medicaid-specific if reported and collected elsewhere. To strengthen the evaluation component, all data should include and be equally applied to fee-for-service and managed care. When applicable, CMS should be required to make appropriate comparisons between fee-for-service programs and managed care in reports and studies.

Recommendation #10: Use Medicaid health plan medical home model as the recommended medical home model in delivery system reform.

When looking at delivery system reform and creating a medical home model as standard practice across all programs, policymaker may look at the medical home concept already being provided in Medicaid health plans. Medicaid health plans have been leaders in using the medical home model to provide a regular source of primary, preventative, and specialty care without an additional administrative cost or fee. Similarly capitated health plan payment systems combined with subsidies to improve the primary care workforce and incentives to increase the dispersion of providers would strengthen the provision of primary care in the United States.

Recommendation #11: Encourage states to partner with Medicaid health plans to strengthen efforts to fight fraud.

States should be encouraged to partner with Medicaid health plans to identify and curtail waste, fraud and abuse in Medicaid. With advanced claims processing systems, data reviews and analytic tools, health plans are better able to identify irregular billing patterns and find outliers that may need corrective action. MHPA supports efforts to strengthen the cooperation between states and health plans in fighting fraud. Such efforts should involve clear, consistent communications on the expectations of the plans, and should not involve additional unfunded administrative burdens. Medicaid health plans want to be the leaders in eliminating fraud and abuse in Medicaid to protect taxpayer dollars.

³ The Lewin Group estimated a potential combined federal and state, Medicare and Medicaid savings of \$301 billion over the 15-year period 2010-2024 if all dual eligibles were transitioned into a capitated managed care plan. The Lewin Group. Increased Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities. November 2008. http://mhpa.org/upload/LewinDual_eligibes2.pdf

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